THE UNITED REPUBLIC OF TANZANIA

Ministry of Health and Social Welfare

Results Based Financing (RBF)

Design Document

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Table of Contents

Foreword

Since the adoption of the Millennium Declaration in 2000, development assistance for health has more than doubled and yet the increase in investments has not translated into the expected health outcomes in low and middle-income countries.Tanzania through the MoHSW is planning to implement the Results Based Financing (RBF) to improve accessibility, utilization (quantity) and quality of health services to the communities including, the vulnerable groups through increased accountability and responsiveness.

RBF is a new strategy which has the potential to reform the health sector with system-wide effects on service delivery, leadership and governance, human resources, health management information systems, medicines and health technology. Strengthening health systems consequently improves accountability, efficiency and equity. This was recognized by the Mid Term Review of the Health System Strategic Plan III which recommended instituting performance management systems through a pay for performance strategy as well as ensuring a functional Open Performance Review and Appraisal System. The recommendation is in keeping with the MoHSW strategy on motivation of human resources through a performance-based approach.

This national RBF system is geared towards achieving universal health coverage (WHO 2010).In 2005; the World Health Assembly described universal health coverage as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access". RBF seeks to increase coverage of the population by incentivizing health facilities to increase deliveryof core services in the Basic Health Services package. The focus is at the council level (Local Government Authority) and health facilities, where the interaction with the population takes place.

In order to facilitate RBF implementation, this Designdocument provides anoverarching guideline for its implementation. The implementation of RBF will be integrated into the existing health system and not run as a parallel system. The government is committed to a successful RBF implementation. All stakeholders have the obligation to ensure that the implementation in Tanzania is successful. We express our sincere gratitude to all for working to achieve the development of RBF. Together we can improve the health of the Tanzanian population.

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The RBF Team would not have been able to perform its majority of its tasks without the financial and technical assistance provided by RBF Task Force under the leadership of the Assistant Director Policy of MoHSW. The Task Force comprised of development partners from World Bank, United States Agencies for International Development (USAID), GIZ, DFID, SDC,Norad as well as MoHSW and PMORALG officers. Furthermore, all stakeholders including the Health Financing Technical Working Group provided constructive contributions and support to contribute toa well designed mechanism.

Special thanks go to the Deputy Permanent Secretary for Health of PMORALG, Permanent Secretary and Chief Medical Officer of MoHSW for their continuing efforts to initiate RBF in the health sector.

Lastly our grateful acknowledgement goes to the RBF Team members for their tireless effort of incorporating all the inputs from different stakeholders that has resulted in a quality Design Document for RBF system in Tanzania.

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Acronyms

AMO	Assistant Medical Officer
ANC	Antenatal Care
CCHP	Comprehensive Council Health Plans
CHF	Community Health Fund
CHMT	Councils Health Management Team
CHSB	Council Health Services Board
CSO	Civil Society Organization
DED	District Executive Director
DHIS	District health Information System
DHS	Demographic and Health Surveys
FBO	Faith based Organization
HC	Health Center
HFGC	Health Facility Governing Committee
HMIS	Health Management Information System
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSSP	Health Sector Strategic Plan
IAG	Internal Auditor General
ICT	Information and Communication Technology
LGA	Local Government Authority
MDG	Millennium Development Goal
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (Strategy for Wealth and Poverty Reduction in Tanzania))
MO	Medical Officer
MoF	Ministry of Finance

MoHSW	Ministry of Health and Social Wellfare
MoU	Memorandum of Understanding
MTR	Midterm Review
NBS	National Bureau of Statistics
NGO	Non- Governmental Organization
NHIF	National Health Insurance Fund
OPD	Out Patient Department
OPRAS	Open Performance Appraisal System
P4P	Pay for Performance
PBF	Perfomance Based Financing
PER	Public Expenditure Review
PMORALG	Prime Minister's Office, Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
RAS	Regional Administrative Secretary
RBF	Results Based Financing
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
SOPs	Standard Operating Procedures
THE	Total Health Expenditure
TMA	Tanzania Mentoring Association
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	World Health Organization
ZRC	Zonal Resource Centre

1. Introduction

Preamble

Results-based financing (RBF) is a relatively new innovation in health financing, with the potential to boost health system functioning and facilitate the move towards universal health coverage. This strategy links financing to pre-determined indicators (or services) and hence accelerates the achievement of health targets as well as strengthening the health system.

The purpose of introducing RBF in the country is to strengthen the health system as well as to accelerate the achievement of universal health coverage (WHO 2010); The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. In 2005, the World Health Assembly described universal health coverage as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access". RBF system require systematic monitoring and documentation of system design and implementation, as well as thorough evaluation of effects.

This RBF design document lays out the main characteristics of the planned RBF system in Tanzania and is a living document which will be adapted according to needs. This document is a guiding tool for the implementation of the system and sets out the principles, objectives, results to be purchased, and institutional arrangements. Detailed information and guidelines for the implementation of RBF, and particularly important resource for those working at regional and council levels, is well elaborated in the RBF Operational Manual.

Country Profile

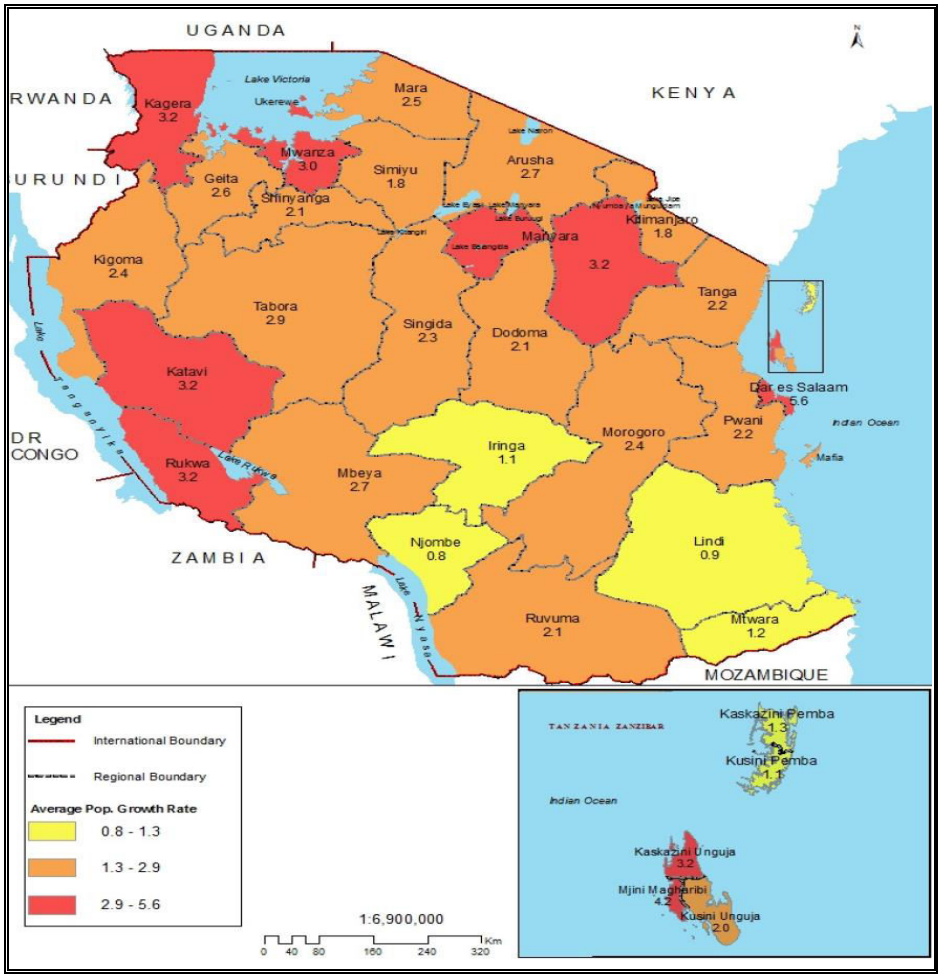
The population of Tanzania mainland is estimated to be about 43,625,354million people with average annual growth rate of 2.7 % (NBS2012). It is the largest country in East Africa, occupying an area of about 945,087 sq. km, and has a common border with 8 neighboring countries. About 75% of the population lives in rural areas. Administratively, Tanzania mainland is divided into 25 regions, shown in Figure 1 below. The regions are further divided into 167Local Government Authorities (LGAs) known also as councils. The council are the implementing units formost services in the country.

Table 1: Tanzania mainland population in 2012

Estimated Population	43,625,354
Population density	51 per km2
Population composition	Male 21,239,313;Female 22,386,041
Total fertility Rate	5.2
Average life expectancy	61 years
Population growth rate	2.7 % per annum

Source: NBS 2012

Figure 1: Map of Tanzania showing regions



The Health System

The Government operates a decentralized health system, organized around three functional levels: council (primary level), regional (secondary level), and referral hospitals (tertiary level). . Within the framework of the ongoing local government reforms, regional and councils have full responsibilities for delivering health services within their areas of jurisdiction, and report administratively to the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG).

Under this system, the councils have full mandate for planning, implementation, monitoring and evaluation of health services. Each council has a District Medical Officer (DMO) who heads the Council Health Management Team (CHMT) and is answerable to the District Executive Director, the head of the council. CHMTs are responsible for provision of services in dispensaries, health centers and district or District-Designated Hospitals[1].(DDH)

The Regional Health Management Teams (RHMTs) are responsible for interpreting health policies at the regional level. The Ministry of Health and Social Welfare (MoHSW) is responsible for policy formulation,supervision and regulation for all health services throughout the country, as well as playing a direct role in the management of tertiary health services

Table 2: Distribution of health facilities in mainland Tanzania

Facility type	Public	Parastatal	FBOs	Private	Total
Hospital	112	9	111	33	264
Health Center	467	19	139	59	684
Dispensary	3,990	192	597	790	5,607
Total	**4,569**	**220**	**847**	**882**	**6,518**

Source: MoHSW 2013

There are about 6,518 health facilities, of which 70% are owned by the public sector (MoHSW2013). The system is in the form of a pyramid on top of which there are specialized hospitals owned by the Ministry and at the bottom are primary health care facilities. Almost 85% of the population gets their health services from primary health care facilities (MoHSW 2013), however they face a lot of challenges in delivering services including poor infrastructure, shortage of skilled staff and essential medicines.

The main challenge of the health sector in Tanzania is the shortage and mal-distribution of human resources for health (HRH) which affects the availability and readiness of health services across regions, districts and health facilities. In 2012, the health sector was reported to have a total of 64,449 staff, the majority of them being medical attendants and allied health professionals (HRH profile, 2012). According to the HRH Public Expenditure Review (PER) of 2010, the HR gap was about 60% (MoHSW HRH Report, 2011). The health sector is challenged with production, attrition and retention of health professionals. A recent study documenting staffing levels and productivity in southern Tanzania (Manzi *et al,* 2012) found inadequate staffing of health facilities, high levels of absenteeism and low productivity.

[1]Faith-based hospitals which are designated to serve as council hospital where no government facility exists.

Table 3: HRH per population in Tanzania: 2008 versus 2012

HRH Cadre	2008	2012
Medical Officer	0.3	0.5
Assistant Medical Officer	0.4	0.4
AMO and MO together	0.7	0.9
Nurse/Midwife	2.6	4.8
Pharmacist/pharmacy technician	0.15	0.13

Health worker per 10,000 populations. Source: 2012 HRHIS

Health Status of the Population

The current data on health status of Tanzania shows progress in achieving 2015 health targets. The Mid Term Review analytical report (MoHSW/WHO 2013) shows that there has been improvement for some HSSPIII indicators toward achieving the 2015 targets, such as infant and under five mortality rates, immunization coverage, HIV management etc. However some indicators show no progress despite the various interventions put in place. Table 4provides a trend analysis of the overall progress for the indicators (second column), giving a green code for indicators which will achieve the target of HSSP III, orange for indicators with progress but not likely to achieve the target in 2015, and red for indicators with little or no progress which will not achieve the target by 2015 (MTR report, 2013).

The table also shows an equity analysis (fifth column), whereby indicators showing moderate or large inequity are coloured orange or red respectively. Where possible the types of inequity are identified (G=gender, R=place of residence (urban-rural, or region) and W=wealth quintile). In the sixth column a comparison is presented for the African sub-region with Tanzania's ranks as shown in the column.

Table 4: Performances of HSSP III Indicators

HSSP III indicators

	Overall progress	Achievement	Target 2015	Equity	Compare (rank)
HEALTH STATUS					
Life expectancy (years)		61 (F) /58 (M) (2011)	62/59		
Under-5 mortality rate		81/1,000 (2006-10)	54		1
Neonatal mortality rate		26/1,000 (2006-10)	19		1
Infant mortality rate		51/1,000 (2006-10)	-		1
Child stunting rate		35% (2011)	22%	G R W	3
Child underweight rate		14% (2011)	14%		5
Maternal mortality ratio		454/100,000 (2004-10)	156	G	2
Total fertility rate		5.4 (2008-10)	5.1	G R W	4
Adolescent fertility rate		44% (2010)	39%	G R W	5
HIV prevalence among young people		2.0% (2011/2)	-	G	
HIV prevalence, pregnant women (15-24)					
TB notification rate		75% (2011) 52% (2012)	70%		
Leprosy cases diagnosed and treated					
Cholera incidence rate		343 cases	0		
Cholera case fatality rate		4.1%	<1%		
Malaria prevalence among OPD (lab)	-	33% (under 5) (2012)	-		
Parasitemia prevalence (children)		9.2% (2012)	5%		
COVERAGE OF INTERVENTIONS					
Measles immunization coverage		100% (2012)	85%		1
DTP-Hb 3 immunization coverage		95% (2012)	85%		4
Vit A coverage (2 doses)		60% (2010)	-	G W	7
TT2 immunization coverage		88% (2011)	90%		
ANC first visit > 16 weeks		15% (2006-10)	60%		5
ANC at least 4 visits		36% (2009-10)	90%	R	7
Births in health facilities		58% (2011)	70%	G R W	
Skilled birth attendance		62% (2010-11)	80%	G R W	8
Postnatal care coverage		31% (2006-10)	-		
Contraceptive prevalence rate		27% (2010)	60%*	G R W	5
ITN use (children / pregnant women)		73% /75% (2011/2)	80%		3
eMTCT coverage among pregnant women		77% (2011)	80%		
ART coverage among those in need		65% (2012)	60%		
TB treatment success rate		90% (2011)	85%		2

Health Financing

The Government of Tanzania remains fully committed to achieving the MDGs and universal health coverage, which are contributing significantly in the National Strategy for Growth and Reduction of Poverty named as MKUKUTA in swahili (MKUKUTA II.) As such, at the outset of the third Health Sector Strategic Plan, for the period 2009-15 (HSSP III), the sector is considered to be one of the priority sectors for investment hence considered to be included in the Big Result Now strategy. HSSP III envisioned an increase in the share of government expenditures dedicated to the health sector, targeting the Abuja goal of 15%.It was anticipated that the development of a comprehensive Health Sector Financing Strategy early in HSSP III would serve to guide financing policy, addressing the role of user fees, exemptions and waivers, output-based financing, public funding to non-government providers, and other issues.

Table 4: Per capita health expenditures in TZS (USD in brackets), 2007/08 – 2012/13

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
	Actual	**Actual**	**Actual**	**Actual**	**Actual**	**Budget**
Real Per Capita Health Spending	9,602 (7.61)	10,259 (7.47)	12,068 (8.32)	10,883 (7.51)	12,066 (7.84)	11,769 (7.49)

Source: Mid Term Review of the Health Sector Strategic Plan III, MoHSW, 2013 based on provisional data from the Public Expenditure Review 2011/12

As the Mid Term Review of the HSSPIII notes, "*The period prior to the adoption of the HSSP III saw significant increases in total health expenditures (THE) in Tanzania. Between 2002/03 and 2009/10, THE had tripled. Over this period, Development Partners' share of health expenditures increased from 27% in 2002/03 to 40% in 2009/10. Of the total expenditures in 2009/10, 26% were financed by the Tanzanian government, while donors provided 40% of resources, and households provided 32% of resources. As a share of total resources, government expenditures were generally stable over this period.*"[2]Public sector spending on health has increased during the period 2007/08 to 2012/13 in absolute terms, however as noted in Table 4, in real terms per capita the level of funding has been flat over the period. Furthermore the level of funding into the health sector from domestic versus foreign sources has remained flat during the same period at 2/3 from domestic sources and 1/3 from foreign sources.

Sustainability

In terms of institutional sustainability, RBF fits within the Health Sector Strategic Plan III and will be a core element of the Health Financing Strategy currently being elaborated. The Pwani Pay for Performance experience has provided a significant amount of institutional knowledge within the MoHSW and partner organizations. In the design outlined in this document, all the roles are performed by existing Government of Tanzania entities and those institutions have been selected based on an assessment of their legislated functions and current capacity. The existing structure of the health sector, via the MoHSW, PMORALG,

[2] MoHSW, 2013. Mid Term Review of the Health Sector Strategic Plan III 2009 – 2015, Health Care Financing, Technical Report, Ministry of Health and Social Welfare, United Republic of Tanzania.

regional government and local government has been respected in this design. RBF is therefore entirely Tanzania-owned and the design has been put in place with a minimum of external assistance. The existing health reporting system, the DHIS2, is to be used for reporting of results and will be adapted in order to allow invoicing for RBF results by facilities and councils. This system will also be used to document verified results.

In terms of financial sustainability, an expenditure analysis of a sample of health facilities was carried out to ascertain what is the existing level of resources which health providers have access to in order to provide services. The goal of RBF is to provide an amount of *additional* funds to allow health providers to invest in their capacity to deliver an increased level and quality of services. It is important that there be no substitution with existing funding to facilities. An analysis has been conducted by the MoHSW to assess the maximum level of funding to be provided to each health facility (which is a figure set by facility type for each quarter – a maximum RBF payment no matter the achievement in numbers of clients / patients and in quality) each quarter with an eye on the sustainability of the mechanism after the funding from the donor has finished. It will be important during the course of the implementation to continuously advocate with senior MoHSW leadership and with the Ministry of Finance using evidence of the results achieved through RBF. In advocating for the scale-up of RBF past the three regions targeted for the pilot with World Bank funds, evidence of the cost-effectiveness and efficiency of RBF will need to be presented. The monitoring and evaluation of RBF is therefore of utmost importance, as it is the basis of creating the political will for national scale-up.

An analysis of potential revenue sources to fund a national scale-up has focused on the government's own funds (Other Charges), and the Basket Fund. It is recommended that RBF be incorporated into the government's funding of the health system with a coherent approach taking into account the public health budget, social health insurance, community health funds and donor funding.

The Pwani Pay for Performance Pilot Experience

During the period 2011 – 2013 the MoHSW piloted Pay for Performance (P4) in Pwani region. The aim was to accelerate the attainment of MDG 4 and 5 and to test program components that could inform the nationwide scale-up. Despite health system challenges such as frequent stock outs of medicines and health commodities, late disbursement of funds for supportive supervision etc, there has been a significant uptake of most of the maternal and child health services and is felt to have improved the timeliness and completeness of reporting through the Health Management Information System (HMIS).

The Pwani P4P pilot has provided key lessons such as the importance of integrating P4P activities within the existing structure, provision of facility autonomy, and teamwork. A key lesson learnt in course of implementation of the pilot is that a well strengthened health system enables smooth implementation and achievements of any output-based financing mechanism. For example the chronic stock outs of HIV test kits and SP at the MSD resulted in facilities performing poorly in PMTCT and IPT 2 Coverage. The availability of essential health commodities will need to be addressed in the RBF design through selected quality indicators.

2. Results-Based Financing

Concepts of Results Based Financing (RBF)

Results-based financing for health refers to any system that transfers financial or non-financial incentives either to a patient when they take health-related actions (demand side), or to health care providers when they achieve pre-agreed results (supply side). RBF can also be defined as an approach to development financing based on payments made after results have been delivered and independently verified. A well-designed RBF mechanism motivates staff to deliver quality services and assists them to access the resources needed.

A critical element of RBF is a clear separation of roles between different health sector stakeholder. The key roles in an RBF mechanism are the following:

- The **Regulator** oversees RBF implementation. The regulator develops the policies, guiding documents and tools used for the RBF mechanism. The regulator also provides clinical and technical oversight and supervision.
- The **Facilitator**, contributes to structure and process so that all key players are able to function effectively to bring about the desired outcome by providing indirect or unabtrusive assistance, guidance and supervision.
- The **Purchaser** "buys" specified health or management services, of a specified quality, and enters into agreement with the service provider, is a recipient of services provided under a contract of service.
- The **Funder-holder** disburses the funds to the service providers in accordance with the RBF contract or agreement.
- The **Service Provider** can be a health facility or an agency providing specified health or management services, as set out in a contract or service agreement with a Purchaser.
- The **Verifier**, can be internal or external. **The Internal Verifier** validates results reported by service providers so as to avoid data falsification and overpayments, while the External Verifier counter-check to ensure that the internal verification is of sound quality. Both the internal and external verifier are contracted by the purchaser.

Rationale

Traditionally, government and Development partners funds for the improvement of service delivery have concentrated on increasing critical inputs, such as infrastructure, equipment, supplies, drugs and vaccines. Since the adoption of the Millennium Declaration in 2000, development assistance for health has more than doubled and yet the increase in investments has not translated into the expected health outcomes in low and middle-income countries. The challenge is that these countries face unequal access and coverage to health services, low quality and inefficient delivery of services, and inadequate management capacity due to limited financial resources in their health systems.

In order to address these challenges, many governments and development agencies are adopting innovative approaches that can help improve health system functioning and thus support the move towards achieving UHC. Results-based financing is one such approach. This strategy links financing to pre-determined results. Performance is measured in terms of the quantity and quality of actual services that health facilities deliver to people, and not in terms of the inputs such as medical equipments, salaries and supplies. MoHSW is currently developing a Health Financing Strategy which is oriented towards the achievement of results and thus incorporates RBF strategy to improve the sector's performance.

Results-Based Financing, as a relative new strategy, which has the potential to reform the health sector with system-wide effects on service delivery, leadership and governance, human resources, health management information system, medical supplies, vaccines and equipment, and financial resources. Strengthening health systems consequently improves accountability, efficiency and equity. This was recognized by the 2013 Mid Term Review of the HSSP III, which recommended instituting performance management systems in part through a Pay for Performance strategy (MoHSW 2013).

Goal

The goal of RBF in Tanzania mainland is to improve utilization and quality of health services offered to the community, especially the underutilized and MDG related services. Specifically:

1. To improve the accessibility and utilization of health care services in primary health care facilities;
2. To improve the quality of health services at all facilities in the council;
3. To improve the productivity and efficiency of service delivery by health care providers;
4. To improve the quality and use of data for evidence based decision making;
5. To improve accountability and responsiveness of health management teams and facilities governing committees;
6. Provide equitable access to cost effective quality health care.

3. Indicators

The core of any RBF system is the definition and measurement of the indicators to be "purchased" from the provider. The indicators for the RBF system have been derived from HSSP III and almost all important areas of the health care delivery have been covered; especially MDG targets. The focus has been put on both the quantity and quality of services delivered. Both quantity and quality indicators are not static; they are subjected to change whenever a need arise. Community health workers will start with few indicators based on quantity but these could be increased subject to initial results from the RBF system. There will be indicators for dispensaries and health centres, of which later will be assessed their quality by using a quality checklist (**ANNEX 15 and 16**). The hospitals will be assessed on quality of services they provide. In addition, the RBF system will purchase managerial services from the Council Health Management Teams (CHMTs) and Regional Health Management Teams (RHMTs).

All quantity indicators will be routinely collected through the existing HMIS, which is used throughout the country. The quality indicators will be assessed by using a quality checklist, which will later be incorporated in the existing HMIS. Quality indicators will change basing on improvement in scores, as well as in case of need to better or more precisely target desired quality standards. The indicators are listed below.

Indicators for Community Health Workers

1. Number of non-institutional maternal and perinatal deaths reported within 24 hours to respective health facility
2. Number of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW
3. Number of household visits by CHW

Quantity indicators for Health Centers and Dispensaries

1. Number of new outpatient consultations
2. Number of low income individuals identified by TASAF's hybrid proxy means testing receiving outpatient care
3. Number of children under one year immunized against measles
4. Number of under-five receiving Vitamin A supplementation
5. Number of new users on modern family planning methods
6. Number of pregnant women receiving 2+ doses of intermittent presumptive treatment of malaria
7. Number of HIV positive pregnant women receiving ARVs
8. Number of mothers receiving post natal care services within 3-7 days after delivery

9. Number of pregnant woman attending for ANC at least four times during pregnancy
10. Number of HIV exposed infants receiving ARVs
11. Number of institutional deliveries
12. Number of clients initiated by health care provider to counsel and test for HIV (PITC)
13. Number of TB suspect referred (already screening)
14. Number of first antenatal visits, with gestation age < 12 weeks

Quantity indicators for District hospitals

These indicators are not yet in the Health Management Information System, however they are being included here as a placeholder. As and when they have been incorporated into the HMIS, these indicators will be used in hospitals alongside the quality checklist.

1. Number of patients receiving management and treatment for hypertension
2. Number of women screened for cervical cancer
3. Number of AFB+Ve pulmonary TB cases detected
4. Number of newly diagnosed Diabetes Mellitus patients
5. Number of Voluntary male circumcision
6. Number of premature neonates who received Kangaroo Mother Care

Management indicators for CHMT

1. 100% of monthly facility HMIS reports timely and completely entered in DHIS-2
2. Average (mean) number of tracer medicines available in facilities
3. Council Profile Reports produced and timely submitted to PMORALG and MoHSW
4. Proportion of health facilities enrolled in RBF system that have minimum qualified staffing requirement
5. Proportion of health facilities which received comprehensive supportive supervision visit in the previous quarter
6. CHF enrolment rate increase in the council
7. Compiled quarterly financial report of all health facilities enrolled in RBF
8. Proportion of Planned Preventive Maintenance performed quarterly as budgeted in CCHP
9. Proportion of maternal deaths in health facilities that are completely and appropriately audited and action plan in place
10. Proportion of perinatal deaths in health facilities that are completely and appropriately audited and action plan in place

11. Council Health Service Board [CHSB] meetings conducted quarterly and with complete minutes available

Management indicators for RHMT

1. Spearhead the verification process of the RBF in the region
2. RBF data management and Quarterly HFs RBF data timely entered in the database
3. Participation in R-RBFC quarterly meetings
4. Management of motivation Agreements
5. Timely submission of regional quarterly report,
6. Quarterly report assessment results,
7. Regional Management Supportive Supervision for CHMT (RMSS-C) implementation rate
8. Regional Management Supportive Supervision for Regional Referral Hospital Management Team (RMSS-H) implementation rate
9. Comprehensive Hospital Operational Plan (CHOP) quarterly report submission
10. Human Resource for Health (HRH) Data collection monthly report

4. Assessments Conducted

Public Financial Management Assessment

The Public Financial Management Assessment is currently being conducted. A summary will be included here when it is finalized.

Supply Chain Assessment

The Supply Chain Assessment is currently being conducted. A summary will be included here when it is finalized.

Infrastructure Assessment

In preparation for the RBF system a survey of the physical conditions in 12 health facilities was carried out in Shinyanga Region, in June 2014.The assessment considered that in health facilities, the physical environment must be safe for patients and staff, in the dry season and during the rains. The ground must be level and accessible by patients, including the less agile and those with physical disabilities. It must represent a safe work environment also for the staff. Rainwater from roofs shall be drained away from the building in a way that ensures safe and accessible grounds at all times.

The building(s) must have floors that are even and without settlements, cracks and loose patches, the foundation and walls must be straight, without settlements and cracks, and the roof must be aligned, have

no loose roofing material, and must not be leaking. The internal ceilings shall be fitted in place and have no sagging parts or damaged spots from roof leakage. Windows and doors shall be in a working condition with all joinery, locks and hinges, in place and working, allowing for the lock up of the facility outside working hours. All walls, internal and external, exposed roof structures, fixtures, doors and windows, and ceilings shall be painted to protect against decay and help maintaining a clean and inviting environment.

In facilities where systems for water supply, water borne sanitation and drainage already are installed these systems shall be functioning. In places where systems for power supply have already been installed, either self standing systems such as PVC systems for production of power by solar panels or systems connected to the main grid, these systems shall be safe and working.

The assessment estimated the cost of bringing facilities up to a minimum standard at an average of roughly 11.76 million TZS ($7,000). As noted later in the section on health facility readiness to participate in RBF, those facilities which pass the readiness assessment will receive an amount of funding differentiated by type or size of facility to make minor renovations using local labor.

Social Assessment

A social assessment is a process which provides an integrated and participatory framework for prioritizing, gathering, analyzing, and using operationally relevant social information. In the context of the RBF system social assessment was conducted in Shinyanga to better understand the social inclusion issues and think through how to address them. The assessment looked at whether gender, ethnicity, age, culture, religion and / or economic status affect access to services. Further questions centered on whether RBF is targeting the needs of stakeholders, what factors affect the ability of stakeholders to benefit from RBF, what the impact of RBF will be on them, what social risks might affect RBF's success and what institutional structures are required to integrate social accountability into system delivery.

The Social Assessment had the following conclusions:

- Initiate special health initiatives targeting the population aged 0 to 19 years;
- Sensitization and involvement of men is essential;
- Initiate dialogue and engagement with traditional healers;
- Integrate social accountability mechanisms in RBF sites;
- Advocate for health system changes within the government.

To address the above challenges the RBF system has developed indicator for ensuring youth friendly services are provided by facilities, further more in the male involvement is captured in the training package of health workers on patient-centered care, responsiveness and attitude of care. Engagement of traditional healers will be done during advocacy of different stakeholders. Social accountability and transparence in health facilities has been addressed by incorporating in the quality checklist of facilities.

Health Management Information System Assessment

The HMIS Assessment has yet to be conducted. A summary will be included here when it is finalized.

Health Facility Expenditure Analysis

An analysis was conducted in a sample of health facilities on the normal level of expenditures in a dispensary, a health centre and a hospital. Given that the funding through RBF is intended to be *additional* to the regular operating budget of a health facility, but equally that there are concerns around absorptive capacity, the goal of this analysis was to set the additional amount of funding through RBF relative to the existing budget of facilities. This analysis assessed that a maximum funding of $2.33 per capita (catchment population) would represent an amount which would help facilities expand the quantity and quality of their service offering whilst also being within their capabilities to manage.

Institutional Capacity Assessment to undertake RBF functions

RBF requires separation of functions among the main actors to minimize conflict of interest. As noted, the main functions of RBF include regulation, purchasing, verification of data, fund holding and providing services. Initial discussions have taken place on assigning these roles to specific entities, however before these decisions are finalized, it is mandatory to carry out an institutional capacity assessment to identify the actual capacities of the proposed institutions, potential gaps, and to provide recommendations on improvements or alternatives. The entities involved have to have:

1. adequate and skilled human resources;
2. substantial experience in performing the function in question;
3. available systems and structures to perform the task;
4. solid knowledge on the health system of the country.

Criteria for regional selection for RBF rolling out

RBF system will be implemented nationwide, whereby the regions will be enrolled in phases. Criteria which have been used in ranking the regions are health outcome and poverty level in the different regions. The poorer the health outcome and the higher the poverty level, the higher the priority of that region to be enrolled in the RBF mechanism.

Health MDG coverage and the socio-economic index for each region have been taken as proxy estimations of regional health outcome and poverty level respectively. These data were extracted from MTR report 2013 and HMIS Report (2011-12). The ranking of regions is based on the average score of the two parameters.

Table 5: Regional ranking of Health MDG coverage index and social economic index

REGION	HEALTH MDG COVERAGE INDEX	SOCIO- ECONOMIC INDEX	AVR HEALTH & SOCIO ECON
SHINYANGA	54	51	53
RUKWA	58	55	57
KIGOMA	56	60	58
TABORA	61	58	60
MWANZA	60	65	63
KAGERA	62	63	63
ARUSHA	63	78	71
DODOMA	65	78	72
SINGIDA	64	80	72
MTWARA	67	80	74
MBEYA	64	90	77
MARA	57	100	79
MOROGORO	64	101	83
DAR ES SALAAM	73	103	88
TANGA	66	113	90
PWANI	72	120	96
IRINGA	69	125	97
LINDI	72	125	99
RUVUMA	70	128	99
KILIMANJARO	71	150	111

The diagram below shows the ranking of regions for inclusion into RBF. Five new regions were created in 2012 which were not included as part of the MDG and socio-economic assessment presented above. These regions are Simiyu, Katavi, Geita, Njombe and Manyara. The Regulator has taken into account the locations of these new regions, and particularly which regions they were previously part of, to insert these regions into a priority ranking for inclusion in RBF. Simiyu region will follow after Shinyanga,Katavi will come after Rukwa, Geita after Mwanza, Njombe will come after Iringa and Manyara will implement after Arusha.

Therefore, the enrollment of regions into the RBF system could follow the arrangement shown in the table below:

Table 6: Proposed phasing of RBF by region according to rank

RANK	REGION	RANK	REGION
1	SHINYANGA	**14**	MTWARA
2	SIMIYU	**15**	MBEYA
3	RUKWA	**16**	MARA
4	KATAVI	**17**	MOROGORO
5	KIGOMA	**18**	DAR ES SALAAM
6	TABORA	**19**	TANGA
7	MWANZA	**20**	PWANI
8	GEITA	**21**	IRINGA
9	KAGERA	**22**	NJOMBE
10	ARUSHA	**23**	LINDI
11	MANYARA	**24**	RUVUMA
12	DODOMA	**25**	KILIMANJARO
13	SINGIDA		

However according to RBF- BRN intervention the list of the starting regions has been amended and the following are the regions to start with since there are additional funding from United state Government (USG) to support the integration of RBF and BRN:

1. Shinyanga
2. Pwani
3. Geita
4. Simiyu
5. Tabora
6. Kigoma
7. Mara

Health Facility Readiness Assessment

Each facility has to undergo readiness assessment before being enrolled to the RBF system. The assessment will be conducted by the assessment teams which will later being institutionalized in collaboration with the RHMTs. The minimum readiness criterion is to have one star with adequate staffing (at least one skilled personnel at a dispensary level). However communication means, conducive infrastructures for provision

of quality health care, emergency transportation arrangement for referral, power supply, availability of running water and waste management facilities are some of the elements in the assessment tool.

The criteria of having skilled personnel must be fulfilled for a facility to be enrolled in RBF. Those facilities with one star will be provided with an initial investment amount (on average 11.5 million TZS) depending on score attained on sections of building, equipments and waste management; facilitate improvement of their infrastructure, equipment, supplies and the quality of health services.

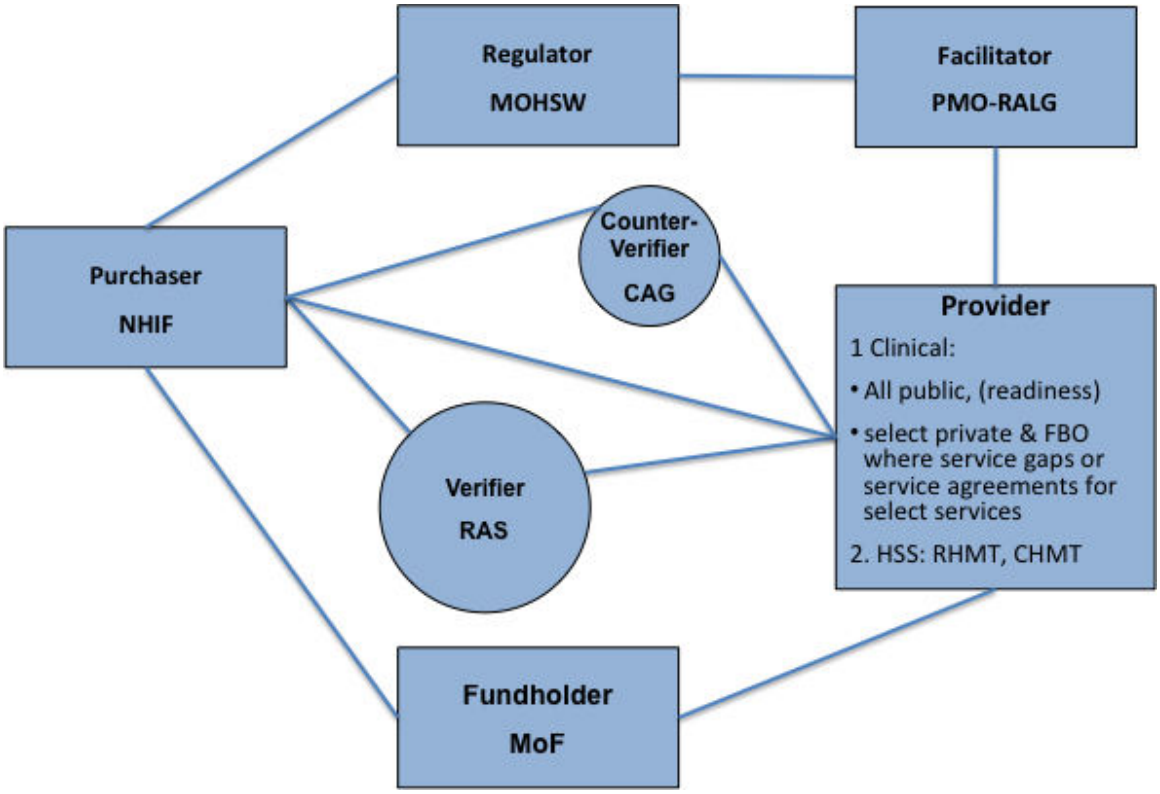
Facilities with two stars and above will be automatically enrolled into the RBF system and these facilities will be given improvement fund if the score in the infrastructure and equipment section is below the recommended score. Facilities with less than one star will not be enrolled at the beginning instead the their RHMT and CHMT will be asked to work on bringing them up to at least the minimum standard of one star so as to participate in RBF. This may require an investment of funds by the LGA or the MoHSW capital investment fund. Facilities which were not qualified due to low score on the readiness assessment will be required to apply for the re-assessment to the RBF system through the DMO's office.

5. Institutional Arrangements

Rationale

Institutional arrangements for implementing Results-Based Financing in the health sector refers to the systems and processes that organizations use to a) perform their related RBF functions, plan and manage their activities efficiently, and b) effectively coordinate with other partners for smooth implementation of the RBF system. There is a well-established health care system and institutional structures in the country that can be used for implementation of RBF. The key functions and responsibilities will be strengthened and adapted so as to integrate the RBF system into the existing health care system to accelerate implementation and contribute to the strengthening of the existing health care system.

Institutional Set Up



Principles Underlying Institutional Arrangements

In Tanzania the following RBF principles have been identified that have a direct impact on the RBF institutional arrangements:

- *Use of existing institutional structures*: this means avoiding the creation of new institutional structures and focus on using the existing entities and their dependencies as appropriate. The formalization of the RBF system is a multi-institutional endeavour. Existing institutions that will be part of RBF will be acting within their legal broad mandates;
- *Separation of functions*: separating regulation, fund holding, provision, facilitating verification and service provision as much as possible taking into account that in the public sector total separation of functions may not be feasible and those specific coordination mechanisms may have to be established;
- *Avoid conflicts of interest*: such as purchasing and provision where the purchaser contracts its own facilities;
- *Gradual development to national scale*: RBF is intended to become part of the National Health Financing Strategy and of the overall health care funding system adding performance payments to fixed costs and other payment mechanisms such as capitation for primary health care and Drug Revolving Grants for hospitals;

- *Local implementation through central and local structures*: a major feature of Tanzania public sector has been devolution and the development of strong decentralized local government structures. These local structures are suitable for the implementation of RBF locally;
- *Simplification of processes and procedures:* It is important to make the principles, processes and procedures as simple as possible to speed up and facilitate RBF implementation.

One of the key principles of RBF implementation is separation of functions among the key actors. Separation of functions means clear lines of responsibility and division of tasks among the main actors to increase efficiency and reduce conflict of interest.

Reasons for separation of functions are:

- Lessen the likelihood of conflict of interest;
- Increase efficiency and accountability;
- Promote autonomy and innovation; and
- Promote transparency.

Even if total separation of RBF functions in a national program implemented by the government with a well-established health system and structures is difficult mechanisms of coordination and inter-institutional formal arrangements in the form of Memorandums of Understanding can contribute to lessen the difficulties. This is because some of these functions are legislated responsibilities of certain institutions that are very difficult to delegate them to another institution. A thorough legal analysis will determine the needs for changes and for specific coordination inter-institutional coordination and the need for legal and regulatory changes. Utilizing existing structures to implement RBF can facilitate program sustainability and efficiency.

RBF Functions

The RBF functions include regulation, fund holding, purchasing, service provision, facilitation and verification of results. Each RBF *function* determines a *role* that is performed by one or more *institution*s. For instance, the regulatory function establishes the role of regulator, and the regulating institution is the MoHSW.

RBF FUNCTIONS, ROLES AND INSTITUTIONS		
FUNCTION	**ROLE**	**INSTITUTION**
Regulation	Regulator	MoHSW
Fund holding	Fund Holder	Ministry of Finance
Purchasing	Purchaser	NHIF
Health services provision	Health care providers	Dispensaries, Health Centres, District Hospitals
Facilitation	Facilitate local government action	PMO-RALG
Internal verification	Authentication	RS-NHIF
External verification		Controller Auditor General

Performance Agreements

There will be one master Agreement between the main actors (regulator, facilitator, purchaser, fund holder) detailing the overall goals of RBF, the underlying principles which all actors must adhere to and respect and the high level roles and responsibilities of each actor. This Agreement will be signed by an authorized signatory for each institution thereby committing them to ensuring the success of RBF.

There will further be individual performance agreements between the Regulator and Purchaser, Purchaser and Verifier, Purchaser and Counter-verifier, Regulator and Fund holder and between Purchaser and Health Facilities.

RBF Steering Committee

Overall direction and guidance for health results-based financing will be provided by an RBF Steering Committee which will be comprised of senior representatives of the MOHSW, PMO-RALG, MOF, NHIF, CAG, the World Bank, USAID, GIZ, SDC and other donors providing financing and appropriate civil society organizations.

Specific roles and responsibilities are:

- Provide strategic and policy direction related to RBF;
- High-level monitoring of project implementation and results;
- Ensure excellent coordination and timely implementation by the managers at all entities of government and contracted agencies;
- Review progress reports prepared by the National RBF Team;

- Review and comment on annual work plans and budgets;
- Ensure that agreed performance targets and timelines for activities under the different components are met;
- Proactively address critical issues that could hinder project implementation.
- Mobilize resources for RBF implementation

Regulating/MoHSW

The Ministry of Health and Social Welfare (MoHSW) will be the regulator of RBF implementation in the country. MoHSW fits the function of regulation since it has a legislated responsibility of overseeing all health services provided to the population of Tanzania. It also has the mandate to ensure the population receive quality health services to improve their livelihood. The Ministry has the necessary required resources for regulating health programs. The resources include knowledge, skills, system and structures, policies and guidelines to which the RBF mechanism must align.

The MoHSW's health care financing policy has to accommodate and include RBF system. The MoHSW will be the overall overseer of the RBF system. It will also develop the guiding documents and tools used to implement RBF. The Ministry will also provide clinical and technical oversight and supervision to ensure quality health services are offered to the population. All directorates of the MoHSW will work together as required to ensure smooth implementation of RBF.

MoHSW Management of RBF
1. The Policy and Planning Department is formally assigned the role of implementing RBF Regulation.
2. An MoHSW RBF Committee is appointed to support the Department in its RBF Regulatory Role with policy and oversight. This MoHSW Committee can have an External RBF Advisory Committee to advise the MoHSW RBF Committee.
3. An RBF National Team is appointed within the Department of Policy and Planning to carry out the day-to-day RBF Regulatory functions and coordination with the other RBF participating institutions.

The MoHSW will oversee RBF through the *RBF Regulatory Committee* that will be formed by the Chief Medical Officer, Assistant Director Policy (secretary), Directors for Quality Assurance, Preventive Services, Human Resources and Curative Services, Chief accountant, Head HMIS Section, Head Health Secretariat and others to be invited as the need arises. The Regulatory Committee will meet twice annually and will have the roles and responsibilities outlined below. The MOHSW RBF Regulatory Committee will have an *External Advisory Committee* formed by a wide range of stakeholders including private sectors, development partners, civil society organizations and NGO representatives. The *RBF Regulatory Team* will provide day-to-day management and coordination as described below. MoHSW's Directorate of Policy and Planning will be taking the lead.

RBF Regulatory Committee

The RBF Regulatory Committee will have the following roles and responsibilities:

- Provide overall oversight of the RBF mechanism including reviewing the RBF Design Document, the Operational Manual and other relevant documents;
- Approve indicators to be included in RBF and their respective prices;
- Review costing and budgeting for the RBF system;
- Mobilize, monitor and allocate adequate resources for implementation of RBF system;
- Monitoring and evaluation of the RBF system;
- Support the RBF Team to carry out their day to day duties in the implementation and management of the system
- Collaborate with other stakeholders for sustainably scaling up RBF;
- Share best practices with other stakeholders within and outside the country.

Facilitating/PMO-RALG

Since RBF is about incentivizing results at the local level, the facilitating role of PMO-RALG becomes fundamental to ensure smooth implementation of the RBF system.

PMO RALG is led by the Permanent Secretary who is assisted by the three deputy permanent secretaries: the Deputy Permanent Secretary for Health (DPS Health) who deals with all matters related to health services provision; Deputy Permanent Secretary PMO-RALG who deal with all matters related to functions of Regional and LGAs; and the Deputy Permanent Secretary Education who deals with all matters related to Secondary and Primary education service delivery in the country. The DPS Health is assisted by Division of Local Government under the section of Services delivery (where a Health Services Working Group has been formulated), and the Division of Regional Administration whereby all regional health matters are worked upon, and other related supporting divisions.

There will be a dedicated unit established at PMO-RALG whose major role and responsibility will be to facilitate and ensure that the councils are supported to carry out their role with respect to health facilities. Specific roles and responsibilities are as follows:

1. Providing sound advice to CHMTs and health facilities on how to plan to maximize the future revenue from RBF;
2. Support the development of health facility business plans;
3. Capacity building of CHMTs and health facilities;
4. Continuous follow up of RBF activities and results in order to improve future results;
5. Providing quality and timely information regarding health services provision in regions and LGAs to higher authorities;

6. Monitoring of health provision through the Regional Secretariats, represented by the RHMT on issues related to health;
7. Providing link, support and advice between regions, LGAs and all other health development partners to ensure health services provision are improved.

Roles and Responsibilities of the National RBF Technical Team

A National RBF Technical Team is created comprising technical staff from PMORALG and MoHSW. The team is responsible for coordination, implementation, monitoring and evaluation of the RBF Program. Within the MoHSW the team reports to the Assistant Director Policy while within PMORALG the team reports to Director of Local Government.

The responsibilities of the National RBF Team for initial implementation of the RBF system are as follows:

- To take all the necessary technical, administrative, tactical and day-to-day running of the programme and operational decisions regarding the programme's implementation; as well as overall coordination;
- To lead the design process for the RBF roll-out, coordinating inputs from all relevant stakeholders and ensuring consistency with existing health sector policies;
- Provide continuous technical assistance in the overall design and implementation, training, monitoring and evaluation, financial management, linkage with partners, contracting, and Independent validation;
- Ensure that all implementing stakeholders understand the RBF concept and are prepared for its implementation;
- Lead the Training of Trainers who will then conduct cascade training at different levels;
- To ensure districts have adequate data collection tools (HMIS) in time for implementation of the RBF program.
- On behalf of MoHSW, to contract the purchaser and fund-holder;
- Develop, with relevant national and regional stakeholders, the necessary processes, guidelines, tools(contracts, reporting tools, verification tools), training materials and other job aides as necessary for the successful implementation of RBF;
- Provide on-going monitoring and evaluation of the programme, with concrete action steps to follow in order to relieve bottlenecks, give targeted support to weak health facilities, build the capacity of CHMTs to appropriately support facility managers;
- Develop a detailed work plan and hold all stakeholders accountable for timely implementation and delivery of results;
- Receive from the NHIF the list of facilities and payment amounts following verification and submit to the MoF for disbursement;
- Prepare an Annual PBF Report, summarizing progress in the yearand conduct advocacy and education relevant to RBF;

- On an annual basis, and in consultation with stakeholders, revise indicators, targets and prices, and the Operational Manual;
- Ensure that training is carried out to roll out revised rules and procedures each year;
- Facilitate appropriate inclusion of RBF activities and resources in the annual district planning and budgeting process;
- Support the design and implementation of the impact evaluation component of the RBF, including undertaking operational research to understand what is working and what needs to be refined;
- Ensure that the Health Management Information System is programmed to provide the necessary functionality for implementation of the RBF;
- Share regular progress reports on the RBF roll-out through the Health Financing TWG;
- Continuous revision of the RBF Design Document based on experience;
- Issue RBF guidance and instructions and issue interpretations of RBF regulations;
- Develop a capacity building plan, implement and evaluate so that all implementers understand the RBF Concept and are able to effectively contribute to implement the RBF system;
- Conflict resolution among RBF institutions.

Fund Holding/Ministry of Finance

The Ministry of Finance (MoF) will be the fund holder. It will be responsible for paying the incentive to the providers (health facility and CHMT) as directed by the Purchaser. There will be two types of funds related to RBF system, namely Administrative and Subsidies/Incentive funds. The administrative funds will be channelled to the MoHSW and the incentive funds will be disbursed to the health care facilities via the respective Councils.

As Fund Holder, the MoF will hold the RBF funds and release them as per the indications of the Purchaser. The Purchaser initiates the payment process by communicating to the MoF the payments to be made. At the MoF, the Commissioner for Budget certifies that the funds are available, and the Accountant General makes the disbursement. The actual disbursement to providers, in the case of PHC, is made through the District Council that owns the health care facilities, not to the Purchaser. The payment issued by the MoF would have specific instructions for immediate payment to health care facilities. Payment through the Council could have implications for health care facility autonomy, an issue that merits consideration.

Specifically the fund holder will have the following responsibilities:

- To ensure that the design of the RBF disbursement and financial reporting processes are consistent with the Government of Tanzania financial management regulations.
- To disburse RBF funds for incentive to health facilities, upon receipt of payment request from the Purchaser.
- To compile disbursement reports for each quarter through Epicor system.

- To share the disbursement schedules with NHIF, MOHSW and PMOLARG immediately after payments are effected.

Purchasing/NHIF

The National Health Insurance Fund will be the Purchaser under the RBF system. The NHIF, with the MoF, MoHSW, and the PMO-RALG will enter into a Master Memorandum of Understanding for RBF implementation.

The Purchaser has the following roles and responsibilities:

- To purchase health services from health facilities according to indicators set by the Regulator;
- Entering into a contract with each participating health facility;
- Participate in the verification process and approve payments after receiving verification reports;
- Prepare a full list of health facilities, health facility addresses, health facility bank accounts and verified payment amounts (including penalties) and initiate the payment process with the MOHSW;
- Recommends to MoHSW necessary actions for any irregularities found during the verification process, as highlighted to the NHIF by the RAS of the relevant region;
- Follow up with Ministry of Finance to ensure approved incentive is timely disbursed to the facilities.

Provider / Health Facilities

Both public and private health facilities at primary health care level will be contracted for providing health care services to the community. These include dispensaries, health centres and hospitals at council level. This will improve accessibility and allow competition in health service delivery. Only private health facilities that have service agreement with government would be enrolled in the program.

Public primary health care facilities (dispensaries, health centres) are not legal entities and local government (councils) own them. This means that health care facilities would have to participate in the RBF process through the Councils. A critical issue is how to make the payments to the individual health care facility. Each health care facility would have a bank account, opened by the Accountant General as government accounts (no fees and no minimum balances required).

Specifically the provider will have the following roles and responsibilities:

- Provide quality health care services to clients and communities.
- Develop clear business plan as part of the CCHP.
- Ensure that all clinical and crosscutting quality standards are observed.
- Prepare reports including HMIS reports, financial and technical report of the business plans.
- Collection, analyse, report and utilization of data for planning
- Collaborate with other key stakeholders and develop strategies for successful implementation of RBF, this also includes leveraging of resources

- Mobilize resources based on available opportunities in the catchments areas.
- Develop or improve system for feedback mechanism to address clients complains.
- Develop capacity building plan that includes meeting, on job training, and mentorship program within the team.
- Ensure that all the resources are properly and efficiently utilized,
- Prepare and submit to the respective Council the RBF implementation and incentives utilization report
- Ensure availability of reporting tools to facilitate data submission to higher level,
- Make sure that all necessary documents are accessible to verification and assessment,
- Report any fraud committed at the Health Facility to the R-RBFC (in writing) via CHMT,
- Implement sanctions against individuals responsible for professional misconduct,
- Support Community actors to carry out their own strategies under the RBF system;
- Lodge a complaint to the regulator via council in an event of a dispute during the execution of this agreement.

Verification/Regional Secretariat and Counter-verification / CAG

Verification is the cornerstone of RBF since payment of results requires quality data. The introduction of payment for performance runs a risk that reported performance could be artificially inflated, however even underreporting is not allowed since it also distort the quality of data. In addition it is a well-documented effect of RBF that data reporting improves dramatically under these mechanisms. Therefore RBF, and verification, can also be used to improve facility-level information, whether there be under- or over-reporting. For both of these reasons it is essential that results be routinely verified before payment is made. Verification improves transparency, credibility and good governance of the RBF system and of data reporting generally.

There will be (a) ex-ante, internal verification and (b)ex-post, independent counter-verification.

The internal verifier will be the RAS, who will identify a verification team using the existing capacity in the region including RHMT, NHIF staff, Regional Hospital, NGOs, Internal Auditors and other experts to undertake the verification. Experts from the purchaser NHIF at the regional level are in order that the NHIF be confident in the results of verification. The identified verification team will conduct internal verification for dispensaries, health centres and hospitals. Furthermore the team will conduct patient tracing for 10% of clients registered to have received services in the facility, which will also check for patient satisfaction for the selected indicator. Patient satisfaction will be assessed through a separate developed checklist; however the score will finally be incorporated in the overall quality score.

A dedicated team will be identified, appointed, trained and mandated to conduct both quantity and quality verification. A team of 4 (2 for quality and 2 for quantity) would be needed to verify dispensaries and

health centres. A team of 6 would verify at hospital level (2 for quantity and 4 for quality). Local quantity verification teams should be well trained to objectively focus on recounting primary data and properly fill summary forms. Performance data forms should be made simple to prevent work over loads.

The *independent verifier* will be the Controller Auditor General (CAG) who will conduct the ex-post counter-verification twice a year, using a sample of 25% of facilities at that time participating in RBF. The independent verifier will counter-verify quantity results as verified by the RAS of each region and will conduct a quality assessment using the in-force quality checklist. Not only that but also the independent verifier will also audit financial management at each selected facility.

The roles and responsibilities of verifiers are the following:

- Verify the results reported by the provider;
- Check correctness and consistency of data entered into HMIS tools and DHIS2;
- Check whether minimum quality standards of service provision in health facilities are met;
- Provide timely feedback to providers, purchaser and regulator on the quality of services basing on agreed indicators;
- Advice the regulator, purchaser and providers on issues of service coverage and quality of care depending on the verification results;
- Conduct patient tracing;
- Report the verified results to the purchaser.

Patient tracing and satisfaction

Patient satisfaction survey as a part of internal verification will be conducted by a dedicated local NGO contracted by the internal verifier as a part and parcel of quality check list. The survey will have two parts: patient tracing and patient satisfaction part.

The contracted local NGO will conduct patient tracing for 10% of clients registered to have received services of a certain indicator e.g health facility deliveries. All the chosen names will be searched for a correspondent client. If it happen that the clients are not found during patient tracing, then those patients/clients have to be subtracted from the total number of that particular indicator. Hence this part has to be treated separately from patient satisfaction part.

The contracted NGO will also look for patient satisfaction for the selected indicator. Patient satisfaction will be assessed through a separate developed checklist shown in **Annex 17**; however the score will finally be incorporated in the overall quality score.

The RAS will form a Regional RBF Committee, which will be responsible for assisting the RAS in ensuring that verification is smoothly implemented. The Regional RBF Committee will comprise of:

- Regional Administrative Secretary, Chair

- RHMT, Regional Medical Officer, Secretary
- RHMT, Regional Health Secretary
- RHMT, HMIS Focal Person
- RHMT, Regional RCH Coordinator
- Regional Auditor
- Regional Local Government Officer
- Regional RBF Coordinator
- Regional NHIF Manager
- Regional Nursing Officer
- Regional Monitoring and Evaluation Officer
- A representative from existing Health NGOs working in the region.

The committee will meet quarterly and they will discuss all matters pertaining RBF implementation.

Roles and Responsibilities of the Regional Administrative Secretaries

The Regional Secretariat is led by a Regional Administrative Secretary, assisted by an Assistant Administrative Secretary who is also a Regional Medical Officer. The Regional Hospital is led by a Medical Officer In-charge. The roles of the Regional Secretariat, in addition to their roles as verifier outlined above, are as follows:

1. Co-ordinate and advise on implementation of health policy, health and social welfare matters in the region;
2. Facilitation of internal and external audits and verification to be undertaken within the region;
3. Supporting the RHMT for coordination of RBF at the district level;
4. Preparation of quarterly progress report to the MoHSW and PMORALG;
5. Monitor proper management of health services provided by public and private sector hospitals and other health facilities in the Region;
6. Build the capacity of LGAs in health service delivery;
7. Provide technical advice on preparation of all health services plans, and assess council health plans and interventions to strengthening health systems in the Region;
8. Provide backstopping support during health epidemics in the region;
9. Provide clinical services under Regional Hospitals to inpatients and outpatients referred to by LGA hospitals; for example on curative specialist services;

10. Provide expert/technical backstopping service to LGA hospitals and health centers during major communicable disease epidemics;
11. Provide referral laboratory services;
12. Coordinate availability of adequate pharmaceuticals products for the hospital and other health facilities;
13. Link between districts and central MoHSW in matters regarding standards and quality of health care both public and private;
14. Mobilize and allocate resources for health service provision to Region and LGAs;
15. Interprets policies into actions that can be implementable to specific LGA's in a region;
16. Documentation of challenges and success for problem solving and future planning;
17. Settlement of all disputes arising during the implementation of the RBF system.

Roles and Responsibilities of Local Government Authorities (LGA)

The LGAs are led by the Executive Director, assisted by the Council Medical Officer who oversees the whole system of service provision in the council through the CHMT.

The major role of LGAs in the health arena is to ensure access to health services for the community, through the availability of both private and public owned health facilities. Councils, through the CHMT, are responsible for planning, management and delivery of health services.

Roles and responsibility of DED are as follows:-

1. Facilitate the Internal and External Audits and Verification to be done within the councils.
2. To sign an agreement on behalf of the council and the health facilities for provision of the RBF interventions with the Purchaser.
3. To ensure all participating health facilities under RBF system have bank account and which the disbursement of RBF payments will be done.
4. Ensuring all financial regulations are adhered too including disbursing the funds to health facilities within 30 days after the Fund Holder disbursing the funds to the Council.

Specific roles and responsibilities for the CHMT are as follows:

1. Incorporate the RBF mechanism into the CCHP.
2. Conduct cascade training for health facility staff, to ensure they fully understand their role and responsibilities for implementation of the RBF system,
3. To ensure that the required resources are available for provision of quality health services.
4. Conduct supportive supervision to all health facilities to ensure delivery of quality health services.

5. To compare and certify the quarterly quality and quantity data that have been entered in the RBF/ DHMIS district database,
6. Ensure all health facility reports are entered into the DHIS-2 database by the 15th of consecutive month

4.5 Ensure each Health Facility use the RBF funds according to guidelines and government financial regulation and financial reports are compiled and submitted on time and provide technical supports on financial matters,

7. In areas where there is no access to Government health facilities, or insufficient capacity to serve the local population, CHMT will facilitate to sign an agreement with Non- Government, FBO or Private health facilities which will be eligible to participate in delivering health services under RBF system.
8. Advocate RBF to all relevant stakeholders at council level,
9. Ensure availability of drugs, supplies and equipment at all health facilities,
10. Mobilizes and manage resources allocated for health care delivery,
11. Ensure communities are responsible in taking care of their own health and also the safety of medicine and equipment in their health facilities
12. Assist the health facilities in developing, approving and implementing quarterly RBF business plans
13. Produce and timely submit Council Profile Reports to PMORALG and MOHSW
14. To ensure that all HFs in the council have minimum qualified staffing requirement
15. The CHMT will have the principle responsibility of making operational mechanisms decisions capable of supporting the success of the RBF system,
16. To impose the respect of the agreements and rules, including if necessary the administration of the sanctions envisaged in the agreements,
17. Facilitate the regional verification team to carry out their activities within the council
18. Support the Health Facilities to implement recommendations made by the verification team on both quality assessment and quantity verification,
19. Share the incentive information among health facilities after the decision of the Regional RBF Committee meeting,
20. To ensure that all dedicated financial resources are disbursed to the respective facilities without reallocation,
21. To help health facilities and community to be able to implement the RBF strategy by:
    - Managing the various resources (material, financial and human) in a transparent manner.
    - Providing information and sensitizing the population on the importance of participating in the various public health strategies.

Other Important RBF Stakeholders

RBF requires collaboration of many health sector stakeholders. In order to bring impact at community level, mutual support and colloboration with stakeholders at that level is important. Therefore the involvement of NGOs, the private sector, CHWs, FBOs, CSOs,traditional healers/TBA, village leaders and councillors is important and expected.

NGOs and Private Sector

The NGOs and Private sector have been working closely with the government supporting health services in the country, under RBF NGOs and Private Sectors are expected to perform the following:

- Liase with the service provider, purchaser,fund holder, verifier and regulator and inform them what is being done at the community and if there is any complaints from them to ensure the quality of health services delivery at all levels.
- Participate in design and implementation of RBF health interventions at all levels.
- Provide support to vulnerable groups in the access of health care services.
- To inform the community by creating awareness about the health services and new mode of delivery under RBF system.
- Ensuring that all complaints from the community are submitted to the relevant stakeholders and the community feedback is given.

Religious leaders, influential people and representative of youth groups

Rerigious leaders, influencial people and representative of youth groups have the greater influence on the population they serve. As, such RBF intervention they can be very potential on the strenghening Primary Health Care System. Their roles on RBF are:

- To advocate health issues to the community they serve within the community in order to create awareness the community .
- To provide support to vulnerable groups on the accessability of health service
- To sensitize the community on issues of Health promotion and prevention at community level

Community Health Workers

Community health workers (CHWs)are members of the community whose task is to assist in improving the health of the community in cooperation with the health care system and public health agencies. CHWs will work very closely with health care providers at the facility, community leaders and other stakeholders.The role of CHW focus is on reaching the community at large and support them in their homes and communities to provide infomation on healthpromotion,prevention of diseases, promotion of health seeking behaviors as well as ensuring a continuum of care. During RBF implementation CHW will work closely with facility management team to facilitate the following:

- Provide support on health issues on health promotion and prevention of diseases;
- Conduct home visiting for identifying the vulnerable people;
- Conduct and participate in community;
- Provide refferal to patients/ clients to the health facility;
- Provide counselling and assist the community in health-related decision making;
- Participate in RBF interventions at community level;
- Collect and compile RBF reports as per suggested indicators;
- Creating awareness to the community for them to attend at health facilities when they get sick.

Traditional healers/Traditional Birth Attendants(TBAs)

Traditional healers and TBAs are respected and trusted with the community as people with convincing power on health care services and they have been providing health services to their communities based on traditional techniques. RBF intends to promote behaviour change towards health care services, thereforeunder RBF they will work closely with local authorities and facility teams to support:

- Identifying clients/patients who need health care services;
- Escorting clients/patients to the appropriate health facility;
- Assist in identifying hamful cultural and traditional practices in relation to health care services;
- Participate in health promotion at community level as per RBF plan.

Village leaders, extention workers, health facility committee and councillors

This is a group of people vested with authority and skills on services delivery at community level, their participation in RBF will have the aim of:

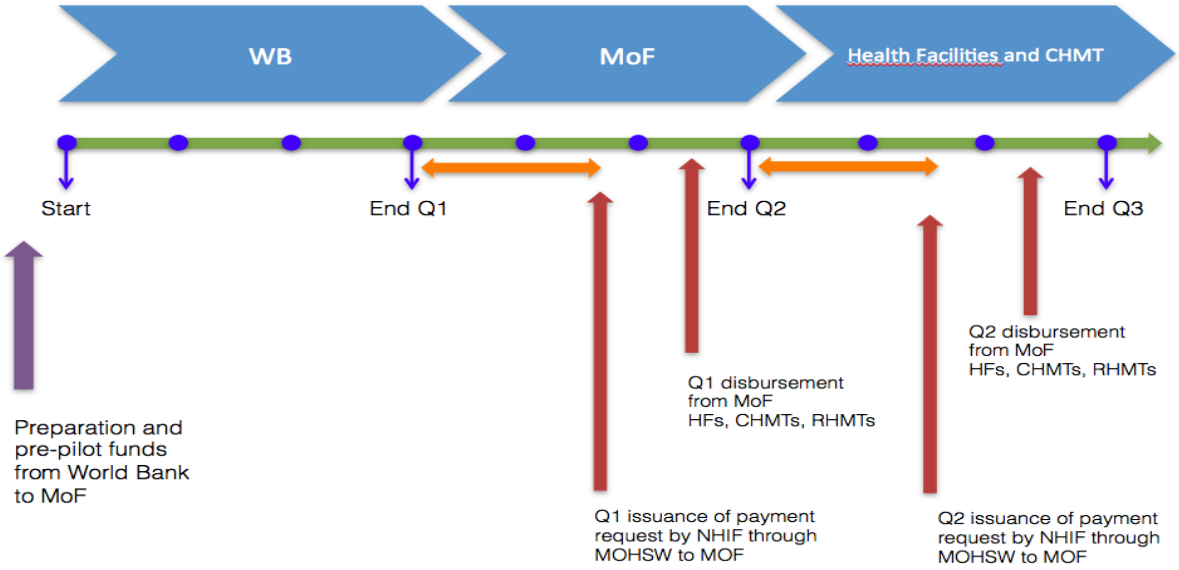
- Convening meetings of stakeholders within the village and give feedback for health services delivered, income generated and funds spent by the health facility to increase transparency;
- Enable community sensitization, mobilization and organization;
- Stregthen village health commitees;
- Participate in selection of CHWs and develop mechanism for supervising and monitoring them;
- Provide support for referal to facility whenever necessary;
- Provide technical support and ensure availablity of working tools for CHWs;
- Act as a link amongst the health management team, the facility and CHWs.

6. Payment Modalities and Guidelines

Preamble

The MoF will be the fund holder and will be responsible for disbursing RBF funds to health facilities and management teams. The disbursement of RBF funds from MoF to health facilities and management teams (RHMT and CHMT) will be effected immediately on receipt of the Quarterly RBF Payment report prepared by the NHIF, and transmitted to the MoF by the MoHSW. This report, which is a compilation of the verified and approved quarterly reports from the RAS, will include the payment amounts and bank account details for each facility and management team.

The funds will flow from the MoF to the respective health facilities. No disbursement will be made in advance. The amount disbursed by the MoF to the health facilities will be exactly the total payments to be made to the respective health facilities and to the management Teams. The MoF will copy the disbursement information to the MoHSW, the NHIF and all levels of PMO-RALG including RAS and DED's office.The diagrams below describe the quarterly fund flow and timelines: (This diagram considered that the funds might pass through the LGAs



The health facilities will be required to open bank accounts (if they do not have the existing account for cost sharing) according to government regulation through DED into which the funds will be deposited. The account will have signatories of two groups namely group A and B respectively. Group A will be formed by facility in charge and any other facility staff. Group B will be formed by Chairperson of HFGC and any member of the committee. For funds to be withdrawn from the account at least one signature from each group is required.

The CHMT and RHMT will also be paid direct through their account formerly known as health fund account. The signatories for CHMT account will be the Chairperson of the Council Health Service Board (CHSB) and another member of the board as group A and DMO and another member of CHMT. For RHMT the

signatories will be RMO and another member of RHMT and the other side will be RAS and another member of regional secretariat.

RBF Incentive Payments

The RBF payments will be made to facilities, not individual staff. However, once the facility receives its incentive payments, it will have a certain degree of autonomy on how to use the funds as it sees fit, within certain parameters. Incentive payments will be split between bonuses to staff members (maximum 25% of the payment in a quarter) and investment funds for facility operations or demand-creation initiatives.

- For staff bonuses at dispensaries and health centres, CHMTs will be responsible for ensuring that the incentives are distributed among all staff according to set criteria. At hospitals, the Hospital Management Teams (HMTs) will be responsible for ensuring that incentives are distributed fairly among all staff. The identified verification team will conduct financial auditing during verification to check and ensure incentives were being distributed as guided.

- Funds for facility investments will be utilized according to the facility's priorities. This can include operating expenses. It could also include investing in the community to support demand-generating activities that could further improve the quality health care. Throughout the implementation the RBF technical team will seek to gather the various experiences and innovations from facilities and share best practices from all regions.

- The RBF funds will be divided between incentives for health facility staff (representing a maximum of 25% of the total RBF payment for the health facility in any quarter) and the remaining amount will be used for facility investments.

- Distribution and use of the RBF funds must be approved every quarter by the Health Facility Governing Committee (HFGC). The minutes of this meeting must be signed by the health facility in-charge and the chair of the HFGC and retained at the facility. These minutes must be available for inspection by supervision and verification teams.

- Use of the RBF funds must be recorded accurately according to the financial record-keeping guidelines. Quarterly financial reports must be prepared according to the guidelines provided and submitted to the DMO office in a quarterly basis.

- Payments will also be made to Community Health Workers for services provided. The CHW have their three indicators with prices indicated to them. The amount obtained from these indicators will be paid to the CHWs only and it will not be shared with the health workers at the respective health facility. Distribution of the funds will base on the no of services provided by that particular CHW. In other words, the more the service the CHW will provide the more the amount of funds to be earned by the CHW.

Maximum Incentive Payment per Quarter

In order to ensure, to the extent possible, that staff across the country have an equitable and fair motivation, ceiling amounts per facility have been established by taking into account the typical staff profile of each facility type. These figures have been established based on the average expenditure of a sample of facilities. As indicated previously, funding through RBF is intended to be *additional* to existing funding and there are therefore considerations of absorptive capacity. The analysis conducted takes the logic that the additional amount of funding should be sufficient to allow facilities to improve their functioning, whilst not representing an amount which will overwhelm facility managers.

Table 7: Maximum RBF incentive payment that each facility type can potentially earn each quarter

Facility Type	Total Payment Maximum	Of which maximum payment to staff
Hospital	**71,405,166**	**19,559,052**
Health Centre	**19,900,459**	**4,595,655**
Dispensary	**4,961,674**	**1,081,157**
CHMT	**Depends on population of district**	
RHMT	**Depends on population of region**	

These figures may be adjusted based on equity considerations (geographic location, available inputs and population served) such that rural and hard-to-reach facilities have a slightly higher maximum payment, whilst those in urban settings or close to main roads have slightly lower maximum payments.

For health centres and dispensaries, each indicator has been assigned its own weight and the total incentives will depend on the indicator weight. The incentive payments will be based on scores across the applicable set of indicators. Each indicator is assigned a fee for that particular service however the fees are subjected to change basing on improvement of the indicator and the availability of resources. The table 6 below shows the weight and fees for each quantity indicator. For District hospitals and management teams the incentive payments will be depend on the assessment on the quality scores i.e the quality score will be multiplied with the total maximum incentives available for hospital or management team.

Table 8: Weight and fees assigned for each quantity indicator for dispensaries and health centres

Indicator	Index	Fee TZS (USD)	Baseline 2014
Number of new outpatient consultations (OPD)	1	415 ($0.25)	50%
Number of TASAF beneficiaries seeking outpatient care (OPD)	3	1,240 ($0.75)	5%
Number of first antenatal visits, with gestation age < 12 weeks (ANC)	20	8,290 ($5.00)	15%
Number of pregnant women attending ANC at least 4 times during pregnancy	15	6,210 ($3.75)	43%
Number of pregnant women receiving two doses of intermittent presumptive Therapy of Malaria (IPT2)	3	1,240 ($0.75)	20%
Number of HIV positive (infected) pregnant women receiving ARVs	8	3,310 ($2.00)	20%
Number of institutional deliveries	50	20,720 ($12.50)	33%
Number of mothers receiving Post Natal Services within 3-7 days after delivery	20	8,290 ($5.00)	24%
Number of children under one year immunized against measles	4	1,650 ($1.00)	75%
Number of under five receiving Vit. A supplements	2	830 ($0.50)	61%
Number of new users on modern Family Planning methods	14	5,800 ($3.50)	0%
Number of clients initiated by health care provider to counsel and Test for HIV (PITC)	1.5	620 ($0.37)	49%
Number of HIV exposed infants receiving ARVs	12	4,970 ($3.00)	20%

Indicator	Index	Fee TZS (USD)	Baseline 2014
Number of TB suspect referred (already screened)*	20	8,290 ($5.00)	75%
Number of non-institutional maternal and perinatal deaths reported within 24 hours by TBA or CHW	10	4,145 ($2.50)	0%
Number of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW	20	8,290 ($5.00)	0%
Number of household visits by CHW	3	1,240 ($0.75)	10%

Quarterly RBF Payment Formula

The total payment for each quarter earned by a facility is the sum of the quality adjusted quantity-based payment, subtracting any penalties arising. Basically the RBF quarterly payments will depend on three factors namely:

- The number of clients meeting the definition of each quantity indicator;
- The quality score achieved per the criteria of the quality checklist, and
- Penalties imposed for mis-reporting or error.

Taking one indicator as an example, the number of clients meeting the definition of the indicator will be counted from the register at the facility level (dependent on the indicator) during verification. This number will be multiplied by the fee for that indicator. The verified figure will be compared to the figure reported by the facility on the Summary. If the verified figure is more than 10% different to the figure on the Summary Form, the facility will incur a 10% penalty on the verified payment for that indicator. Further the summary form figure will be compared to the figure entered into the DHIS 2 by the CHMT. If the figure is different to the figure entered into the DHIS, the CHMT will be subject to a penalty.

The formula used to calculate these three components and the overall RBF Payment is shown in the following table.

Table 9: Payment Presentation below

Quantity Indicator	Declared (A)	Verified (B)	Difference (C)	% Difference (D) D=(C/A)*100%	Indicator Price (E)	Income Earned (F) F=B*E	Income Loss (due to >10% error) (G) G=10% *F
Indicator 1	A1	B1	B1-A1	(C1/A1)*100%	E1	B1*E1	10%*F1
Indicator 2	A2	B2	B2-A2	(C2/A2)*100%	E2	B2*E2	10%*F2
Indicator 3	A3	B3	B3-A3	(C2/A2)*100%	E3	B3*E3	10%*F3
Indicator n	A_n	B_n	B_n-A_n	(C_n/A_n)*100%	E_n	B_n*E_n	10%*F_n
Total Income Earned due to Quantity Score (H)							ΣF–ΣG
Quality Score (in %)							I
Total Income Earned due to quality Score							I*H

Incentive Sharing Formula among Staff

The distribution of incentives among staff within a health facility will be done according to criteria agreed by staff and the indices formula for staff remuneration. The amount to be earned by each staff member will be calculated according to a formula pre-agreed amongst the staff, the outlines of which will be detailed in the Operational Manual.

Integration of RBF Invoices in the DHIS 2

In order to facilitate payment calculation and RBF Reports, the RBF Payment modal will be customized in the DHIS 2 software which is a web based tool to store routine health information system. This application will also facilitate RBF team, RHMTs, CHMTs and other key stakeholders to monitor the progress of RBF through different reports that will be generated. The scores of quality indicators will also be entered in this system and the overall payment that combines quantity and quality scores generated automatically. At some point, as separate form will also be designed in the DHIS 2 to track quantity indicators that are not reported through the HMIS. The system will also generate a quantity indicator data validation form that will be printed out for the verification process. This will also be able to print out score cards for health facilities and management teams that will be used as invoices for payments. The system will also distribute

payments to staffs based on their cadres. This means; at some point the system will be linked to the HRMS to track health staffs in the health facilities.

Financial Record Keeping

All Government financial regulations and procedures will be applied in the course of implementation of the RBF programme. The local councils at district level will have responsibility of monitoring financial record-keeping and reporting for the devolved services. The Local Council will monitor the health facility's financial record keeping. The internal verifiers will indicate on the verification form whether or not the health facility records are satisfactory. The health facility financial reports should be submitted to the DMO office after two weeks upon receives of incentive payments. The DMO office will aggregate all financial reports of all facilities in the district and submit to RAS. The RAS will compile all council and RHMT financial reports and submit to the RBF technical team at the MoHSW and PMO-RALG.

Mis-reporting (Falsification), Error and Penalties

If erroneous results are observed during the internal and independent verification process, two aspects will be considered:

i. the accuracy and quality of data; and

ii. Intentional/deliberate falsification.

If issues with the accuracy or quality of data are spotted, the district and regional administrative authorities will be notified and 10% of the total incentives earned for each falsified indicator by a facility will be deducted. If intentional/deliberate falsification cases are spotted, the applicable Tanzanian laws for fraud and falsification of medical records will be applied and the responsible health care worker will entail disciplinary actions according civil servant regulations.

Summary of the Key Processes and Timelines

The following table and graphic outline the key actors, processes and timelines in RBF. It will be essential that these timelines are followed by the RBF Team and that blockages are resolved swiftly. Much of the power of RBF lies in the financial incentive being made available to facilities soon after results are verified. Delays have been shown to weaken the power of the incentive.

Table 10: Timeline of Key Processes

Process	Time for Process in Working Days	Cumulative Time
Facilities finalize Summary Form and claim	5	5
CHMT enters data into HMIS	5	10
RAS conducts verification (quantity, quality, CHMT, RHMT)	10	20
RAS enters verified data, quality scores into HMIS	5	25
RAS notifies NHIF verification complete	3	28
NHIF retrieves invoices from HMIS –conducts internal checks and submits summary of payments to MoHSW	5	33
DMO prints confirmation receipt and provides to HFs	--	--
MoHSW submits payment request to MoF	2	35
MoF disburses to HF accounts	10	45

7. Capacity building for RBF implementation and Advocacy

Capacity building for RBF implementation is very important so as to create a pool of persons capable of transferring the RBF knowledge and skills to others through technical assistance, training, supervision and coaching. Furthermore the knowledgeable persons will support the various partners assisting health sector as it transforms financing into result based system. The strategy of capacity building aims at developing a cadre of trainers at all levels with understanding of RBF principles, tools and processes.

Training will start by training of trainers who will subsequently train Regional and Council health management teams who will later be trainers of health workers at the health facilities. A master trainer will be identified who will coordinate all the training activities, however will be working very closely with the technical assistant for the RBF system.

The training package for RBF will be developed by the regulator, which will be translated in Swahili (national local language). The package has nine modules namely:

1. RBF concept
2. Client –centered- care
3. Health facility business plan
4. Social marketing
5. Quality management
6. Financial management
7. Leadership and Governance
8. HMIS and DHIS2
9. Community participation

Training will be conducted in cascade method. The National RBF team will train the RHMT and CHMT as mid level TOTs. Service providers will be trained by the mid level TOTs. Number of health workers to be trained in dispensary, health centre and hospital level will be two, five and ten respectively. Maximum no of trainees in each class will be 45. The mid level ToTs training will be conducted at the Region HQ whereas the providers training will be conducted at the council HQ. However there will be a special training of the key actor which are verification team, NHIF regional and HQ staff, MoF staff who will be dealing with disbursing RBF funds to the providers.

Orientation.

RBF is a new strategy in the country and need support from different stakeholders. For the stakeholders to accept and support RBF they need to have little knowledge which will assist them during decision making. Orienting them on RBF concept and their role in RBF implementation is very crucial. The stakeholders to be oriented on RBF as soon as new region is entered include:

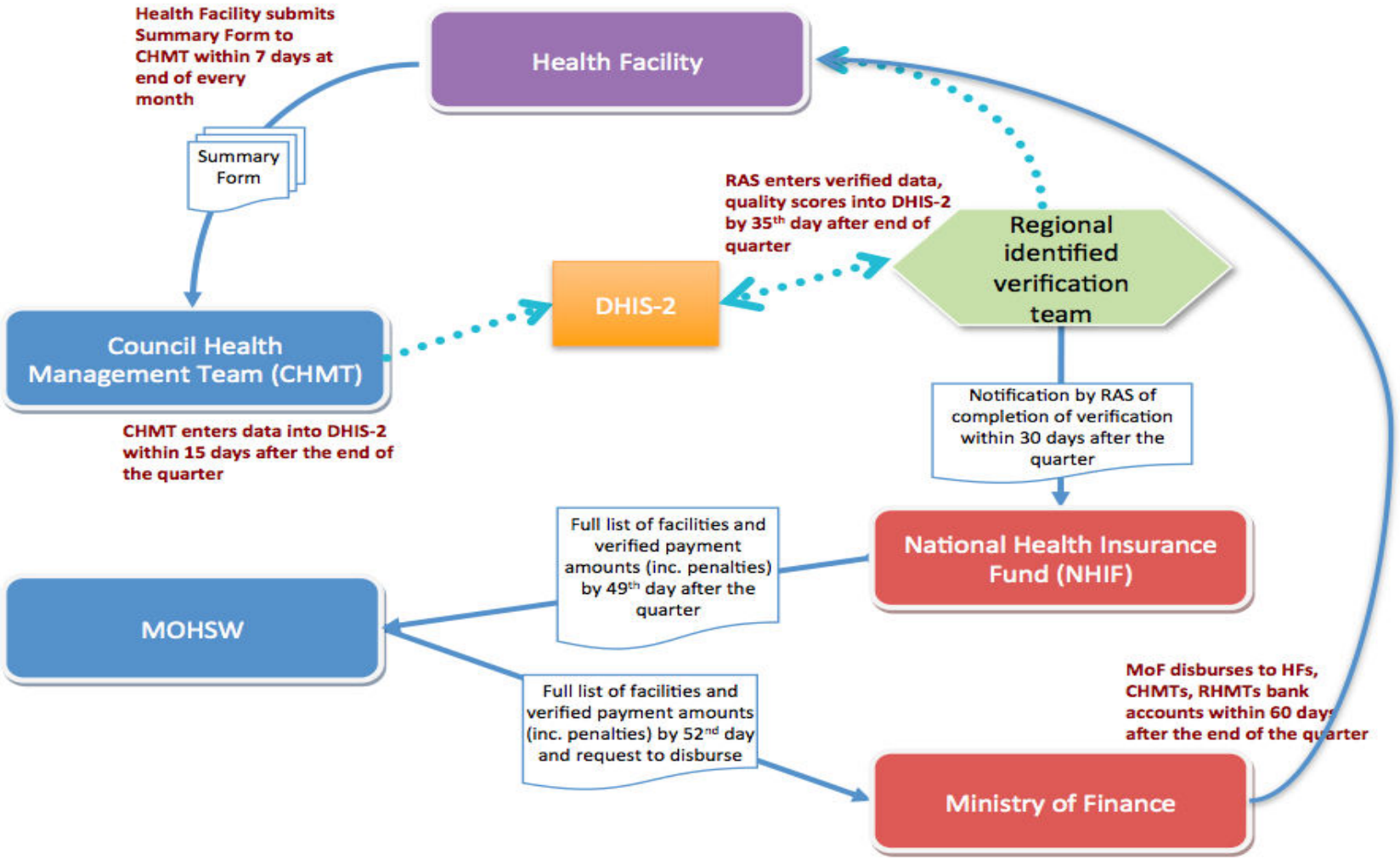
- Regional leaders (RC, RAS, Regional secretariat)
- NGOs present in the region
- District and Council Leaders (DC, DAS, DED, CMT members) Counselors and MPs
- Health Facility Governing Committee members and identified Community Health workers.

The orientation will be conducted by the mid level ToTs under the supervision of National RBF team and it will be basically on the RBF concept and the implementation of the system, leadership

and governance and financial management. The orientation will be of one day at the region and council HQ. After the Orientation the participants will be given leaflets for their reference.

Advocacy of RBF system

Sustainability of RBF in the country depends very much on advocacy strategies to be employed by the regulator.RBF advocacy is aiming at promoting RBF system to all key stakeholders as an efficient and effective strategy to strengthen health system and eventually accelerate the achievement of universal Health coverage. It is expected advocacy might influence their decision making and eventually support RBF implementation. The Mid level ToTs together with the national RBF team will be conducting RBF advocacy at the national, regional and council levels. An advocacy business plan developed by the regulator will guide the implementation of this important activity. Communication channels which will be used include routine legal meetings conducted at regional and council levels; leaflets, media (TV and radio presentations.) The follow up of implementation of advocacy business plan will be done by the routine RBF monitoring and evaluation system.


Health Facility submits Summary Form to CHMT within 7 days at end of every month
Health Facility
Summary Form
RAS enters verified data, quality scores into DHIS-2 by 35th day after end of quarter
Regional identified verification team
DHIS-2
Council Health Management Team (CHMT)
CHMT enters data into DHIS-2 within 15 days after the end of the quarter
Notification by RAS of completion of verification within 30 days after the quarter
National Health Insurance Fund (NHIF)
Full list of facilities and verified payment amounts (inc. penalties) by 49th day after the quarter
MOHSW
Full list of facilities and verified payment amounts (inc. penalties) by 52nd day and request to disburse
MoF disburses to HFs, CHMTs, RHMTs bank accounts within 60 days after the end of the quarter
Ministry of Finance

8. Monitoring and Evaluation

Monitoring is a fundamentally important aspect of RBF. In order to allow the full power of RBF to incentivize results in health facilities, there must be a continual feedback loop between observed weaknesses in the system and corrective actions taken to redress those weaknesses. Monitoring must therefore be systematic, have dedicated resources and be seen as an key driver of success. Both quantity indicators, and more frequently quality checklists, should be subject to change as improvements are seen. RBF incentivization should not be static, but rather should retain the flexibility to be modified as circumstances dictate. In many countries there are quick improvements seen in quantity provision. In addition quality checklists can improve over one or two years from a low base to an acceptably high level. At this point the components of the checklists should be changed to focus on new areas.

The underlying basis of all the analyses outlined in this section is the availability of data. In addition to what is outlined in the next paragraphs, other ad hoc analyses will be possible using those same data sources for even richer assessments.

The routine monitoring of RBF will have several facets.

Monitoring of Training

The training of regional, council and health facility staff will be assessed both at the time of training as well as at a pre-defined later stage to understand how effective the training has been, what level of knowledge has been retained and how the training can be improved in light of practical experience with implementing RBF.

Process Monitoring

Process monitoring will look at some of the underlying factors contributing to the success of RBF. These will be of two main types. The first type is operational factors such as the length of time for a given activity to be completed (e.g. submission of data into DHIS2 or quarterly verification). The second type is regular assessment of the influence of RBF on health facility staff motivation. These two types of process monitoring are key to addressing the bottlenecks to the success of RBF, and having the ability to swiftly address them. They will form the basis of targeted follow-up actions by the RBF Team and other actors, the effectiveness of which will then be assessed by the following quarter's process data.

Monitoring of Quantity Trends

Quantity indicators for RBF have been established based on national public health priorities as well as interventions whose coverage is so far seen to be low. The basic monitoring of quantity will be the overall increase in use of RBF services from quarter to quarter and year to year. Indicators which are not seen to be improving over time will need to be subject to root cause analysis. Potential factors impeding improvement might be lack of required inputs, insufficient funding of

that indicator (throug the fee) or others. In addition, improvements in indicators specific to councils and health facilities will be monitored to assess more specific bottlenecks.

The results of quantity verification will be analysed every quarter to understand which facilities or indicators demonstrate large deviances between reported and verified data. In addition there will be a mechanism to assess whether CHMTs are accurately submitting data into the DHIS2 on behalf of health facilities.

A further type of analysis will be to look at the data for non-RBF services to assess whether the participation of a health facility in RBF is having a positive or negative effect on services not specifically incentivized by RBF.

Monitoring of Quality Trends

The monitoring of quality will, as with quantity, have a basic component of analysing the trends in changes in quality scores from quarter to quarter and year to year, by region, council and health facility. Further than this, each section of the quality checklist will be scrutinized to allow two types of analysis. The first is to target low-performing facilities with specific follow-up to improve the quality of the provision of services. The second is to assess whether there are areas common to facilities both within and across regions which under-perform or over-perform.

Overall the scores achieved on the quality checklists should be monitored such that the Regulator can take the decision at the appropriate time to modify the checklists to focus on new areas.

Once the national health facility accreditation mechanism is operational, a link should be made between what is assessed through that mechanism and the aspects of quality incentivised through the quality checklists.

Impact Evaluation

There will be two impact evaluations conducted on Tanzanian RBF. The first will be by the World Bank, and the second by Ifakara Health Institute in collaboration with CMI (Norway) and LSHTM (London), and funded by Global Health and Vaccination Research (Globvac). The topic areas of these impact evaluations is yet to be decided and will form the subject of a meeting / workshop to be held.

Outcome Evaluation

There is the potential to make use of a newly established nationwide mortality surveillance system to assess how RBF impacts on health outcomes. Ifakara Health Institute has implemented a mortality surveillance platform called SAVVY (Sample Vital Registration with Verbal Autopsy - SAVVY) for a representative sample of households that captures births, deaths, and causes of deaths. SAVVY is set up to produce yearly estimates and trends in all-cause mortality and HIV related deaths in each of the eight geographically defined zones. 167,000 households and 850,000 individuals are enrolled in the surveillance, which takes place in 23 out of 119 districts. There will

shortly be further work done on establishing how the data from SAVVY can be used in treatment and control districts to assess the impact on outcomes of RBF.

9. References

NBS 2012

MoHSW 2013

Mid Term Review

HSSPIII

ANNEXES: 1 - 25

ANNEX 1: Pilot and rollout Plan for the Regions and Districts with targeted Health Facilities

Name of the	*Name of the District*	*Time flame*	*Activity*	*Number of HFs*
SHINYANGA	1. Kishapu DC	2015	Pilot	59
	2. Kahama TC	2015 & 2016	Pilot/Roll out	31
	3. Msalala DC	2016	Roll out	19
	4. Shinyanga DC			42
	5. Shinyanga MC			27
	6. Ushetu DC			22
	Total			**200**
PWANI	1. Bagamoyo DC	2016	Roll out	75
	2. Kibaha DC			25
	3. Kibaha TC			23
	4. Kisarawe			25
	5. Mafia DC			17
	6. Mkuranga DC			42
	7. Rufiji DC			70
	Total			**277**
GUEITA	1. Bukombe DC	2016	Roll out	19
	2. Chato DC			34
	3. Geita DC			48
	4. Geita TC			17
	5. Mbogwe DC			15
	6. Nyang'hwale DC			16
	Total			**149**
KAGERA	1. Biharamulo DC	2016	Roll out	27
	2. Bukoba DC			40
	3. Karagwe DC			39
	4. Kyerwa DC			30
	5. Misenyi DC			34
	6. Muleba DC			45
	7. Ngara DC			58
	Total			**297**
KIGOMA	1. Buhigwe DC	2016	Roll out	32
	2. Kakonko DC			27
	3. Kasulu DC			38
	4. Kasulu TC			20
	5. Kibondo DC			41
	6. Kigoma DC			35
	7. Kigoma MC			22
	8. Uvinza DC			45
	Total			**260**

MARA	1. Bunda DC	2016	Roll out	49
	2. Butiana DC			36
	3. Musoma DC			26
	4. Musoma MC			26
	5. Rorya DC			41
	6. Serengeti DC			53
	7 Tarime DC			28
	8. Tarime TC			12
	Total			**271**
SIMIYU	1. Bariadi DC	2016	Roll out	25
	2. Bariadi TC			18
	3. Busega DC			26
	4. Itilima DC			27
	5. Maswa DC			41
	6. Meatu DC			42
	Total			**179**
TABORA	1. Igunga DC	2016	Roll out	62
	2. Kaliua DC			41
	3. Nzega DC			57
	4. Sikonge DC			34
	5. Tabora DC			47
	6. Urambo DC			24
	7. Uyui DC			48
	Total			**313**
Grand Total				**1,946**

ANNEX 2: Key Implementers agreement between MOHSW, PMO-RALG, NHIF & MOF

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING (RBF) AGREEMENT BETWEEN

MINISTRY OF HEALTH AND SOCIAL WELFARE

AND

PRIME MINISTER's OFFICE REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

AND

MINISTRY OF FINANCE

AND

NATIONAL HEALTH INSURANCE FUND

Regulator:

Ministry of Health and Social Welfare (MOHSW)

Facilitator:

Prime Minister's Office Regional Administration and Local Government (PMORALG)

Fund holder:

Ministry of Finance (MOF)

Purchaser:

National Health Insurance Fund (NHIF)

The Performance Agreement for Results Based Financing

This performance agreement is entered on this……..day of……2015 between the Ministry of Health and Social Welfare of 6 Samora Machel Avenue 11478 Dar es Salaam (hereinafter referred to as **Regulator**), the Prime Minister's Office Regional Administration, Local Government of P.O Box 1923 Dodoma (hereinafter referred to as **Facilitator)**, the Ministry of Finance of P.O.Box 9111 Dar es Salaam (hereinafter referred to as **Fundholder**) and National Health Insurance Fund of P.O.Box 11360 Dar es Salaam (hereinafter referred to as **Purchaser)**

WHEREAS the main objective of this Agreement is to get commitment of the key actors on the implementation of Results Based Financing system (here in after referred as RBF). Furthermore, the commitment of each actor will allow smooth implementation of the system.

AND WHEREAS the RBF is designed to strengthen the health system and improve utilization and quality of health services to the communities including, the vulnerable groups through increased accountability and responsiveness.

WHEREAS in order to facilitate the work of the RBF implementation, the RBF design document and the RBF operational manual provide a systematic guideline for its implementation. The implementation of RBF will be integrated into the existing health and governance system with the aim of strengthening the provision of health services to the people of Tanzania

WHEREAS the health system of Tanzania operates a decentralized health system organized around three functional levels: Council (primary level), regional (secondary level) and referral hospitals (tertiary level).

WHEREAS under this system, the councils have full mandate for planning, implementation, monitoring and evaluation of health services.

WHEREAS the Government of Tanzania is fully committed to achieving the MDGs and the universal health coverage, which are part of the National Strategy for Growth and Reduction of Poverty (MKUKUTA). As such, the health sector is considered as one of the top priority sectors for investment.

WHEREAS during the period of 2011 – 2013 the MOHSW piloted the Pay for Performance (P4P) project in the Pwani region with the aim to accelerate the attainment of MDGs 4 and 5 and to test program component that will inform the national scale up in the country.

WHEREAS Results Based Financing (RBF) as a new strategy, has potential to reform the health sector with system wide effects on service delivery, leadership and governance, human resource, health management information system, medical supplies, vaccines and equipment and health care financing in order to improve accountability, efficiency and equity.

WHEREAS the implementation of RBF requires a **Regulator** which has the capacity to regulate and coordinate the RBF system implementation by the various actors.

WHEREAS the Ministry of Health and Social Welfare (MOHSW) qualifies to be the regulator of RBF, since naturally it has responsibility to oversee the health services provided to the people of Tanzania. It also has the mandate to ensure the population receives quality health services to improve their livelihood.

WHEREAS RBF needs an institution to be the **Purchaser** with experience of purchasing health services and adequate capacity in terms of human resource, managerial skills and strong analytical skills on data reports.

WHEREAS NHIF qualifies to be the purchaser because it has a vast experience of purchasing health services from almost all health facilities in the country. Moreover, NHIF has a well-organized networking and robust payment systems and a well-established relationship with health facilities system up to the council level.

WHEREAS RBF needs an institution to be **Fund holder** for holding and disburse funds to the providers timely as required.

WHEREAS MOF qualifies to be Fund holder of the system since it has strong system and capacity of holding and disbursing funds in the country.

WHEREAS RBF needs an institution to be a **Facilitator** for RBF system to facilitate the smooth implementation at the regional, council and community levels.

WHEREAS PMORALG qualifies to be the facilitator of the RBF since it has a mandate to supervise and operates a decentralized health system organized at the local levels.

WHEREAS Verification is the cornerstone of RBF since payment of results requires quality data, there will be internal and independent verification.

Whereas the internal verifier will be the Regional Secretariat, which will identify a verification team among the existing capacity in the region including RHMT, NHIF staff, Regional Hospital staff, NGOs, Internal Auditors and other experts to undertake the verification. Staffs from NHIF at the regional level participate in verification so that the NHIF is confident on the verified results

And whereas The independent verifier will be the Controller Auditor General (CAG) who will conduct the ex-post counter-verification twice a year, using a sample of 25% of facilities at that time participating in RBF

NOW THEREFORE the parties agree as follows;-

ARTICLE 1

COMMITMENT

By signing this performance agreement all parties agree in good faith to enter in a collaboration to implement RBF, working as a team by performing their responsibilities for the improvement of health services in the country.

ARTICLE 2

RESPONSIBILITIES OF THE PARTIES

2.1 Shared roles and responsibilities

1. Coordinating resources for effective implementation
2. Sharing information
3. Acting in a timely and prompt manner according to the details set forth in the Design Document and Operational Manual

2.2 The roles and responsibilities of the Regulator shall be to:

In implementation of the RBF the Regulator has to perform the hereunder functions which are;-

1. Provide overall oversight of the RBF mechanism including reviewing the RBF Design Document, the Operational Manual and other relevant documents;
2. Approve indicators to be included in RBF and their respective prices;
3. Review costing and budgeting for the RBF system;
4. Mobilize, monitor and allocate adequate resources for implementation of RBF system;
5. Monitoring and evaluation of the RBF system;
6. Support the RBF Team to carry out their day to day duties in the implementation and management of the system
7. Collaborate with other stakeholders for sustainably scaling up RBF;
8. Share best practices with other stakeholders within and outside the country.

2.2 The roles and responsibilities of the Purchaser shall be to:

1. To purchase health services from health facilities according to indicators set by the Regulator;
2. Entering into a contract with each participating health facility;
3. Participate in the verification process and approve payments after receiving verification reports;
4. Prepare a full list of health facilities, health facility addresses, health facility bank accounts and verified payment amounts (including penalties) and initiate the payment process with the MOHSW;
5. Recommends to MoHSW necessary actions for any irregularities found during the verification process, as highlighted to the NHIF by the RAS of the relevant region;
6. Follow up with Ministry of Finance to ensure approved incentive is timely disbursed to the facilities.

2 .4 **The roles and responsibilities of Fund holder shall be to:-**

1. To ensure that the design of the RBF disbursement and financial reporting processes are consistent with the Government of Tanzania financial management regulations.
1. To disburse RBF funds for incentive to health facilities, upon receipt of payment request from the Purchaser.
2. To compile disbursement reports for each quarter through Epicor system.
3. To share the disbursement schedules with NHIF, MOHSW and PMOLARG immediately after payments are effected.

2.5 The roles and responsibilities of Facilitator shall be to:-

1. Providing sound advice to CHMTs and health facilities on how to plan to maximize the future revenue from RBF;
2. Support the development of health facility business plans;
3. Capacity building of CHMTs and health facilities;
4. Continuous follow up of RBF activities and results in order to improve future results;
5. Providing quality and timely information regarding health services provision in regions and LGAs to higher authorities;
6. Monitoring of health provision through the Regional Secretariats, represented by the RHMT on issues related to health;
4. Providing link, support and advice between regions, LGAs and all other health development partners to ensure health services provisions are improved.

2.6 **The roles and responsibilities of a verifier shall be to:-**

1. Verify the results reported by the provider by checking the correctness and consistency of data entered into HMIS tools and DHIS2;
2. Check whether minimum quality standards of service provision in health facilities are met;
3. Provide timely feedback to providers, purchaser and regulator on the quality of services basing on agreed indicators;
4. Advice the regulator, purchaser and providers on issues of service coverage and quality of care depending on the verification results;
5. Conduct patient tracing and satisfaction survey
6. Report the verified results to the purchaser.

ARTICLE 3

PERIOD OF AGREEMENT

The period of this Agreement shall be from the …….day of …….2015 to the …… day of ……... 201... unless terminated sooner, amended by written consensus between the Parties, or extended in accordance with the terms of this Agreement. This Agreement, upon expiry, may be renewed by mutual consent of the Parties.

ARTICLE 4

NOTICES

Whenever any notice is to be given hereunder, it shall be in writing and shall be deemed received, if delivered by courier on a working day, or if such day is not a working day, the first business day thereafter, or on the second business day following mailing, if sent by first class mail, postage prepaid. Notices shall be addressed to the contacts as aforementioned.

ARTICLE 5
RBF INCENTIVE PAYMENTS

The RBF payments will be made to facilities, not individual staff. However, once the facility receives its incentive payments, it will have a certain degree of autonomy on how to use the funds as it sees fit, within certain parameters.

Incentive payments will be split between bonuses to staff members (maximum 25% of the payment in a quarter) and investment funds for facility operations or demand-creation initiatives (Minimum 75% of the total).

a. For staff bonuses at dispensaries and health centres, CHMTs will be responsible for ensuring that the incentives are distributed among all staff according to set criteria. At hospitals, the Hospital

Management Teams (HMTs) will be responsible for ensuring that incentives are distributed fairly among all staff. The identified verification team will conduct financial auditing during verification to check and ensure incentives were being distributed as guided.

b. CHMTs and RHMTs shall receive quarterly incentives as well upon their performances and the distribution of these incentives are well explained in their performance agreement with the purchaser
c. Funds for facility investments will be utilized according to the facility's priorities. This can include operating expenses. It could also include investing in the community to support demand-generating activities that could further improve the quality health care. Throughout the implementation the RBF technical team will seek to gather the various experiences and innovations from facilities and share best practices from all regions.
d. The Health Facility Governing Committee (HFGC) must approve distribution and use of the RBF funds every quarter. The minutes of this meeting must be signed by the health facility in-charge and the chair of the HFGC and retained at the facility. These minutes must be available for inspection by supervision and verification teams.
e. Use of the RBF funds must be recorded accurately according to the financial record-keeping guidelines. Quarterly financial reports must be prepared according to the guidelines provided and submitted to the DMO's office in a quarterly basis.
f. Payments will also be made to Community Health Workers for services provided, according to the set criteria

ARTICLE 6
PAYMENT MODALITIES

The MOF as the fund holder will be responsible for disbursing RBF funds to health facilities and management teams. The disbursement of RBF funds from MOF to health facilities and management teams (RHMT and CHMT) will be effected immediately on receipt of the Quarterly RBF Payment report prepared by the NHIF, and transmitted to the MOF by the MOHSW. This report, which is a compilation of the verified and approved quarterly reports from the RS, will include the payment amounts and bank account details for each facility and management team.

The RS will receive operational funds for the RBF activities upon meeting all requirements as stipulated in their agreement with the purchaser but the 1st operational funds will be paid in advance at 100% to allow smooth implementation of RBF.

ARTICLE 7

AMENDMENTS AND TERMINATION

7.1 Any modification(s) to this Memorandum of Understanding shall be made in writing and must be signed by the authorized representatives of both parties

7.2 This memorandum of Understanding may be terminated by either party giving a ninety (90) days notice to the other party in writing. Provided however that such termination shall not affect the completion of any programme or activity underway at the time that the notice of termination is given.

ARTICLE 8

IRREGULARITIES, PENALTIES AND SANCTIONS

8.1 If it found that there are Misreporting or falsifying service delivery information, Misusing RBF funds (not within official guidelines) and misreporting the use of RBF funds, the following sanctions will be applied as appropriate:

8.2 If issues with the accuracy or quality of data are spotted, the district and regional administrative authorities will be notified and 10% of the total incentives earned for each falsified indicator by a facility will be deducted. If intentional/deliberate falsification cases are spotted, the applicable Tanzanian laws for fraud and falsification of medical records will be applied and the responsible health care worker will entail disciplinary actions according civil servant regulations.

8.3 The penalty will be in addition to any legal proceedings that the Anti-Corruption Commission might wish to institute, where criminal acts have been committed. Furthermore the following action will be taken

ARTICLE 9

THE DISPUTE RESOLUTION

9.1 If the provider does not agree with a performance payment they must submit the dispute in writing to the attention of the Regulator not later than 60 days after the discovery of the underpayment. A Joint team of Verifier, Regulator and Purchaser will meet, review the case and make recommendations.

9.2 The response to complaint will be made not later than 30 days from the receipt of the complaint. If additional payment needs to be done, the payment will be added to the next quarter performance payment. If there is no agreement on the performance payment, the regulator (MoHSW) will conduct mediation and propose a final recommendation.

ARTICLE 10

APPLICABLE LAW

This implementation and operation if this agreement shall be, construed and governed in all respects and for all purposes by and in accordance with the laws of the United Republic of Tanzania.

For and on behalf of the MINISTRY OF HEALTH AND SOCIAL WELFARE

In the Presence of Witness:

Signature: _____

Title: **THE PERMANENT SECRETARY**

Name: _____

Date:_____

Signature: _____

Title: _____

Name:_____

Date:_____

FOR AND ON BEHALF OF THE MINISTRY OF FINANCE

In the Presence of Witness:

Signature: _____

Title: **THE PERMANENT SECRETARY**

Name: _____

Date: _____

Signature: _____

Title: _____

Name:_____

Date:_____

FOR AND ON BEHALF OF THE PMORALG

In the Presence of Witness:

Signature: _____

Title: **THE PERMANENT SECRETARY**

Name: _____

Date: _____

Signature: _____

Title: _____

Name:_____

Date:_____

FOR AND ON BEHALF OF THE NHIF

In the Presence of Witness:

Signature: _____

Title: **THE DIRECTOR GENERAL**

Name: _____

Date: _____

Signature: _____

Title: _____

Name:_____

Date:_____

ANNEX 3: Agreement between the NHIF and RAS

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING (RBF) AGREEMENT
BETWEEN THE NATIONAL HEALTH INSURANCE FUND (NHIF) AND THE REGIONAL SECRETARIAT (RS)

Purchaser:

National Health Insurance Fund (NHIF)

And

Verifier:

Regional Secretariat of SHINYANGA

THIS PERFORMANCE AGREEMENT (the Agreement) is made this …… day of…… 2015 between National Insurance Health Fund (**NHIF**) of P.O.Box 11360 Dar es Salaam (hereinafter referred to as **Purchaser**) and Shinyanga Regional Secretariat (**RS**) of P.O.Box …… (hereinafter referred to as **Verifier**)

WHEREAS the RBF is designed to strengthen the health system and improve utilization and quality of health services to the communities including, the vulnerable groups through increased accountability and responsiveness

WHEREAS Verification is the cornerstone of RBF since it reduces the risk that the reported results could be artificially inflated and ensures that reported data are of quality

WHEREAS Internal Verification for RBF will be conducted by the Region Secretariat

WHEREAS NHIF is the purchaser and it has a vast experience of purchasing health services from almost all health facilities in the country. Moreover, NHIF has a well-organized networking and robust payment systems and a well-established relationship with health facilities system up to the council level.

NOW THEREFORE the parties agree as follows:-

ARTICLE 1
ROLES AND RESPONSIBILITIES OF INTERNAL VERIFIER

The internal verifier will be the Regional Secretariat, which will identify a verification team among the existing capacity in the region including RHMT, NHIF staff, Regional Hospital staff, NGOs, Internal Auditors and other experts to undertake the verification. Staffs from NHIF at the regional level participate in verification so that the NHIF is confident on the verified results.

Therefore, the **internal verifier** will be responsible for the following:

1. Verify the results reported by the provider by checking the correctness and consistency of data entered into HMIS tools and DHIS2;
2. Check whether minimum quality standards of service provision in health facilities are met;
3. Provide timely feedback to providers, purchaser and regulator on the quality of services basing on agreed indicators;
4. Advice the regulator, purchaser and providers on issues of service coverage and quality of care depending on the verification results;
5. Conduct patient tracing and satisfaction survey
6. Report the verified results to the purchaser

ARTICLE 2
ROLES OF THE PURCHASER

NHIF will be the purchaser because it has a vast experience of purchasing health services from almost all health facilities in the country. Moreover, NHIF has a well-organized networking and robust payment systems and a well-established relationship with health facilities system up to the council level.

The roles of the Purchaser shall be to:

1. Purchase health services from health facilities according to indicators set by the Regulator;
2. Enter into a contract with each participating health facility;
3. Participate in the verification process and approve payments after receiving verification reports;
4. Prepare a full list of health facilities, health facility addresses, health facility bank accounts and verified payment amounts (including penalties) and initiate the payment process with the MOHSW;
5. Recommend to MoHSW necessary actions for any irregularities found during the verification process, as highlighted to the NHIF by the RAS of the relevant region;
6. Follow up with Ministry of Finance to ensure approved incentive is timely disbursed to the facilities.

ARTICLE 3
OPERATIONAL BUDGET FOR THE RS

Based on the number of CHMTs, Health facilities and administrative cost for verification, the maximum budget of **TZS 11,383,333** (Eleven Million, Three Hundred and Eighty Three Thousand, Three Hundred and Thirty Three Tanzanian Shillings) shall be allocated to Shinyanga RS per quarter.
But this can be lower depending on the actual performance achieved. For example, a score equivalent to 90% will mean that the RS can only receive 90% of **TZS 11,383,333** which is equivalent to TZS 10,244,999.
The maximum amount can change based on the number of CHMTs, health facilities to be verified/assessed in the region and distances.
The budget allocated for the operations of the RS shall be sent within 60 days after the end of the quarter to the RS account, based on the conditions defined in this agreement
These operational funds shall be used for:

- Organizing and carrying out the verification/Assessment of CHMTs, Health facilities
- Conducting patient tracing and satisfaction surveys,
- Organizing and holding R-RBF meetings,
- Conducting of the field visits by the RS members on activities related to RBF in the intervention councils
- Any other activity related to RBF in the region

ARTICLE 4
CONDITIONS FOR OBTAINING OPERATIONAL BUDGET OF THE RS

4.1 Timely and Completeness of data entry
The data/results of each verified/assessed facility or CHMT is supposed to be entered into the database as follows:

- Not later than 5th day of May of current year (1st quarter)
- Not later than 5th day of August of current year (2nd quarter)
- Not later than 5th day of November of current year (3rd quarter)
- Not later than 5th day of February of Following year (4th quarter)

In case of delay of data entry for even one CHMT/Health Facility, the RS shall lose 0.5% of their quarterly budget per day of delay per CHMT/Health facility with delays in data entry.

4.2 Timely R-RBFC Quarterly meetings as follows:

- Not later than 10th day of May of current year (1st quarter)
- Not later than 10th day of August of current year (2nd quarter)
- Not later than 10th day of November of current year (3rd quarter)
- Not later than 10th day of February of Following year (4th quarter)

In case of any delay in the holding of the quarterly R-RBFC meetings, the RS shall lose 0.5% of their quarterly budget per day of delay

4.3 Timely transmission of approved quarterly consolidated invoice to the NHIF as follows:

- Not later than 15th day of May of current year (1st quarter)
- Not later than 15th day of August of current year (2nd quarter)
- Not later than 15th day of November of current year (3rd quarter)
- Not later than 15th day of February of Following year (4th quarter)

In case there is any delay in the transmission of the above documents, the RS will lose 1% of funding per day of delay

The RS will receive operational funds for the RBF activities upon meeting all these above requirements but the 1st operational funds will be paid in advance at 100% to allow smooth implementation of RBF.

Quarter two activities by RS, they will have to use funds paid based on quarter one assessment by MOHSW.

The RS will be assessed once per quarter by the MOHSW and PMOLARG using the RS quarterly assessment checklist which will allow to determine the amount to be paid according the their performance in that particular quarter.

ARTICLE 5
PERIOD OF THE AGREEMENT

The period of this Agreement shall be from the …….day of ……..2015 to the ……. day of ……..201… unless terminated or amended sooner by written consensus between the Parties, or extended in accordance with the terms of this Agreement. This Agreement, upon expiry, may be renewed by mutual consent of the Parties.

ARTICLE 7
NOTICES

Whenever any notice is to be given hereunder, it shall be in writing and shall be deemed received, if delivered by courier on a working day, or if such day is not a working day, the first business day thereafter, or on the second business day following mailing, if sent by first class mail, postage prepaid. Notices shall be addressed to the contacts as aforementioned.

ARTICLE 8
AMENDMENTS AND TERMINATION

Any modification(s) to this agreement shall be made in writing and must be signed by the authorized representatives of both parties

Either party giving a ninety (90) days notice to the other party in writing may terminate this agreement. Provided however that such termination shall not affect the completion of any programme or activity underway at the time that the notice of termination is given.

ARTICLE 9
DISPUTE RESOLUTION

The Parties shall in good faith attempt to resolve any disagreement or dispute among them as to the application or meaning of any provisions of this agreement amicably through consultation.
If there is no agreement on the dispute, the regulator (MoHSW) will conduct mediation and propose a final recommendation.

ARTICLE 10
APPLICABLE LAW

This Agreement, its implementation and operation shall be construed and governed in all respects and for all purposes by and in accordance with the laws of the United Republic of Tanzania.

For and on behalf of the RS:

Signature:……..

Name: ……..

Regional Administrative Sec.

Date:……..

For and on behalf of the NHIF:

Signature:……..

Name:……..

Director General

Date:……..

In the Presence of Witness:

Signature:……..

Name: ……..

……..

Date:……..

In the Presence of Witness:

Signature:……..

Name: ……..

……..

Date:……..

ANNEX 4: Agreement between the NHIF and RHMT

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING (RBF) AGREEMENT
BETWEEN THE NATIONAL HEALTH INSURANCE FUND (NHIF) AND THE REGIONAL HEALTH MANAGEMENT TEAM (CHMT)

Purchaser

National Health Insurance Fund (NHIF)

And

Provider

……RHMT

THIS PERFORMANCE AGREEMENT (the Agreement) is made this …… day of…… 2015 between the Shinyanga **RHMT** and the National Health Insurance Fund (hereinafter both referred to as "**the Parties**)

A. **WHEREAS** the Ministry of Health and Social Welfare (hereinafter referred to as **"MoHSW"**) is piloting a Result based Financing (hereinafter referred to as **"RBF'** in the Shinyanga Region with support from the World Bank.

B. **AND WHEREAS** the RBF is designed to strengthen the health system and improve utilization and quality of health services to the communities including, the vulnerable groups through increased accountability and responsiveness.

C. **AND WHEREAS** NHIF is responsible for purchasing the health services from the providers.

D. **AND WHEREAS the RHMT** members in each Region are responsible to ensure the health services (coverage and quality) are improved by supporting CHMTs, Health facilities and the community levels

NOW THEREFORE this Agreement WITNESSETH AS FOLLOWS:-

The system will provide incentives for health services delivered and quality improved as per set indicators

ARTICLE 1
OBJECTIVE OF THIS AGREEMENT

This agreement establishes the organs and rules of governing the RBF system in Tanzania. The general regulation of the RBF in Tanzania is the mandate of the Ministry of Health to lead the RBF system with strategic planning and policy coordination among the various actors; provide guidelines, norms and standards and overall support and supervision and all RHMT Staff motivation agreements shall be subject to the existence of this agreement.

ARTICLE 2
THE ROLES AND RESPONSIBILITIES OF THE PURCHASER

1.1 To purchase health services from the providers according to set indicators,
1.2 Enter into agreement with the health providers,
1.3 Participate in the verification process, approve payment after receiving verification reports and initiate the payment process with the Fund holder via the Ministry of Health,
1.4 Recommend to the regulator necessary actions for any irregularities found during the verification process,
1.5 Follow up with Fund holder via the Ministry of Health to ensure approved incentive is timely disbursed to the providers.

ARTICLE 3
THE ROLES AND RESPONSIBILITIES OF THE MINISTRY OF HEALTH AND SOCIAL WELFARE

3.1 Provide overall oversight of the RBF mechanism including reviewing the RBF Design Document, the Operational Manual and other relevant documents;
3.2 Approve indicators to be included in RBF and their respective prices;
3.3 Review costing and budgeting for the RBF system;
3.4 Mobilize, monitor and allocate adequate resources for implementation of RBF system;
3.5 Monitoring and evaluation of the RBF system;
3.6 Support the RBF Team to carry out their day to day duties in the implementation and management of the system
3.7 Collaborate with other stakeholders for sustainably scaling up RBF;
3.8 Share best practices with other stakeholders within and outside the country.

ARTICLE 4
ROLES AND RESPONSIBILITIES OF RHMT

4.1 Spearhead the verification process of the RBF in the region and enter timely the verified data into DHIS2,
4.2 Timely submission of regional quarterly report,
4.3 Quarterly report assessment results,
4.4 Regional Management Supportive Supervision for CHMT (RMSS-C) implementation rate,
4.5 Comprehensive Hospital Operational Plan (CHOP) quarterly report submission,
4.6 Human Resource for Health (HRH) Data collection support,

ARTICLE 5
ASSESSMENT OF THE RHMT

The team composed by people from the different departments of the MOHSW and PMORALG will assess the RHMT once per quarter to ascertain the extent to which it has performed its mandate as outlined in RHMT checklist.

The MOHSW and NHIF, reserve the right to communicate to the citizens of Tanzania, via the national media, the variations of performance observed in RHMTs where the RBF scheme is being implemented.
The MOHSW and PMOLARG, reserve the right to modify the composition of the RHMT if serious dysfunctions are observed on a countrywide scale.

ARTICLE 6
DETERMINATION OF THE AMOUNT TO BE PAID TO THE CHMT AS PERFORMANCE INCENTIVE

After the results from quarterly assessment have been entered in RBF database, the invoice will be generated, signed by the MoHSW Director Policy and Planning, approved by the MoHSW Permanent Secretary and finally sent to Ministry of Finance to release the funds.

RHMT's performance against the indicators specified in the RHMT's RBF Assessment Checklist on a quarterly basis. The maximum amount of money that Shinyanga RHMT can get as Performance

Incentive is TZS 25, 447,117 (Twenty-Five Million, Four Hundred and Forty Seven Thousand, One Hundred and Seventeen Tanzanian Shillings) per quarter, but this can be lower depending on the actual performance achieved. For example, a score equivalent to 75% will mean that the CHMT can only receive 75% of TZS 25, 447,117 which is equivalent to TZS 19, 085,337.

The maximum amount can change based on the population in the region.

ARTICLE 7
DISTRIBUTION AND USE OF INCENTIVES AT RHMT LEVEL

From the total amount earned as Performance Incentive, 25% should cater for staff bonuses while the remaining 75% shall be used for re-investments, monitoring, and other activities at the RHMT. The RMO will coordinate the distribution of bonus amounts for staff on a quarterly basis. The bonus to be paid to the employee will be based on responsibility points category and the days worked.

The reinvestment funds shall not be used for any payments to individuals such as lunch/extra duty allowances, daily substance allowances

ARTICLE 8
PAYMENT FOR SERVICES RENDERED

Payment of the RHMT Performance Incentives should be done within 60 days after the end of the quarter. The payment shall be a fixed amount with adjustments made on the verifiable performance of the RHMT. The RHMT will be paid 100% of the applicable amount if it executes its duty satisfactorily as required.

ARTICLE 9
ENTRY INTO FORCE

This agreement constitutes the entire agreement between the National Health Insurance Fund and the Regional Health Management Team Office. There shall be no variation of it, except in writing and signed by duly appointed representatives from the National Health Insurance Fund and the Regional Health Management Team Office. This agreement shall enter into force on the date of signature by duly appointed representatives from the both parties.

IN WITNESS WHEREOF the undersigned, being duly authorized by their respective representatives, have caused their hands and seals to be hereby affixed the day and year first before written.

For the National Health Insurance Fund

Signature:……..

Name: ……

Director General

Date:……..

In the Presence of Witness:

Signature:……

Name: ……

……..

Date:……..

For the Regional Health Management Team

Signature:……..

Name:……

Regional Medical Officer

Date:……

In the Presence of Witness:

Signature:……..

Name: ……

Regional Administrative Sec.

Date:……

ANNEX 5: Agreement between the NHIF and CHMT

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING (RBF) AGREEMENT
BETWEEN THE NATIONAL HEALTH INSURANCE FUND (NHIF) AND THE COUNCIL HEALTH MANAGEMENT TEAM (CHMT)

Purchaser

National Health Insurance Fund (**NHIF**)

And

Provider

CHMT of **Kishapu** Council

Located in **Shinyanga** Region

THIS PERFORMANCE AGREEMENT (the Agreement) is made this …… day of…… 2015 between the Kishapu **CHMT** and the National Health Insurance Fund (hereinafter both referred to as "**the Parties**)

A. **WHEREAS** the Ministry of Health and Social Welfare (hereinafter referred to as **"MoHSW"**) is piloting a Result based Financing (hereinafter referred to as **"RBF'** in the Shinyanga Region with support from the World Bank.

B. **AND WHEREAS** the RBF is designed to strengthen the health system and improve utilization and quality of health services to the communities including, the vulnerable groups through increased accountability and responsiveness.

C. **AND WHEREAS** NHIF is responsible for purchasing the health services from the providers.

D. **AND WHEREAS** the CHMT members in each Council are responsible to ensure the health services (coverage and quality) are improved by supporting Health facilities and the community levels

NOW THEREFORE this Agreement WITNESSETH AS FOLLOWS:-
The system will provide incentives for health services delivered and quality improved as per set indicators

ARTICLE 1
OBJECTIVE OF THIS AGREEMENT

This agreement establishes the organs and rules of governing the RBF system in Tanzania. The general regulation of the RBF in Tanzania is the mandate of the Ministry of Health to lead the RBF system with strategic planning and policy coordination among the various actors; provide guidelines, norms and standards and overall support and supervision and all CHMT Staff motivation agreements shall be subject to the existence of this agreement.

ARTICLE 2
THE ROLES AND RESPONSIBILITIES OF THE PURCHASER

1.1 To purchase health services from the providers according to set indicators,
1.2 Enter into agreement with the health providers,
1.3 Participate in the verification process, approve payment after receiving verification reports and initiate the payment process with the Fund holder via the Ministry of Health,
1.4 Recommend to the regulator necessary actions for any irregularities found during the verification process,
1.5 Follow up with Fund holder via the Ministry of Health to ensure approved incentive is timely disbursed to the providers.

ARTICLE 3
THE ROLES AND RESPONSIBILITIES OF THE MINISTRY OF HEALTH AND SOCIAL WELFARE

3.1 Provide overall oversight of the RBF mechanism including reviewing the RBF Design Document, the Operational Manual and other relevant documents;
3.2 Approve indicators to be included in RBF and their respective prices;
3.3 Review costing and budgeting for the RBF system;

3.4 Mobilize, monitor and allocate adequate resources for implementation of RBF system;
3.5 Monitoring and evaluation of the RBF system;
3.6 Support the RBF Team to carry out their day to day duties in the implementation and management of the system
3.7 Collaborate with other stakeholders for sustainably scaling up RBF;
3.8 Share best practices with other stakeholders within and outside the country.

ARTICLE 4
ROLES AND RESPONSIBILITIES OF CHMT

22. Incorporate the RBF mechanism into the CCHP.
23. Conduct cascade training for health facility staff, to ensure they fully understand their role and responsibilities for implementation of the RBF system,
24. To ensure that the required resources are available for provision of quality health services.
25. Conduct supportive supervision to all health facilities to ensure delivery of quality health services.
26. To compare and certify the quarterly quality and quantity data that have been entered in the RBF/ DHMIS district database,
27. Ensure all health facility reports are entered into the DHIS-2 database by the 15th of consecutive month

4.6 Ensure each Health Facility use the RBF funds according to guidelines and government financial regulation and financial reports are compiled and submitted on time and provide technical supports on financial matters,

28. In areas where there is no access to Government health facilities, or insufficient capacity to serve the local population, CHMT will facilitate to sign an agreement with Non- Government, FBO or Private health facilities which will be eligible to participate in delivering health services under RBF system.
29. Advocate RBF to all relevant stakeholders at council level,
30. Ensure availability of drugs, supplies and equipment at all health facilities,
31. Mobilizes and manage resources allocated for health care delivery,
32. Ensure communities are responsible in taking care of their own health and also the safety of medicine and equipment in their health facilities
33. Assist the health facilities in developing, approving and implementing quarterly RBF business plans
34. Produce and timely submit Council Profile Reports to PMORALG and MOHSW
35. To ensure that all HFs in the council have minimum qualified staffing requirement

36. The CHMT will have the principle responsibility of making operational mechanisms decisions capable of supporting the success of the RBF system,
37. To impose the respect of the agreements and rules, including if necessary the administration of the sanctions envisaged in the agreements,
38. Facilitate the regional verification team to carry out their activities within the council
39. Support the Health Facilities to implement recommendations made by the verification team on both quality assessment and quantity verification,
40. Share the incentive information among health facilities after the decision of the Regional RBF Committee meeting,
41. To ensure that all dedicated financial resources are disbursed to the respective facilities without reallocation,
42. To help health facilities and community to be able to implement the RBF strategy by:
    - Managing the various resources (material, financial and human) in a transparent manner.
    - Providing information and sensitizing the population on the importance of participating in the various public health strategies.

ARTICLE 5
PERFORMANCE OF THE CHMT INDICATORS

5.1 The identified RBF verification team will assess the CHMT once per quarter to ascertain the extent to which it has performed its mandate as outlined in CHMT checklist.
5.2 The Council reserve the right to communicate to the people within their councils, via the national/local media, the variations of performance observed in health facilities where the RBF system is being implemented
5.3 The MOHSW and PMOLARG, reserve the right to modify the composition of the CHMTs if serious dysfunctions are observed on a countrywide scale.

ARTICLE 6
DETERMINATION OF THE AMOUNT TO BE PAID TO THE CHMT AS PERFORMANCE INCENTIVES

The Regional RBF Committee (R-RBFC) shall validate the CHMT's performance against the indicators specified in the CHMT's RBF assessment Checklist on a quarterly basis. The ceiling amount of money that Kishapu CHMT can get as Performance Incentive is TZS 18, 104,697 (Eighteen Million, Hundred and Four Thousand, Six Hundred and Ninety Seven Tanzanian Shillings) per quarter, but this can be lower depending on the actual performance achieved. For example, a score equivalent to 75% will mean that the CHMT can only receive 75% of TZS 18, 104,697 which is equivalent to TZS 13,578,523.
The ceiling amount can change based on the population in the council.

ARTICLE 7
DISTRIBUTION AND USE OF INCENTIVES AT CHMT LEVEL

From the total amount earned as Performance Incentive, 25% should cater for staff bonuses while the remaining 75% shall be used for re-investments, monitoring, and other activities at the CHMT. The DMO will coordinate the distribution of bonus amounts for staff on a quarterly basis. The bonus to be paid to the employee will be based on responsibility points category and the days worked.

The reinvestment funds shall not be used for any payments to individuals such as lunch/extra duty allowances, daily substance allowances

ARTICLE 8
PAYMENT FOR SERVICES RENDERED

Payment of the CHMT Performance Incentives should be done within 60 days after the end of the quarter. The payment shall be a fixed amount with adjustments made on the verifiable performance of the CHMT. The CHMT will be paid 100% of the applicable amount if it executes its duty satisfactorily as required.

ARTICLE 9
ENTRY INTO FORCE

This agreement constitutes the entire agreement between the National Health Insurance Fund and the Council Health Management Team. There shall be no variation of it, except in writing and signed by duly appointed representatives from the National Health Insurance Fund and the Council Health Management Team. This agreement shall enter into force on the date of signature by duly appointed representatives from the both parties.

IN WITNESS WHEREOF the undersigned, being duly authorized by their respective representatives, have caused their hands and seals to be hereby affixed the day and year first before written.

For the NHIF	**For the CHMT**
Signature:……..	Signature:……..
Name: ……..	Name:……..
Director General	District Medical Officer
Date:……	Date:……..

In the Presence of Witness:

Signature:……..

Name: ……..

……

Date:……..

In the Presence of Witness:

Signature:……..

Name: ……..

District Executive Director

Date:……..

ANNEX 6: Agreement between the NHIF and Health Facility

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING (RBF) AGREEMENT
BETWEEN THE NATIONAL HEALTH INSURANCE FUND (NHIF) AND THE HEALTH FACILITY

Purchaser

National Health Insurance Fund (NHIF)

And

Provider

Health Facility:. ……District Hospital/Health Center/Dispensary

Located in …… Council & ..... Region

THIS PERFORMANCE AGREEMENT (the Agreement) is made this …… day of…… 2015 between the …… **Health Facility** and the National Health Insurance Fund (hereinafter both referred to as "**the Parties**)

A. **WHEREAS** the Ministry of Health and Social Welfare (hereinafter referred to as **"MoHSW"**) is piloting a Result based Financing (hereinafter referred to as **"RBF'** in the Shinyanga Region with support from the World Bank.
B. **AND WHEREAS** the RBF is designed to strengthen the health system and improve utilization and quality of health services to the communities including, the vulnerable groups through increased accountability and responsiveness.
C. **AND WHEREAS NHIF** is responsible for purchasing the health services from the providers.
D. **AND WHEREAS** the health facility responsibility is to ensure the health services are improved in both quantity and quality.

NOW THEREFORE this Agreement WITNESSETH AS FOLLOWS:-

NOW THEREFORE this Agreement WITNESSETH AS FOLLOWS:-

The system will provide incentives for health services delivered and quality improved as per set indicators

ARTICLE 1
HEALTH FACILITY OBLIGATION

The health facility is obligated to provide quality health services to the community of their service area. Furthermore, the facilities are will be mandated to fill the HMIS monthly summary form for all services delivered. These monthly summary forms must be submitted to the CHMT by the 7th day of every subsequent month. Complete, accurate, and timely submission of the monthly reports will qualify the facility for the full payment associated with this indicator.

The Health Facility governing Committee must take care that the funds generated through the RBF are managed in the general interest of the Health Facility. These incomes must be used to implement initiatives likely to improve public health and quality service delivery.

ARTICLE 1
RESPONSIBILITIES OF HEALTH FACILITY

Under the present agreement, the Health Facility governing Committee Chairperson and the Health Facility In-Charge represents the Health Facility.
Therefore, health facility will coordinate in executing the following responsibilities:

- Provide quality health care services to clients and communities.
- Develop clear business plan as part of the CCHP.
- Ensure that all clinical and crosscutting quality standards are observed.
- Prepare reports including HMIS reports, financial and technical report of the business plans.
- Collection, analyse, report and utilization of data for planning

- Collaborate with other key stakeholders and develop strategies for successful implementation of RBF, this also includes leveraging of resources
- Mobilize resources based on available opportunities in the catchments areas.
- Develop or improve system for feedback mechanism to address clients complains.
- Develop capacity building plan that includes meeting, on job training, and mentorship program within the team.
- Ensure that all the resources are properly and efficiently utilized,
- Prepare and submit to the respective Council the RBF implementation and incentives utilization report
- Ensure availability of reporting tools to facilitate data submission to higher level,
- Make sure that all necessary documents are accessible to verification and assessment,
- Report any fraud committed at the Health Facility to the R-RBFC (in writing) via CHMT,
- Implement sanctions against individuals responsible for professional misconduct,
- Support Community actors to carry out their own strategies under the RBF system;
- Lodge a complaint to the regulator via council in an event of a dispute during the execution of this agreement.

ARTICLE 3
RBF PAYMENT FORMULA

The RBF payments made to each facility will depend directly on:

1. Services delivered and verified
2. Penalties imposed for miss-reporting
3. The Quality score Factor

All Health facilities will allocate 75% of funds received towards Health Service Strengthening and 25% towards staff bonuses.

Facility management will meet with all staff within the first month of signing this agreement to communicate all the information outlined in this document, discuss fund distribution within the facility and discuss strategies through which business plan can be executed.

The Ministry of Health and Social Welfare reserves the right to amend the formula of its support to the Health Facilities during the tenure of this agreement.

ARTICLE 4
CHMT COMMITMENTS

For the smooth implementation of RBF system at the facility level, the CHMT will need to assist the health facilities by being committed to following responsibilities:

1. Conduct cascade training for health facility staff, to ensure they fully understand their role and responsibilities for implementation of the RBF system,
2. To ensure that the required resources are available for provision of quality health services.
3. Conduct supportive supervision to all health facilities to ensure delivery of quality health services.
4. Ensure all health facility reports are entered into the DHIS-2 database by the 15th of consecutive month
5. Ensure each Health Facility use the RBF funds according to guidelines and government financial regulation and financial reports are compiled and submitted on time and provide technical supports on financial matters,
6. In areas where there is no access to Government health facilities, or insufficient capacity to serve the local population, CHMT will facilitate to sign an agreement with Non- Government, FBO or Private health facilities which will be eligible to participate in delivering health services under RBF system.
7. Ensure availability of drugs, supplies and equipment at all health facilities,
8. Mobilizes and manage resources allocated for health care delivery,
9. Ensure communities are responsible in taking care of their own health and also the safety of medicine and equipment in their health facilities
10. Assist the health facilities in developing, approving and implementing quarterly RBF business plans
11. To ensure that all HFs in the council have minimum qualified staffing requirement
12. Support the Health Facilities to implement recommendations made by the verification team on both quality assessment and quantity verification,
13. Share the incentive information among health facilities after the decision of the Regional RBF Committee meeting,
14. To ensure that all dedicated financial resources are disbursed to the respective facilities without reallocation

ARTICLE 5
VERIFICATION PROCESS

The identified regional verification team (internal Verifiers) will verify both quantity and quality data accuracy, completeness and consistency.

The Control Auditor General (independent verifiers) will counter verify the verified reports. Furthermore, the local NGO contracted by the internal verifier to conduct patients tracing to avoid ghost clients and carry out patient satisfaction survey to get community feedback and establish their level of satisfaction. The regional RBF committee (R-RBFC) will approve verification reports during the RBF Quarterly committee meeting.

ARTICLE 6
AGREEMENT TYPE AND PAYMENT SCHEDULE

This is a performance agreement with results payments based on the achievement of 17 quantity indicators in which 14 health facility based found in the HMIS, 3 are community based and deemed as critical in improving health care services.

The quantity indicators for health centers and dispensaries are as follows:

1. Number of new outpatient consultations
2. Number of low income individuals identified by TASAF's hybrid proxy means testing receiving outpatient care
3. Number of children under one year immunized against measles
4. Number of under-five receiving Vitamin A supplementation
5. Number of new users on modern family planning methods
6. Number of pregnant women receiving 2+ doses of intermittent presumptive treatment of malaria
7. Number of HIV positive pregnant women receiving ARVs
8. Number of mothers receiving post natal care services within 3-7 days after delivery
9. Number of pregnant woman attending for ANC at least four times during pregnancy
10. Number of HIV exposed infants receiving ARVs
11. Number of institutional deliveries
12. Number of clients initiated by health care provider to counsel and test for HIV (PITC)
13. Number of TB suspect referred (already screening)
14. Number of first antenatal visits, with gestation age < 12 weeks
15. Number of non-institutional maternal and perinatal deaths reported within 24 hours to respective health facility
16. Number of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW
17. Number of household visits by CHW

Areas of quality assessment for the Dispensary are as follows:

1. Hygiene and sanitation
2. Privacy
3. Water supply
4. Waste management
5. Ante Natal Care (ANC)
6. Labour ward
7. Post-natal care
8. Maternal death audits
9. Perinatal death audits
10. Family planning
11. Immunization
12. Nutrition for under-five children
13. Pharmacy
14. Community
15. Community health fund
16. Facility profile reports (inc. RBF)
17. Transparency

Areas of quality assessment for the Upgraded Health Centre and District Hospital are as follows:

1. Social Accountability
2. Facility Profile Reports (Inc. RBF)
3. Medical Records
4. Privacy
5. Hygiene and sanitation
6. Water supply
7. Labour Ward
8. Waste management
9. Obstetric emergencies
10. Partogram
11. Complicated deliveries including c/s
12. Post-natal care
13. Kangaroo mother care
14. Family planning
15. Maternal death audits
16. Perinatal death audits
17. Immunization
18. Sterilization
19. IPD
20. Laboratory
21. TB Services
22. Pharmacy

A Health Facility fee schedule outlining the respective fees per indicator is available.

The Regional RBF Committee shall validate the facility's performance against the indicators at the end of each quarter. The achievement of the indicators will be a combination of the quantities and quality scores attained during verification and the penalties due to errors in reported data will also apply to get final payment of the facility

ARTICLE 7
PAYMENT FOR DISTRICT HOSPITAL

The payment shall be a fixed amount with adjustments made on the actual performance of the District Hospital during the quarterly assessment.

After taking into consideration of all the costs required for undertaking the activities and service improvement, administrative costs, total number of the District Hospital and bonus fees for the staff.
With all those consideration, each District Hospital participating in RBF shall be entitled to the amount of **TZS 71,405,166** (Seventy-One Million, Four hundred and Five Thousand, One Hundred and Sixty Six Tanzanian Shillings) to be paid per quarter.

The participating District Hospital will only be paid 100% of the this amount if it performs 100% according to the quarterly quality assessment tool administered by identified team from the regional level. For example, a score equivalent to 70% will mean that the Hospital can only receive 70% of **TZS 71,405,166** which is equivalent to TZS 49,983,616.

ARTICLE 8
INCENTIVES DISBURSEMENT

The MOF will be the fund holder and will be responsible for disbursing RBF incentives at the completion of each quarter to all providers after being directed by the MOHSW to do so. A regional RBF committee (R-RBFC) will approve the invoices for payment on a quarterly basis.
The providers will be informed via CHMT on the final amount to receive immediately the R-RBFC has approved.

ARTICLE 9
HEALTH FACILITY AUTONOMY

The use of the funds earned from the RBF will be decided by the Health Facility governing Committee within the limits stated above. Against this background the Health Facility in charge, should ensure that all documents are well secured. All payments made to staff and other beneficiaries should be clearly signed or thumb printed.

ARTICLE 10
IRREGULARITIES, PENALTIES AND SANCTIONS

10.1 If it found that there are Misreporting or falsifying service delivery information, Misusing RBF funds (not within official guidelines) and misreporting the use of RBF funds, the following sanctions will be applied as appropriate:

10.2 If issues with the accuracy or quality of data are spotted, the district and regional administrative authorities will be notified and 10% of the total incentives earned for each falsified indicator by a facility will be deducted.

10.3 If intentional/deliberate falsification cases are spotted, the applicable Tanzanian laws for fraud and falsification of medical records will be applied and the responsible health care worker will entail disciplinary actions according civil servant regulations.

10.4 The penalty will be in addition to any legal proceedings that the Anti-Corruption Commission might wish to institute, where criminal acts have been committed. Furthermore the following action will be taken

ARTICLE 11
BUSINESS PLAN

The Health Facility Business Plan approved by the DMO is an integral part of this agreement. The absence or the non-observance of the quarterly Business Plan will result in the cancellation of this agreement.
The Health Facility will submit the first Business Plan for three months within two weeks after signing this agreement and within the first week every quarter.
The Business plan specifies the strategies to be implemented to increase the quantity and the quality of the services. This plan will indicate the essential resources (human, material and financial) required in achieving the business plan objectives

ARTICLE 12
NON-INCENTIVIZED INDICATORS

In order to avoid a situation where the incentivized indicators become the center of attention and improve at the detriment of all other health indicators, efforts to improve the non-incentivized indicators should also be made.

Thus, during the implementation of the RBF, the Health Facility agrees to ensure that both the incentivized and non-incentivized indicators are improved. If the non-incentivized indicators fall below 80% of the expected trend (based on historical data) at any time during the agreement period, the Health Facility should meet with the CHMT to discuss the situation and define corrective measures. If the downward trend continues, the CHMT will bring the issue to NHIF, which reserves the right to nullify this agreement.
The Health Facility agrees to participate in all organized RBF technical assistance and capacity building activities.

ARTICLE 13
TERM AND TERMINATION

This agreement constitutes the entire agreement between the NHIF and the Health Facility. There shall be no variation of it, except in writing and signed by duly appointed representatives from the NHIF and the Health Facility. The term of this Agreement shall commence on the date signed and shall continue until when the purchaser decides to amend or cease to purchase the indicators.
However, either party may terminate this Agreement if the other party fails to perform its obligations hereunder and such failure to perform is not cured within thirty (30) days following written notice from the complaining party of such failure to perform.

For the NHIF

Signature:……..

Name:……..

Director General

Date:……..

For the Health Facility

Signature:……..

Name: ……..

Health Facility In-Charge

Date:……..

In the Presence of Witness:

Signature:……..

Name: ……..

……..

Date:……

In the Presence of Witness:

Signature:……

Name:……

HFGC Chairperson

Date:……..

ANNEX 7: Motivation Agreement between the RHMT and RHMT Staff

This is a **Motivation agreement** which has been entered into between ……RHMT represented by the RMO and ..... occupying the position of ....., and hereafter called the "Employee" and the two collectively known as "Parties". When the RMO is signing this agreement, the Regional Administrative Secretary and a witness by the choice of RAS represent the RHMT.

The Parties declare to have entered into an agreement on the payment of performance incentives according to the following modalities:

ARTICLE 1
GENERAL INFORMATION

This agreement lies within the scope of the Results Based Financing (RBF) set up in the health system in Tanzania, and more specifically within the framework of the agreement stating the remuneration of health workers on the basis of their performance between RHMT and National Health Insurance Fund.

It is understood that the payment of incentives in the agreement between …… RHMT and National Health Insurance Fund constitutes a commitment but not a right. In the event of change in policy or force majeure, the Government of the United Republic of Tanzania or the external partners could decide to cease the payment of the incentives before the closing date of the agreement.

The Motivation agreement institutes a mode of conditional remuneration to the Employee, by variable bonuses according to personal work performance and in respect of his/her engagement.

ARTICLE 2
LIMITS OF THE AGREEMENT

The Employee acknowledges that this agreement includes the conditions of services of the Employee, his/her job description, and profile of his/her duty station. Nonetheless, this Motivation agreement is different from the normal work Contract. The Motivation agreement may end automatically and without royalty when the Employee's employment is terminated or when either Party terminates the Motivation agreement itself.

ARTICLE 3

VALIDITY

The validity of this agreement is strictly subordinated to the existence and the duration of the agreement stating the remuneration of Employees on the basis of their performance. If the agreement between the RHMT and NHIF suddenly ends in accordance with its clauses, this Motivation agreement will have to be regarded as null and void.

ARTICLE 4

OBLIGATION OF BOTH PARTIES

The Employee commits him/herself to respect the various obligations, which are assigned to him/her by this agreement and its appendices (Responsibility Points Form). He/she particularly commits him/herself to delivery of quality Services, working in harmony and in a team spirit with his colleagues at the RHMT and/or others from outside the RHMT. He/she personally commits to transparency and authenticity of information that will be transmitted to his/her supervisor and/or to the Regional Office. He/she will be held responsible for the errors or frauds made individually or severally on the information or data transmitted.

The RHMT represented by the RMO commits to be evaluating the performance of the Employee on a quarterly basis, in an objective and transparent manner, on the tasks assigned to him/her. The RMO further commits to the payment of quarterly motivation bonuses as defined in Articles 5, 6 and 7 of this agreement. Moreover, it will be the responsibility of RHMT office to commit within the limits of its mandate, to place at the disposal of the Employee - the essential resources to the achievement of his/her tasks.

ARTICLE 5

INDIVIDUAL PERFORMANCE EVALUATION

The RMO will evaluate the performance of each Employee in accordance with the tasks, which are assigned to him/her by using the Individual Evaluation Form on a quarterly basis. The result of the evaluation will be valid and applicable for the motivation of the Employee during the evaluated quarter.

The evaluation of all RHMT staff one by one including RMO shall be done in the presence of every one for transparency purpose and these score will be used to pay bonuses.

ARTICLE 6

DETERMINATION OF THE AMOUNT TO BE ALLOCATED AS MOTIVATION BONUS

When the amount for incentives is know by the RHMT, the management at the RHMT will determine an amount intended for the Motivation bonuses of the personnel. At the same time they will approve the payment of those bonuses. To maintain equity between the Employees, it is agreed that the individual monthly Motivation fees will be defined by the total amount available for the staff incentives, responsibility Points, and scores obtained based on the contribution or effort brought in by the individual for the RHMT to get these incentives (Days Worked).

Documented Workshop, meetings and other official duties are considered as worked days.

All types of leave and other absence from work with/without permission or any other personal businesses are not considered as worked days.

Individual Motivation Fees = (Responsibility Points + Attendance Points) X Quarterly Indices

Please refer to the example on Bonus Calculation in the RBF Operational Manual for more details on how to calculate the individual staff indices.

ARTICLE 7

PAYMENT OF MOTIVATION FEES

Motivational fees will be paid to the Employees on a quarterly basis.

ARTICLE 8

TEMPORARY SUSPENSION OF THE MOTIVATION BONUSES

In the event of fraud, record falsification, or any other serious irregularity, the National Health Insurance Fund can decide to suspend the bonuses of an Employee for a maximum period of 3 months. This decision will have to be subject to approval by the Regional RBF Committee.

ARTICLE 9

RESOLUTION OF DISPUTES

In the event of disputes in the application of this agreement, either party shall lodge a complaint to the National Health Insurance in writing via Regional RBF Committee.

ARTICLE 10

DURATION OF THE AGREEMENT

This agreement will be valid for a period of 12 months from the date of signature by both Parties. The agreement will be automatically renewed as long as the Performance agreement between the RHMT and National Health Insurance exists.

For the RHMT

Signature:……

Name: ……

RMO

Date:……..

In the Presence of Witness:

Signature:……

Name: ……

Regional Administrative Secretary

Date:……

For the Employee

Signature:……

Name: ……

Position:……

Date:……

In the Presence of Witness:

Signature:……

Name: ……

Date: ……

ANNEX 8: Motivation Agreement between the CHMT and CHMT Staff

This is a **Motivation agreement** which has been entered into between ……CHMT represented by the DMO and ..... occupying the position of ....., and hereafter called the "Employee" and the two collectively known as "Parties". When the DMO is signing this agreement, the council health service committee chairperson and another member of the committee represent the CHMT.

The Parties declare to have entered into an agreement on the payment of performance incentives according to the following modalities:

ARTICLE 1

GENERAL INFORMATION

This agreement lies within the scope of the Results Based Financing (RBF) set up in the health system in Tanzania, and more specifically within the framework of the agreement stating the remuneration of health workers on the basis of their performance between CHMT and National Health Insurance Fund.

It is understood that the payment of incentives in the agreement between …… CHMT and National Health Insurance Fund constitutes a commitment but not a right. In the event of change in policy or force majeure, the Government of the United Republic of Tanzania or the external partners could decide to cease the payment of the incentives before the closing date of the agreement.

The Motivation agreement institutes a mode of conditional remuneration to the Employee, by variable bonuses according to personal work performance and in respect of his/her engagement.

ARTICLE 2

LIMITS OF THE AGREEMENT

The Employee acknowledges that this agreement includes the conditions of services of the Employee, his/her job description, and profile of his/her duty station. Nonetheless, this Motivation agreement is different from the normal work Contract. The Motivation agreement may end automatically and without royalty when the Employee's employment is terminated or when either Party terminates the Motivation agreement itself.

ARTICLE 3

VALIDITY

The validity of this agreement is strictly subordinated to the existence and the duration of the agreement stating the remuneration of Employees on the basis of their performance. If the agreement between the CHMT and NHIF suddenly ends in accordance with its clauses, this Motivation agreement will have to be regarded as null and void.

ARTICLE 4

OBLIGATION OF BOTH PARTIES

The Employee commits him/herself to respect the various obligations, which are assigned to him/her by this agreement and its appendices (Responsibility Point Form). He/she particularly commits him/herself to delivery of quality Services, working in harmony and in a team spirit with his colleagues at the CHMT and/or others from outside the CHMT. He/she personally commits to transparency and authenticity of information that will be transmitted to his/her supervisor and/or to the District Medical Office. He/she will be held responsible for the errors or frauds made individually or severally on the information or data transmitted.

The CHMT represented by the District Medical Officer commits to be evaluating the performance of the Employee on a quarterly basis, in an objective and transparent manner, on the tasks assigned to him/her. The District Medical Officer further commits to the payment of quarterly motivation bonuses as defined in Articles 5, 6 and 7 of this agreement. Moreover, it will be the responsibility of CHMT office to commit within the limits of its mandate, to place at the disposal of the Employee - the essential resources to the achievement of his/her tasks.

ARTICLE 5

INDIVIDUAL PERFORMANCE EVALUATION

The DMO will evaluate the performance of each Employee in accordance with the tasks, which are assigned to him/her by using the Individual Evaluation Form on a quarterly basis. The result of the evaluation will be valid and applicable for the motivation of the Employee during the evaluated quarter.

The evaluation of all CHMT staff one by one including DMO shall be done in the presence of every one for transparency purpose and these score will be used to pay bonuses.

ARTICLE 6

DETERMINATION OF THE AMOUNT TO BE ALLOCATED AS MOTIVATION BONUS

When the amount for incentives is know by the CHMT, the management at the CHMT will determine an amount intended for the Motivation bonuses of the personnel. At the same time they will approve the payment of those bonuses. To maintain equity between the Employees, it is agreed that the individual monthly Motivation fees will be defined by the total amount available for the staff incentives, responsibility Points, and scores obtained based on the contribution or effort brought in by the individual for the CHMT to get these incentives (Days Worked).

Documented Workshop, meetings and other official duties are considered as worked days.

All types of leave and other absence from work with/without permission or any other personal businesses are not considered as worked days.

Individual Motivation Fees = (Responsibility Points + Attendance Points) X Quarterly Indices

Please refer to the example on Bonus Calculation in the RBF Operational Manual for more details on how to calculate the individual staff indices.

ARTICLE 7

PAYMENT OF MOTIVATION FEES

Motivational fees will be paid to the Employees on a quarterly basis.

ARTICLE 8

TEMPORARY SUSPENSION OF THE MOTIVATION BONUSES

In the event of fraud, record falsification, or any other serious irregularity, the National Health Insurance Fund can decide to suspend the bonuses of an Employee for a maximum period of 3 months. This decision will have to be subject to approval by the Regional RBF Committee.

ARTICLE 9

RESOLUTION OF DISPUTES

In the event of disputes in the application of this agreement, either party shall lodge a complaint to the National Health Insurance in writing via Regional RBF Committee.

ARTICLE 10

DURATION OF THE AGREEMENT

This agreement will be valid for a period of 12 months from the date of signature by both Parties. The agreement will be automatically renewed as long as the Performance agreement between the CHMT and National Health Insurance exists.

For the CHMT

Signature:……..

Name: ……..

DMO

Date:……

For the Employee

Signature:……..

Name: ……..

Position:……..

Date:……

In the Presence of Witness:

Signature:……

Name: ……..

Council Health Service Board Chair P.

Date:…….. ….

In the Presence of Witness:

Signature:……..

Name: ……..

Date: ……..

ANNEX 9: Motivation Agreement between the Health Facility and Health Facility Staff

This is a **Motivation agreement** which has been entered into between ……..Health Facility represented by the Health Facility In-Charge and ..... Occupying the position of ....., and hereinafter called the "Employee" and the two collectively known as "Parties". When the health facility in-charge is signing this agreement, the Health Facility Governing committee chairperson and another member of the committee represent the Health Facility.

The Parties declare to have entered into an agreement on the payment of performance incentives according to the following modalities:

ARTICLE 1
GENERAL INFORMATION

This agreement lies within the scope of the Results Based Financing (RBF) set up in the health system in Tanzania, and more specifically within the framework of the agreement stating the remuneration of health workers on the basis of their performance between Health Facility and National Health Insurance Fund.

It is understood that the payment of incentives in the agreement between ……Health Facility and National Health Insurance Fund constitutes a commitment but not a right. In the event of change in policy or force majeure, the Government of the United Republic of Tanzania or the external partners could decide to cease the payment of the incentives before the closing date of the agreement.

The Motivation agreement institutes a mode of conditional remuneration to the Employee, by variable bonuses according to personal work performance and in respect of his/her engagement.

ARTICLE 2

LIMITS OF THE AGREEMENT

The Employee acknowledges that this agreement includes the conditions of services of the Employee, his/her job description, and profile of his/her duty station. Nonetheless, this Motivation agreement is different from the normal work Contract. The Motivation agreement may end automatically and without royalty when the Employee's employment is terminated or when either Party terminates the Motivation agreement itself.

ARTICLE 3

VALIDITY

The validity of this agreement is strictly subordinated to the existence and the duration of the agreement stating the remuneration of Employees on the basis of their performance. If the agreement between the Health Facility and National Health Insurance Fund suddenly ends in accordance with its clauses, this Motivation agreement will have to be regarded as null and void.

ARTICLE 4

OBLIGATION OF BOTH PARTIES

The Employee commits him/herself to respect the various obligations, which are assigned to him/her by this agreement.

He/she particularly commits him/herself to delivery of quality health care, working in harmony and in a team spirit with his colleagues at the Health Facility and/or others from outside the Health Facility. He/she personally commits to transparency and authenticity of information that will be transmitted to his/her supervisor and/or to the District Medical Office. He/she will be held responsible for the errors or frauds made individually or severally on the information or data transmitted.

The Health Facility governing Committee represented by its Chairperson commits to be evaluating the performance of the Employee on a quarterly basis, in an objective and transparent manner, on the tasks assigned to him/her. The Health Facility Committee Chairperson further commits to the payment of quarterly motivation bonuses as defined in Articles 5, 6 and 7 of this agreement. Moreover, the Health Facility commits within the limits of its mandate, to place at the disposal of the Employee - the essential resources to the achievement of his/her tasks.

ARTICLE 5

INDIVIDUAL PERFORMANCE EVALUATION

The Health Facility governing Committee chaired by its Chairperson will evaluate the performance of each Employee in accordance with the tasks, which are assigned to him/her by using the Individual Evaluation Form on a quarterly basis. The result of the evaluation will be valid and applicable for the motivation of the Employee during the evaluated quarter.

The evaluation of all Health Facility staff one by one including in-charge shall be done in the presence of every one for transparency purpose and these scores will be used to pay bonuses.

ARTICLE 6

DETERMINATION OF THE AMOUNT TO BE ALLOCATED AS MOTIVATION BONUS

When the amount for incentives is known by the facility, the management at the Health Facility will determine an amount intended for the Motivation bonuses of the personnel. At the same time they will approve the payment of those bonuses. To maintain equity between the Employees, it is agreed that the individual quarterly Motivation fees will be defined by the total amount available for the staff incentives, responsibility Points, and scores obtained based on the contribution or effort brought in by the individual for the Health facility to get these incentives (Days Worked).

Days worked means the only days when the staff was at the facility without considering, Workshops, leave and other absence at the facility with or without permission.

Individual Motivation Fees = (Responsibility Points + Attendance Points) X Quarterly Indices

Please refer to the example on Bonus Calculation in the RBF Operational Manual for more details on how to calculate the individual staff indices.

ARTICLE 7

TEMPORARY SUSPENSION OF THE MOTIVATION BONUSES

In the event of fraud, record falsification, or any other serious irregularity, the National Health Insurance Fund can decide to suspend the bonuses of an Employee for a maximum period of 3 months. This decision will have to be subject to approval by the Regional RBF Committee.

ARTICLE 8

RESOLUTION OF DISPUTES

In the event of disputes in the application of this agreement, either party shall lodge a complaint to the CHMT in writing and the response should come within 15 days from the day of receipt of the complaint.

ARTICLE 9

DURATION OF THE AGREEMENT

This agreement will be valid for a period of 12 months from the date of signature by both Parties. The agreement will be automatically renewed as long as the Performance agreement between the Health Facility and National Health Insurance Fund exists.

For the Health Facility

Signature:……..

Name: ……..

Health Facility In-Charge

Date:……

For the Employee

Signature:……..

Name: ……

Position:……..

Date:……

In the Presence of Witness:

Signature:……..

Name: ……

Health Facility G. Committee Chairperson

Date:……..

In the Presence of Witness:

Signature:……..

Name: ……

Date: ……..

ANNEX 10: Guidelines on Agreements Management

This paper attempts to list the basic requirements to set up and maintain a reliable, simple and cost efficient management system for a large number of national Results Based Financing (RBF) Contracts/agreement It takes into account the administrative regional or council authorities, and the respective roles and responsibilities of actors at various levels on RBF System. The agreements to be managed are:

a. Agreement between the Ministry of Health and Social Welfare (MOHSW), Primer Minister's Office Regional administration and Local Government (PMORALG), Ministry of Finance (MoF) and National Health Insurance Fund (NHIF)
b. Agreement between NHIF and Regional Administrative Secretariat (RAS)
c. Agreement between NHIF and Regional Health Management Team (RHMT)
d. Agreement between NHIF and Council Health Management Team (CHMT)
e. Agreement between NHIF and Health Facility (HF)
f. Motivation agreement between the RHMT Office and individual staff
g. Motivation agreement between the CHMT Office and individual staff
h. Motivation agreement between the Health Facility and the individual staff

All these different types of agreements indicated above will require close follow-up as they are tied to payments and business plans. Close follow-up is aimed at ensuring maximum delivery of the outputs/outcomes of the RBF system, and transparent performance-based distribution of RBF related bonuses.

The following are proposals aimed at putting in place a comprehensive agreements management within the health system, both at central and decentralized level:

Section 1: Agreement Management at Central Level

1. The aim is to create an efficient and reliable **filing system** in order to keep track and be accountable for all the agreements. This requires:
   (a) The original signed copies of all agreements between the MOHSW, PMORALG, MoF and NHIF kept at MOH, ideally in the Director Policy and Planning (DPP) office, at PMORALG, at MoF and at the NHIF
   (b) The original signed copies of all RAS must be kept at NHIF,
   (c) The original signed copies between NHIF & RHMTs should be kept at NHIF,
   (d) The original signed copies between NHIF & CHMTs should be kept at NHIF,
   (e) The original signed copies between NHIF & HFs should be kept at NHIF
   (f) One folder with one hard copy sample of: (i) MOH, PMORALG, MoF and NHIF agreement, (ii) NHIF and RAS agreement, (iii) NHIF and RHMT agreement, (iv) NHIF

and CHMT agreement, (v) NHIF and Health Facility agreement, (vi) Motivation agreement between the RHMT Office and individual staff, (vii) Motivation agreement between the CHMT Office and individual staff, (viii) Motivation agreement between the Health Facilities and individual staff, (ix) Business Plan template, (x) Quality Checklists for all levels and verification Forms

2. Preferably a dedicated and access-controlled agreements office should be set-up.
3. A specific folder with the Minutes of the R-RBFC and National RBF meetings, each in separate folders.

Section 2: Agreements Management at NHIF Regional office

1. The **filing system** in place at central level should be duplicated in order to keep track and be accountable for all the agreement at Regional level. This includes:
   (a) A signed copy of agreement between the MOHSW, PMORALG, MoF and NHIF
   (b) A signed copy of RAS must be kept at NHIF,
   (c) A signed copy between NHIF & RHMTs should be kept at NHIF,
   (d) A signed copies between NHIF & CHMTs should be kept at NHIF,
   (e) Signed copies between NHIF & HFs should be kept at NHIF,
   (f) RBF Operational Manual and design document
2. Preferably a dedicated and access-controlled agreements office should be set-up.
3. A specific folder with the Minutes of the R-RBFC, each in separate folders.
4. One specific folder with approved quarterly invoices copies,
5. Ideally there should be a dedicated Contracts Management lockable area with restricted access or at the very least, dedicated filing/storage cabinets. One person needs to be made formally responsible for Contract Management. This can be done by formally assigning (in writing) an existing staff to manage the Contracts.

Section 3: Contract Management at the Regional Administration Level

1. The **filing system** in place at regional level is very important in order to keep track and be accountable for all the documents at regional level. This includes:
   a) The original signed copy of NHIF and RS
   b) RBF Operational Manual and design document,
   c) A specific folder with Minutes of the Regional RBF Committee meetings,
   d) A specific folder with reports on community surveys (Patient satisfaction).
   e) One specific folder with quantity verification results signed by verifiers and health facilities,
   f) One specific folder with quarterly quality assessment results well arranged and signed by the quality assessment team members and Health Facilities
   g) One specific folder with approved quarterly invoices

Section 4 : Contract Management at RHMT Level

The **filing system** in place at RHMT level is needed in order to keep track and be accountable for all the contracts at RHMT level. This includes:

a) The original signed copy of NHIF and RHMT agreement,

b) RBF Operational Manual and design document

c) Original signed copies of each Motivation contracts with the employees in separate folders,

d) One specific folder with documentation related to the distribution of bonuses to staff and additional documentation related to incentives/bonuses, if any.

Section 5: Contract Management at CHMT Level

1. The **filing system** in place at district level is also important in order to keep track and be accountable for all the contracts at this level. This includes:

a) The original signed copy of NHIF and CHMT Agreement,

b) RBF Operational Manual and design document

c) The original signed copies of all Health Facilities Contracts in separate folders including the respective Health Facilities' Quarterly Business Plans

d) CHMT should ensure that every participating Health Facility in RBF acknowledges receipt of quarterly funds. Special folders with receipts (per quarter) should be kept,

e) Original signed copies of each Motivation contract with the employees in separate folders,

f) One specific folder with approved quarterly invoices copies,

g) One specific folder with documentation related to the distribution of bonuses to staff and additional documentation related to incentives/bonuses, if any.

Section 6: Contract Management at Health Facility Level

1. Due to work overload, health facilities will only be requested to perform minimal contract management functions. This includes:

a) Filing the original copies of their own contracts with the NHIF, complete with their own Business Plans,

b) RBF Operational Manual and design document,

c) Original signed copies of each Motivation contract with the employees in separate folders,

d) One specific folder or file with provisional invoices for quantity signed by evaluators and the Health Facility,

e) One specific folder or file with quarterly quality assessment results well arranged and signed by the quality assessment team and Health Facility

f) One specific folder with documentation related to the results of individual evaluation of health facility staff,

g) One specific folder with approved quarterly invoices copies,

h) One specific folder with documentation related to the distribution of bonuses to staff and additional documentation related to incentives/bonuses, if any

ANNEX 11: Template of Business Plan for a Health Facility agreement

Business plan for the health facility RBF contract _ *Year: 20……; Quarter:……*

I. GENERAL INFORMATION

Council: …… Health Facility:……

HEALTH FACILITY STATISTICS & ANALYSIS FOR PREVIOUS YEAR

Previous Year Population:. ……..

Data for Previous Year	# OPD new Outpatient consultation [Expected /Quarter:……..]	OPD: Number of low income individuals identified by TASAF's hybrid proxy means testing receiving outpatient care [Expected /Quarter:……..]	ANC: # of first antenatal visits, with gestation age < 12 weeks [Expected /Quarter:……..]	ANC: # of pregnant women attending ANC at: least 4 times during pregnancy [Expected/ Quarter:……..]	ANC/MALARIA: #of pregnant women receiving two doses of intermittent presumptive Therapy of Malaria (IPT2) [Expected /Quarter:……..]	PMTCT/HIV: # of HIV positive pregnant women receiving ARVs [Expected /Quarter:……..]	LABOR/DELIVERY: # of institutional deliveries [Expected /Quarter:……..]	POSTNATAL CARE: # of mothers receiving Post Natal Services within 3-7 days after delivery [Expected /Quarter:……..]	IMMUNIZATION: # of children under one year immunized against measles [Expected /Quarter:……..]
Jan.									
Feb.									
March									
Subtot.									
April									
May									
June									
Subtot.									
July									
August									
Septem.									
Subtot.									
Octob.									
Novem.									
Decem.									
Subtot.									
TOT (Yr)									

Data for Previous Year	NUTRITION: # of under-five receiving Vit. A supplements [Expected /Quarter:……..]	FP: # of new users on modern Family Planning methods [Expected /Quarter:……..]	HIV/AIDS: # of clients initiated by health care provider to counsel and Test for HIV (PITC) [Expected /Quarter:……..]	HIV/AIDS: # of HIV exposed infants receiving ARVs [Expected /Quarter:……..]	TB: # of TB suspect referred (already screened)* [Expected /Quarter:……..]	COMMUNITY: # of non-institutional maternal and perinatal deaths reported within 24 hours by TBA or CHW [Expected /Quarter:……..]	COMMUNITY: # of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW [Expected /Quarter:……..]	COMMUNITY: # of household visits by CHW [Expected /Quarter:……..]
Jan.								
Feb.								
March								
Subtot.								
April								
May								
June								
Subtot.								
July								
August								
Septem.								
Subtot.								
Octob.								
Novem.								
Decem.								
Subtot.								
TOT (Yr)								

HEALTH CENTRE STATISTICS & ANALYSIS FOR CURRENT YEAR

Current Year Population:. ……..

Data for Previous Year	# OPD new Outpatient consultation [Expected /Quarter:……..]	OPD: Number of low income individuals identified by TASAF's hybrid proxy means testing receiving outpatient care [Expected /Quarter:……..]	ANC: # of first antenatal visits, with gestation age < 12 weeks [Expected /Quarter:……..]	ANC: # of pregnant women attending ANC at: least 4 times during pregnancy [Expected/ Quarter: …..]	ANC/MALARIA: #of pregnant women receiving two doses of intermittent presumptive Therapy of Malaria (IPT2) [Expected /Quarter:……..]	PMTCT/HIV: # of HIV positive pregnant women receiving ARVs [Expected /Quarter:……..]	LABOR/DELIVERY: # of institutional deliveries [Expected /Quarter:……..]	POSTNATAL CARE: # of mothers receiving Post Natal Services within 3-7 days after delivery [Expected /Quarter:……..]	IMMUNIZATION: # of children under one year immunized against measles [Expected /Quarter:……..]
Jan.									
Feb.									
March									
Subtot.									
April									
May									
June									
Subtot.									
July									
August									
Septem.									
Subtot.									
Octob.									
Novem.									
Decem.									
Subtot.									
TOT (End of the Yr)									

Data for Previous Year	NUTRITION: # of under-five receiving Vit. A supplements [Expected /Quarter:……..]	FP: # of new users on modern Family Planning methods [Expected /Quarter:……..]	HIV/AIDS: # of clients initiated by health care provider to counsel and Test for HIV (PITC) [Expected /Quarter:……..]	HIV/AIDS: # of HIV exposed infants receiving ARVs [Expected /Quarter:……..]	TB: # of TB suspect referred (already screened)* [Expected /Quarter:……..]	COMMUNITY: # of non-institutional maternal and perinatal deaths reported within 24 hours by TBA or CHW [Expected /Quarter:……..]	COMMUNITY: # of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW [Expected /Quarter:……..]	COMMUNITY: # of household visits by CHW [Expected /Quarter:……..]
Jan.								
Feb.								
March								
Subtot.								
April								
May								
June								
Subtot.								
July								
August								
Septem.								
Subtot.								
Octob.								
Novem.								
Decem.								
Subtot.								
GRAND TOT (At the end of the Yr)								

II. ANALYSIS OF PROBLEMS AND STRATEGIES TO IMPLEMENT

1. OPD: NUMBER OF NEW OUTPATIENT CONSULTATIONS

   What are the problems concerning the attendance, and quality of care in OPD in your facility?

   ……
   ……
   ……

2. OPD: NUMBER OF LOW INCOME INDIVIDUALS IDENTIFIED BY TASAF'S HYBRID PROXY MEANS TESTING RECEIVING OUTPATIENT CARE

   What are the problems for these individuals not to come to your HF and the quality of their care?

   ……
   ……
   ……

3. ANC: NUMBER OF FIRST ANTENATAL VISITS, WITH GESTATION AGE < 12 WEEKS

   What are the problems concerning the 1st Visits of ANC at < 12 weeks women attending your HF?
   What are the problems concerning the expected and the quality of care on this indicator?

   ……

   ……

   … ……

4. ANC: NUMBER OF PREGNANT WOMEN ATTENDING ANC AT: LEAST 4 TIMES DURING PREGNANCY

   What are the problems concerning Pregnant Women attending at least 4 times during pregnancy at your HF?
   What are the problems concerning the expected and the quality of care on this indicator?

   ……
   ……
   ……

5. ANC/MALARIA: NUMBER OF PREGNANT WOMEN RECEIVING TWO DOSES OF (IPT2) FOR MALARIA PREVENTION

   What are the problems concerning the 2 doses of IPT at your HF?
   What are the problems concerning the expected number of this indicator?

   ……
   ……
   ……

6. PMTCT/HIV: NUMBER OF HIV POSITIVE PREGNANT WOMEN RECEIVING ARVs

   What are the problems concerning HIV Positive women receiving ARVs at your Health Facility?
   What are the problems concerning the expected and the quality of care on this indicator?

   ……
   ……
   ……

7. LABOR/DELIVERY: NUMBER OF INSTITUTIONAL DELIVERIES

What are the problems concerning Institutional deliveries at your Health Facility?
What are the problems concerning the expected and the quality of care in institutional Deliveries?
……
……
……

8. PNC: NUMBER OF MOTHERS RECEIVING POST NATAL SERVICES WITHIN 3-7 DAYS AFTER DELIVERY

What are the problems concerning Post Natal Visits within 3-7 days attending your health facility?
……
……
……

9. IMMUNIZATION: NUMBER OF CHILDREN UNDER ONE YEAR IMMUNIZED AGAINST MEASLES

What are the problems concerning Fully Immunized Children in your Health Facility?
……
……
……

10. NUTRITION: NUMBER OF UNDER-FIVE RECEIVING VIT. A SUPPLEMENTS

What are the problems concerning vitamin A supplement in your Health Facility?
……
……
……

11. FAMILY PLANING: NUMBER OF NEW USERS ON MODERN FAMILY PLANNING METHODS

What are the problems concerning Family Planning new acceptors attending your health facility?
What are the problems concerning the expected and the quality of care on this indicator?
……
……
……

12. HIV/AIDS: NUMBER OF CLIENTS INITIATED BY HEALTH CARE PROVIDER TO COUNSEL AND TEST FOR HIV (PITC)

What are the problems concerning PITC for HIV at your health facility?
What are the problems concerning the expected and the quality of care on this indicator?
……
……
……

13. HIV/AIDS: NUMBER OF HIV EXPOSED INFANTS RECEIVING ARVS

What are the problems concerning HIV Exposed Infants receiving ARVs at your facility?
What are the problems concerning the expected and the quality of care on this indicator?
……
……
……

14. TB: NUMBER OF TB SUSPECT REFERRED (ALREADY SCREENED)*

What are the problems concerning TB suspect referrals at your facility?
What are the problems concerning the expected and the quality of care on this indicator?

……
……
……

15. COMMUNITY: NUMBER OF NON-INSTITUTIONAL MATERNAL AND PERINATAL DEATHS REPORTED WITHIN 24 HOURS BY TBAs OR CHWs

What are the problems concerning these deaths not being reported on time at you HF or not being reported?
What are the problems concerning the expected and the quality of care on this indicator?

……
……
……

16. COMMUNITY: NUMBER OF PREGNANT WOMEN ESCORTED FOR DELIVERY AT A HEALTH FACILITY BY KNOWN OR REGISTERED TBAs OR CHWs

What are the problems concerning women being escorted to deliver at your Health Facility?
What are the problems concerning the expected and the quality of care on this indicator?

……
……
……

17. COMMUNITY: NUMBER OF HOUSEHOLD VISITS BY CHWs

What are the problems concerning CHWs visiting Households in your catchment area?
What are the problems concerning the expected and the quality of care on this indicator?

……
……
……

III. HUMAN RESSOURCE IN ENDED QUARTER AND NEW QUARTER

How was the Staffing level in ended quarter and how is it going to be in the new quarter?

No	Staff Categories	Available Staff in Numbers	
		Ended Quarter	New Quarter
		Number	Number
1	Facility-In charge		
2	Medical Doctor		
3	Assistant medical officer		
4	Clinical officer		
5	Assistant nursing officer		
6	Nurse – OPD		
7	Nurse – RCH		
8	Nurses		
9	Medical recorder		
10	Medical attendants		
11	Health lab technologist		
12	Assistant lab technologist		
13	Pharmaceutical technologist		
14	Dental therapist		
15	Assistant social welfare		
16	Community health		
17	Worker/social welfare assistant		
18	Assistant environment health officer I		
19	Mortuary attendant		
20	Dobie		
21	Security guard 2		
22	Other Supporting Staff		
23	Others (Specify)……		

IV. FINANCIAL PLANNING FOR ENDED AND NEW QUARTER

Revenues	Last Quarterly Revenues	Proposed Quarterly Revenues for this new Quarter
Impressed from government or other source		
RBF Incentives		
Contribution from other aid agencies		
Taking from reserve in bank account		
Other (Specify) ……..		
TOTAL		

Estimate your financial needs based on the above proposed strategies:

Expenditures	Last Quarterly expenditures	Proposed Quarterly expenditures for new quarter
Performance bonuses		
Contracted staff by the facility		
Drugs and medical equipment		
Cleaning and office costs		
Transport costs		
Social marketing		
Infrastructure rehabilitation		
Equipment, furniture		
Setting aside for reserve		
Other (Specify) ……		
TOTAL		

V. OTHER RESOURCES

Describe the situation regarding the availability of ***essential drugs*** (including for family planning) and how will you improve it during this new quarter?

……
……
……

Describe the situation concerning the availability of ***medical equipment*** and how will you improve it during this new quarter?

……
……
……

Describe the situation regarding the availability of ***furniture and office supplies*** and how will you improve it during this new quarter?

……
……
……

Describe the situation with regard *to infrastructure* and how will you improve it during this new quarter?

……
……
……

Develop detailed Business Plan which includes: (i) Expected, (ii) Strategies, (iii) Dates/times, (iv) Essential resources (human, material, financial)

Indicators & Expected in Numbers per quarter		Strategies	Times/Date	Essential Resources		
				Human	Material	Financial
1.OPD: Number of new Outpatient consultations						
Ended Quarter #:	New Q Expected#:					
2.OPD: Number of low income individuals identified by TASAF's hybrid proxy means testing receiving outpatient care						
Ended Quarter #:	New Q Expected#:					
3.ANC: Number of first antenatal visits, with gestation age < 12 weeks						
Ended Quarter #:	New Q Expected#:					
4.ANC: Number of pregnant women attending ANC at: least 4 times during pregnancy						
Ended Quarter #:	New Q Expected#:					
5.ANC/MALARIA: Number of pregnant women receiving 2 doses of IPT2 for Malaria prevention						
Ended Quarter #:	New Q Expected#:					
6.PMTCT/HIV: Number of HIV positive pregnant women receiving ARVs						
Ended Quarter #:	New Q Expected#:					
7.LABOR/DELIVERY: Number of institutional deliveries						
Ended Quarter #:	New Q Expected#:					
8.PNC: Number of mothers receiving Post Natal Services within 3-7 days after delivery						
Ended Quarter #:	New Q Expected#:					
9.IMMUNIZATION: Number of children under one year immunized against measles						
Ended Quarter #:	New Q Expected#:					
10.NUTRITION: Number of under-five receiving Vit. A supplements						
Ended Quarter #:	New Q Expected#:					
11.FAMILY PLANING: Number of new users on modern Family Planning methods						
Ended Quarter #:	New Q Expected#:					
12. HIV/AIDS: Number of clients initiated by health care provider to counsel & Test for HIV						
Ended Quarter #:	New Q Expected#:					
13.HIV/AIDS: Number of HIV exposed infants receiving ARVs						
Ended Quarter #:	New Q Expected#:					
14.TB: Number of TB suspect referred (already screened)*						
Ended Quarter #:	New Q Expected#:					
15.COMMUNITY: Number of non-institutional maternal and perinatal deaths reported within 24 hours by TBA/CHW						
Ended Quarter #:	New Q Expected#:					
16.COMMUNITY: Number of pregnant women escorted for delivery at HF by known or registered TBA/CHW						
Ended Quarter #:	New Q Expected#:					
17.COMMUNITY: Number of household visits by CHW						
Ended Quarter #:	New Q Expected#:					

Note: Ended quarter results of current year are compared with the similar quarter of previous year for analysis

Health Facility In-charge Names; Signature & HF Stamp:

……; Date ……../……/20……

Health Facility Governing Committee Chairperson Names & Signature:

……; Date ……../……/20……

District Medical Officer, Names, Signature & CHMT Stamp

……; Date ……../……/20……

Copies:

- ✓ Health Facility,
- ✓ CHMT Office,
- ✓ Council Office,
- ✓ NHIF Regional level

Annex: Business Plan development steps

ANNEX 12: Guide on Business Plan Development

S/N	ACTIVITIES	STAGES
I	**Introduction and Situation Analysis**	1. Obtain and analyze data on incentivized indicators for the previous year. 2. Identify current strengths and weaknesses 3. Analyze the causes of identified weaknesses: a) Structure (Infrastructure and equipment, personnel, organization) b) Population (financial, geographical, and cultural accessibility) c) Community and political-administrative authorities
II	**Workout the Main Plan**	4. Identify the appropriate strategies for attaining what is expected 5. Priorities amongst the strategies. 6. Work out a detailed Business Plan; which includes: a) Expected b) Strategies c) Dates and times d) Essential resources (human, material, and financial)
III	**Business Plan Approval Process**	7. Discuss the Business with the District Medical Officer for approval 8. Make the Business Pan approved by the District Medical Officer

ANNEX 13: RBF Quantity Verification Form for Health Centre & Dispensary

THE UNITED REPUBLIC OF TANZANIA, Ministry of Health and Social Welfare (MOHSW)

Results Based Financing (RBF), Quarterly Health Centre/Dispensary Data Verification Form

Region:…….. Council:…….. Health Facility:……..

Year: 20…….. Quarter:…….. Date:……..

SN	Indicator	Month 1		Month 2		Month 3		Total Declared (D)	Total Verified (T)	Difference	%Error	Price (Tsh)	Quarterly Provisional Total Amount	Income Loss (Due to 10% & Above Error)
		R1	V1	R2	V2	R3	V3	(R1+R2+R3)	(V1+V2+V3)	(T-D)	%(T-D)/D			
1	OPD: Number of new Outpatient consultations											415		
2	OPD: Number of low income individuals identified by TASAF's hybrid proxy means testing receiving outpatient care											1,240		
3	ANC: Number of first antenatal visits, with gestation age < 12 weeks											8,290		
4	ANC: Number of pregnant women attending ANC at: least 4 times during pregnancy											6,210		
5	ANC/MALARIA: Number of pregnant women receiving two doses of intermittent presumptive Therapy of Malaria (IPT2)											1,240		
6	PMTCT/HIV: Number of HIV positive pregnant women receiving ARVs											3,310		
7	LABOR/DELIVERY: Number of institutional deliveries											20,720		
8	POSTNATAL CARE: Number of mothers receiving Post Natal Services within 3-7 days after delivery											8,290		
9	IMMUNIZATION: Number of children under one year immunized against measles											1,650		
10	NUTRITION: Number of under-five receiving Vit. A supplements											830		

SN	Indicator	Month 1		Month 2		Month 3		Total Declared (D)	Total Verified (T)	Difference	%Error	Price (Tsh)	Quarterly Provisional Total Amount	Income Loss (Due to 10% & Above Error)
		R1	V1	R2	V2	R3	V3	(R1+R2+R3)	(V1+V2+V3)	(T-D)	%(T-D)/D			
11	FAMILY PLANING: Number of new users on modern Family Planning methods											5,800		
12	HIV/AIDS: Number of clients initiated by health care provider to counsel and Test for HIV (PITC)											620		
13	HIV/AIDS: Number of HIV exposed infants receiving ARVs											4,970		
14	TB: Number of TB suspect referred (already screened)*											8,290		
15	COMMUNITY: Number of non-institutional maternal and perinatal deaths reported within 24 hours by TBA or CHW											4,145		
16	COMMUNITY: Number of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW											8,290		
17	COMMUNITY: Number of household visits by CHW											1,240		
Total Payments due to Quantity Indicators														

Verified Data Certified to be a true representation of the data at the health facility by:

Health Facility In-charge	Data Verification Team
Name:……..	Name & Signature:……
	Name & Signature:……
Signature & Health Facility Stamp:……	Name & Signature:……
Date:……..	Date:……..

ANNEX 14: Definitions of Health Facility Quantity RBF Indicators

NO	Service Category	Indicator	Description/Definition of indicator	Source of data
1	Outpatient	Number of New outpatient consultations	Number of new clients attending and receiving outpatient services during the quarter	HMIS- OPD Register book 5
2	Outpatient	Number of low income individuals identified by TASAF's hybrid proxy means testing receiving outpatient care	Number of low income individuals registered by TASAF attending and receiving outpatient services at the health facilities during a periods of that quarter	TASAF Register and HMIS book 5
3	Reproductive and Child health	Number of children under one year immunized against measles	Total number of children age nine month vaccinated against measles under period of the quarter	HMIS -Child Register book 7
4	Reproductive and Child health	Number of children under five years of age receiving Vit. A supplementation	Number of children under five years receiving vitamin A at health facility or through outreach done by health staff in the quarter	HMIS Register 7
5	Reproductive and Child health	Number of newusers on modern Family Planning methods	Number of women newly accepting contraception by pills, injection, implant, IUCD, at the facility or through outreach and CBD within the particular quarter	HMIS-Family Planning Register book 8
6	Reproductive and Child health	Number of pregnant women receiving 2+ doses of intermittent presumptive treatment of malaria	Number of pregnant women receiving 2+ doses of SP during pregnancy at that particular quarter	HMIS -ANC Register book 6
7	Reproductive and Child health	Number of HIV infected pregnant women receiving ARVs for PMTCT	Number of HIV infected pregnant women receiving ARVs Prophylaxis for PMTCT at health facility in that particular quarter	HMIS -ANC Register book 6
8	Reproductive and Child health	Number of postnatal mothers receiving Post Natal Care services within 2-7 days after delivery	Number of women receiving post natal care at the facility within seven day after delivery	HMIS-Post Natal Register book 13
9	Reproductive and Child health	Number of institutional deliveries	Number of deliveries conducted at the health facility and attended by a health professional during the period of that quarter	HMIS Book 12
10	HIV/AIDS	Number of clients initiated by health care provider to counsel and Test for HIV (PITC)	Number of patients/clients attended at the health facility and initiated by the health provider to test for HIV	ART register
11	HIV/AIDS in Children	Number of HIV exposed infants receiving ARV	Number HIV exposed infants receiving ARV prophylaxis within a period of quarter	HMIS –book 7
12	RCHS	Number of first antenatal visits, with gestation age < 12 weeks.	Number of women starting ANC before 12 weeks of gestation age at the health facility.	HMIS - Register book 6
13	RCHS	Number of pregnant woman attending ANC at least 4 times during pregnancy	The number of pregnant women receiving fourth ANC consultation with a health professional at the facility or through outreach by facility staff at the particular quarter	HMIS - Register book 6
14	TB infection	Number of referred TB suspected (already screening)	Number of screened TB suspect cases referred to higher level facility for further investigation in that quarter	HMIS-Book 5 /TB register
15	Community based services	Number of non- institutional maternal and perinatal deaths reported within 24 hours by TBA or CHW.	Number of non - institutional maternal and perinatal deaths reported within 24 hours by TBA or CHW in that quarter	Community maternal and perinatal death register
16	Community based services	Number of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW	Number of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW in that quarter	Escorted women register
17	Community based services	Number of household visits by CHW	Number of household visits by CHW in that quarter	House Hold Register

ANNEX 15: RBF Quarterly Quality Checklist for dispensary

MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING

DISPENSARY QUARTERLY QUALITY ASSESSMENT TOOL

TANZANIA 2015

Quarterly Quality Assessment

Frequency of Assessment

The evaluation is quarterly and each of the 18 activities/areas is assessed once per quarter.

Assessment Process

- ✓ The visit of the assessors is scheduled the day when the services assess are available.
- ✓ The provider may be assessed carrying out the activity (for purposes of case observation)
- ✓ The available medical documents at the facility are assessed in some cases (Registers, cards e.tc)
- ✓ The assessment of each activity is done in the presence of the Health Facility staff to witness the findings and avoid the conflicts when announcing the results,
- ✓ At the end of the assessment, the results are approved with names and signatures of the of the assessor's head and the health facility's in-charge
- ✓ At the end of the assessment, the team of the assessors takes time to discuss with the Health Facility in-charge and staff **1)** The positive findings and **2)** The issues to be improved upon. After discussion, the team of the assessors, together with the In-charge and other staff, make recommendations including those requiring technical support.
- ✓ A complete copy of the assessment results is given to the health facility; one to CHMT, and the other one is carried for data entry into the RBF database, the analysis, compilation and filing.

Note: It is the responsibility of the health facility to ensure the availability and the accessibility of all required documents by the assessors

Use of Quality Assessment Tool

Checklist of Areas of assessment

The checklist of activities assessment is presented in the form of table, which is composed of 6 columns.

- **1st** Column: Classification of the areas
- **2nd Column**: Dimension or Area to be assessed
- **3rd Column**: Checklist Elements & Verification Method; it allows assessing the quality of the activity/area in execution. These elements are assessed by the analysis of the documents and by direct observation of activity or equipment and supplies
- **4th Column**: Criteria; this explains how to assess each element and to attribute a score to it.
- **5th Column**: Possible maximum score
- **6th Column**: Obtained Score; this is the result of the checklist elements assessment according to the attributed points.
- **7th Column:** Justification of score; explains the reasons for the variance between the maximum score and the obtained score.

Sampling Cases for Validation

The selection of cases to be validated is done randomly.

Selection of Cases

The number of cards to be selected shall depend on the size of the sample needed from the total quantity. If the activities with available quantities services not exceeding the needed cases, the assessor analyses all the cards available.

Random Selection

The random selection method is used to draw the number of cases to be analyzed. Systematic random sampling consists of calculating the step of sampling (K), which is achieved by dividing the total number of cases (N) by the number of cases to be chosen (4) and by rounding it to the nearest unit. To determine the first file to draw from the register, the assessor randomly draws a figure between 1 and (K) which becomes thus the first file. Then, the assessor adds (K) to first file figure to draw the next file and so on.

If the assessor does not find a case from the drawn file, he/she replaces it by the following case.

For example:

- ✓ Health Facility with 70 consultations FP from the register.
- ✓ Number of cases to be chosen from the register = 4 cases to which we apply the criteria of validation of quality.
- ✓ Step of sampling (K) = 70/4 = 17.5; we use 17 as (K)
- ✓ The assessor randomly chooses a figure between 1 and 17 (for example 8). The figure proposed represents the first card.
- ✓ From card 8, all 17th cards are selected up to 4 cards (for example, the second card is 25th; the third is 42nd, fourth is 59th).

Direct Observation

The number of cases to be observed for each activity is indicated in the tool. This is very important because the assessment is done while the provider is preforming the activity.

Summary of Quarterly Quality Activities Assessment Results of the Facility

This page of the assessment is presented in the form of table, which is composed of 6 columns:

- ➢ **1st Column**: N = Classification of the quality assessment areas
- ➢ **2nd Column**: Assessed areas
- ➢ **3rd Column**: Possible Maximum (total points for each assessed area)
- ➢ **4th Column**: Obtained Points to each area (total points obtained for each area)
- ➢ **5th Column**: Percentage (= Obtained points / Possible Max. points X 100)
- ➢ **6th Column**: Observations (Explanation of the variation)

QUARTERLY OBSERVATIONS AND RECOMMENDATIONS ON THE SERVICE OF THE DISPENSARY

This page is composed by five rows:

- **1st Row:** List of recommendations not addressed from the previous quarter and justifications provided by the facility
- **2nd Row:** Identified strengths during this assessment
- **3rd Row:** Identified weaknesses to improve upon during next quarter
- **4th Row:** Recommendations regarding the identified weaknesses.
- **5th Row:** Recommended Technical Support.

For assessment to be valid, this last page of observations and recommendations must be signed by both the head of the assessors and the In-charge of the assessed health facility

Distribution of Points

The distribution of points for the 18 activities/areas to be assessed will be carried out according to the criteria of national priority and based on problems on the ground likely to be solved by contribution of RBF. The attribution of the points of the elements within each activity/area was given by comparing the importance of one element to another.

General Information

HEALTH FACILITY IDENTIFICATION

Health Facility Name:		Assessed Quarter: ……	Year: 20…….
District:		Region:	
Phone No:	Fax:	PO Box:	
Status: Public: ☐	Missionary : ☐	Private : ☐	Partner: ☐
Catchment Population:		Number of beds:	
Name of In-charge:		Phone No:	
P.O. Box:	E-mail:		

18 Activities / Areas of Quality Assessment

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
1	HYGIENE AND SANITATION	**Presence of clean and functioning disinfected toilet/s for patients, staffs and physically challenged people:** 1a. 1) Functioning toilet [VIP latrine which is not full OR a flushing toilet with working or improvised flushing system], 2) Toilets clean inside and out with no stagnant water and no foul smells], 3) Toilet paper or water. And in case of flushing toilet, a dust bin. 4) Hand-washing facilities just outside the toilet or with basin inside toilet [soap and source of water]	All element available for all toilets = 4 Element missing for one or all toilets = Deduct 1 Point per missing element	**9**		
		1b. Cleanliness of the facility environment: No cobwebs and clean floor [with no rubbish, stains, and sand] in all rooms	- If all rooms are clean=2 - If not all = 2 X Number of the rooms/Clean rooms			
		1c. No organic waste, used syringes, needles, used bandages or dangerous products on the ground of the HF that are easily accessible to the public (including waste pit area) and grounds surrounding the HF entirely cleared of weeds and stagnant water drained	Yes = 1 If present = 0/1			
		1d. Presence of: Functioning incinerator, fenced in and ash pit. If no incinerator, it must have waste pit with evidence of use by burn and bury but also fenced in. Presence of placenta pit with slab and cover	Functioning incinerator =2 If it is Placenta pit in use meeting all criteria = 1 If not available =0			
2	PRIVACY	Privacy in ALL Individual treatment /service delivery rooms have full privacy during service provision: 1) Doors that close, 2) A screen to partition the examination area/bed, 3) If the service delivery room has windows, they must all have curtains or be painted windows or frosted glass,	Privacy Assured in rooms and all criteria met = 4 Service room with all criteria = 4/number of	**4**		

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		4) If the service delivery room is shared, it must have a divider	service rooms Privacy not assured = 0			
3	WATER SUPPLY	Availability of reliable supply of safe running water: 1) Availability of water source (Piped water or well, pump or water tower/tank)	Water Source Available = 2 Water source not available=0	**4**		
		Availability of Functioning running water or improvised water dispensers in all service delivery rooms	Available in all rooms = 2 Not in all rooms = 0/2			
4	WASTE MANAGEMENT	Waste management done as per standard guidelines in clinical procedures rooms: Availability of: 4.1) *Labor ward and dressing room*: Three buckets, each bucket clearly labeled with today's date, 1 bucket with chlorine 0.5%, 1 with soapy water and 1 with clean water;	3 buckets available = 1 Not available or not meeting criteria = 0/1	**6**		
		2) *Inpatient wards (Including labor ward, laboratory and immunization/Injection room):* At least 1 safety box with sharps not exceeding ¾ full, and no sharps sitting on top of the box	Available and criteria met=2 If partial= 0/2			
		3) *In labor ward, laboratory and minor theatre:* Proper waste segregation using Red, Yellow and Black/Blue bins with color coded bin liners – labeled bin liners ok in lieu of colored	All Criteria met in these rooms = 3 If partial= 0/3			
5	ANC	**Pregnant women receive appropriate focused ANC:** On actual day of the ANC Visits observe the waiting area; **1)** Availability of seats or benches to allow every woman to seat, **2)** Health education session provided to the waiting women, **3)** No woman available who has waited for more than 1 hour to be seen (interview some)	All 3 Elements fulfilling criteria = 3 Element with criteria not met = Deduct 1			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		Analyze RCH card number 4 of 5 women present *I. Confirm that following have been noted for first visit*: **(5 Pts)** **1)** Height of the mother in CMs, **2)** Gravida and Parity, **3)** LNMP and EDD, **4)** Filling of the danger signs (vidokezo vya hatari), **5)** HIV Check – PMTCT	A card with all 5 items recorded = 1 A card with even 1 item not Recorded = 0/1	**13**		
		II. Confirm that following have been noted for all visits: **(5 Pts)** **1)** Hemoglobin, **2)** VDRL/RPR, **3)** Blood pressure checks, **4)** IPT for malaria (If pregnancy over 20 Weeks), 5) Tetanus vaccine administered accordingly, 6) Fetal heart rate/lie/presentation, 7) Ferrous sulphate/Folic acid	All elements noted=5 Even one element missing=0			
6	LABOUR WARD	**Available and functional equipment and supplies for quality service delivery:** **6a.** Adjustable clean Delivery bed(s) with a footstool	All delivery beds meeting all criteria = 1 If not all=1/#beds*bed meeting criteria If none meets criteria=0	**13**		
		6b. 1) One Functional goose neck lamp or torch, **2)** Functional newborn weighing scale, **3)** Drum with Sterile gauze, **4)** functional Suction machine, **5)** Functional Resuscitation kit (ambu-bag, tubes), **6)** Mackintosh and plastic mattress cover for each delivery bed	All elements available= 6 Element missing = Deduct 1 per missing element			
		6c. At least 2 sterilized delivery trays (1 kidney dish, 1 gallipot, 2 scissors, 2 clamp forceps, 1 stitching forceps, 1 dissecting forceps, 1 sponge holding forceps, 2 needles with suture, 1 plastic umbilical cord clamp)	Two Sterilized trays available and complete = 3 If less than two even if fit criteria = 0/3			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		6d. PPEs: 1) Plastic aprons, **2)** Two pairs Gumboots/closed shoes, **3)** Two Masks, **4)** Two Goggles, **5)** At least 1 full or nearly full box of Clean, **6)** At least 1 full or nearly full box of Sterile gloves (50 pairs)	All elements available = 3 Even one missing = 0			
7	POST-NATAL CARE	Post Natal care according to national guideline: On actual day of the Post Natal Visits, request the RCH card number 4 and number 1 (3 cards). If woman selected has suffered baby loss, then only confirm part (a). a) POST NATAL WOMAN *I. Confirm that following have been noted for first PNC visit:* 1) Involution of the uterus, 2) Color of lochia, 3) Condition of the perineum (condition of operation site if delivered by C-section), 4) Family planning counseling on FP methods appropriate for postpartum women, and for women no longer postpartum; timing of return to fertility after live birth; 5) Temperature, 6) Blood pressure, 7) Hemoglobin level, 8) Any engorged breast, 9) Any cracked nipples b) BABY *Confirm that following have been noted for first PNC visit:* **1)** Condition of the umbilical cord, **2)** Feeding option (Breast feeding or artificial feeding), **3)** Birth Weight, **4)** Temperature, **5)** Vaccination status (Polio and BCG Vaccine)	<u>Mother</u> A card with at least 7/9 items Recorded during 7th day = 2 A card with more than 2 items not Recorded = 0/2 <u>Infant</u> A card with at least 4/5 items recorded = 1 A card with more than 1 item not Recorded = 0/1	**9**		

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
8	MATERNAL DEATH AUDITS	**Proportion of maternal deaths in health facility that are completely and appropriately audited and action plan in place:** The number of maternal deaths in health facilities and reported by CHWs in the previous quarter that are completely and appropriately audited and action plan in place. (Form B) – numerator The number of maternal deaths per the register in the facility in the previous quarter – denominator	If the reported are >= 80% = 10 If the reported are < 80% = 0/10	**10**		
9	PERINATAL DEATH AUDITS	Proportion of perinatal deaths in health facility that are completely and appropriately audited and action plan in place: The number of perinatal deaths in health facilities and reported by CHWs in the previous quarter that are completely and appropriately audited and action plan in place. (Form B) – numerator The number of perinatal deaths per the register in the facility in the previous quarter – denominator	If the reported are >= 80% = 10 If the reported are < 80% = 0/10	**10**		
10	FAMILY PLANNING	**Direct Observation of the Room and Supplies: Contraceptive methods: (6Pts)** 1.Pills 2.Injectable contraceptives 3.Implant 4.Intrauterine Contractive device (IUCD) 5.Condoms both male and female 6.Emergency Contraceptives A) Availability of contraceptive with theoretical stock	One contraceptive method fulfilling both criteria A & B = 1 A contraceptive method with one unmet criterion			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		corresponding to physical stock; and B) Minimum & Maximum stock levels maintained	= 0.5	**17**		
		Analysis of 2 randomly chosen FP clients Cards to check if they are correctly examined, counseled on FP methods choice: (4 Pts) *A. Proper history taken:* **1)** Number of children, **2)** Number of deliveries / Live birth / still birth / abortions / miscarriages, **3)** Menstrual history – completely filled as per card ***B.** Availability of Referral or Acceptance of FP Referral:* 1. A referral to another facility or outreach service indicated if the client's method was not available at the facility (as noted on the card), 2. A referral noted in the client's record as required by guidelines (e.g. method of choice, points of referral), if the client was referred to the facility for a family planning service	A card with A&B fulfilled = 2 A card with even one element missing = 0/2			
		Availability of Trained FP Providers: **(2Pts)** At least two providers at post today that are trained to counsel and provide family planning services according to the national guidelines for this facility.	2 or more providers are available = 2 Only 1 provider available = 1 If no FP trained provider available today = 0/2			
		Conduct exit interview about informed choice of FP methods (select 1 client at random) = 5 Pts **1.** What methods were you taught? [Must be able to mention 3 of the following: Condoms, Injectable, Pills,	A question answered			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		Implants, IUCDs] **2.** Did you receive your method of choice or advised which methods were appropriate for you following examination today? If not, were you provided information on where you could receive the method, or referred to a facility or outreach service where the method is provided? **3.** Today or when you first initiated use of your current method, did the provider discuss with you what to do if side effects arise during use of the method? **4.** Did you wait for less than <u>one hour</u> at the clinic from time of arrival until being seen by the family planning provider? **5.** Can the client correctly identify the fertile period in monthly cycle?	with YES = 1 A question answered with NO = 0/1			
11	IMMUNIZATION	Quality of vaccination services as guided by national vaccine management guideline and availability of functional cold chain maintenance of vaccines: 1) A functional refrigerator, with temperature (In or/and outside Thermometer) indicating between +2C and +8C, 2) Two LP gas cylinders, 1 connected to refrigerator and 1 full as a spare, (if the facility has electricity an alternative (gas cylinder or generator) should be available, 3) Two Vaccine carriers, 4) Temperature monitor chart, with every day's temperature filled up to date and for last 3 months, 5) One Functional thermometer, located in the refrigerator	Maximum points: 5 If the fridge is functional: Start scoring 1 point per available element If fridge not available or not functional: No need of checking other items	**7**		
		All vaccines available as per guideline: 1) BCG, 2) Polio, 3) Measles, 4) Pentavalent, 5) Rotavirus 6) Pneumococcal Vaccine (PCV 13), 7) Tetanus Toxoid, 8) Diluent	If all vaccines & Diluent available = 2 Even one missing= 0/2			
		Availability of seats or benches to allow every woman and child to seat	If yes = 1 If no= 0/1			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
12	NUTRITION FOR UNDER-FIVE CHILDREN	**Growth monitoring to assess nutritional status of under five children:** Analysis of 4 RCHS Cards Number 1 (for children under 5) to confirm if the child has been monitored for growth using the following anthropometric measurement and documented: [Select 4 random cards] **A)** Weight plotted Vs age accurately on the chart for all visits **B)** Vitamin A from 6 months, all courses for which child is old enough must have been administered and recorded	A card with both A & B done in the previous visits = 1 A card with even one missing = 0/1	**4**		
13	PHARMACY	**Availability of tracer medicines, supplies, vaccines and Stock management and according to national guidelines:** **A)** Stock ledger Vs shelf (Agreement between theoretical and physical stock) **(12Pts):** Select 6 drugs / consumables from the list below and check stock for TODAY in HMIS book 4 (Ledger book) and verify the stock on the shelf in the pharmacy: **1)** DPT + Hep B/HiB Vaccine, **2)** Artemether (ALU) oral, **3)** Amoxycillin or Cotrimoxazole, **4)** Albendazole or Mebendazole, **5)** Oral Rehydration salts (ORS), **6)** Inj. Ergometrine or Oxytocin or tabs Misoprostol **7)** Iv fluids Dextrose 5% or Sodium Chloride + Dextrose) **8)** Disposable syringes (Autodisposable)	A drug/Consumable with agreement on the ledger and shelf = 2 A drugs/Consumable with disagreement between the quantities on the ledger and shelf =	**22**		

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		9) Malaria Rapid Diagnostic Test (MRDT)	0/2			
		B) Months of stock on hand **(10 Points)** Check E-LMIS for the months on hand of stock of all 10 of the drugs in the list above. Compare the figure from E-LMIS to the range described by the norms.	For each drug/consumable where months of stock on hand is within the range described by the norms = 1 A drug/consumable where months of stock on hand is not within the range described by the norms = 0/1			
14	COMMUNITY	**Available minutes of the HF Governing Committee [HFGC] for the assessed quarter; Minutes should contain:** *1) Meeting minutes available for assessed quarter, 2) Attendance list and signatures available, 3) Evidence of use of RBF investment funds discussed during the meeting, 4) Evidence of approval of distribution of RBF funds to staff, 5) Evidence of discussion of challenges confronting the facility and action points documented*	Each element available = 1 Missing element=Deduct 1 Note: This applies if 1&2 are available.	**5**		
15	COMMUNITY HEALTH FUND	**CHF enrolment rate increase in the catchment area of the facility:** Verify the number of active households (Current enrolment of assessed quarter) in CHF in the catchment area of the health	>= 5% increase versus last quarter = 10			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		facility in the quarter and sum – numerator Total households in facility's catchment area – denominator (Perform same calculation for last previous quarter)	< 5% = 0/10	**10**		
16	FACILITY PROFILE REPORTS (INC. RBF)	**Availability of assessed quarter Facility Profile Report which includes:** **1)** Technical chapter, **2)** Financial chapter	Report with both element = 6 Even one element missing = 0/6	**6**		
17	TRANSPARENCY	**The facility is working transparently and information sharing.** Availability of the following on the notice board: **1)** List of services and their prices (inc. free services), **2)** Income and Expenditures reports [quarterly], **3)** Health Facility Governing Committee meeting minutes, **4)** Working hours, **5)** Mobile/phone number and names for complaints	All elements available = 5 Even one missing = 0/5	**5**		

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
18	CLIENT SATISFACTION	**From Client Satisfaction Form, check the followings:** **A.** Patient tracing and **B.** Patient satisfaction part **Note:** 10% of the assessed total quarterly number of clients reported by the HF for: Deliveries, ANC 1st Visits, and PNC visits 3-7 days after deliveries women, then use sampling method found in this tool introduction to pick the actual clients to trace.	If 100% of clients traced from those three indicators are found = 10 If less than 100% = From 10 you deduct missing clients X 10/Total number to be traced If some clients are not being existing, they should be deduced from the quantity reported in terms of % of those not found and total reported If 100% of clients traced are satisfied to the maximum= 10 If less than 100% = From 10 you deduct missing clients X 10/Total number to be traced	**20**		
TOTAL SCORE				**174**		

Information on Assessments

Region: District: Date of assessment: ……/……/ 20….

#	Activity or assessed services	Possible Maximum	Score of previous assessment	Score of current assessment	Name (s) of the current assessor/s	Function & work location	Starting time of assessment	Ending time of assessment
1	Hygiene and sanitation	9						
2	Privacy	4						
3	Water supply	4						
4	Waste management	6						
5	ANC	13						
6	Labour ward	13						
7	Post-natal care	9						
8	Maternal death audits	10						
9	Perinatal death audits	10						
10	Family planning	17						
11	Immunization	7						
12	Nutrition for under-five children	4						
13	Pharmacy	22						

#	Activity or assessed services	Possible Maximum	Score of previous assessment	Score of current assessment	Name (s) of the current assessor/s	Function & work location	Starting time of assessment	Ending time of assessment
14	Community	5						
15	Community health fund	10						
16	Facility profile reports (inc. RBF)	6						
17	Transparency	5						
18	Client Satisfaction	20						
TOTAL		174						

Summary of Quarterly Quality Activities/Areas Assessment Results of the Facility

QUALITY EVALUATION OF DISPENSARY: _____

DISTRICT:_____ _____QUARTER 20_____

N	Dimension	Possible Maximum	Obtained Points	%	Observations
1	Hygiene and sanitation	9			
2	Privacy	4			
3	Water supply	4			
4	Waste management	6			
5	ANC	13			
6	Labour ward	13			
7	Post-natal care	9			
8	Maternal death audits	10			
9	Perinatal death audits	10			
10	Family planning	17			
11	Immunization	7			
12	Nutrition for under-five children	4			
13	Pharmacy	22			
14	Community	5			
15	Community health fund	10			
16	Facility profile reports (Inc. RBF)	6			
17	Transparency	5			
18	Client Satisfaction	20			
TOTAL		174			

QUARTERLY OBSERVATIONS AND RECOMMENDATIONS ON THE SERVICES OF THE DISPENSARY

District: _____ Dispensary: _____ Date:_____
1. List recommendations not addressed from the previous quarter and provided justifications
2. Identified Strengths during the assessed quarter

3. Identified weaknesses to improve upon during next quarter
4. Recommendations regarding the weaknesses

5. Recommended Technical support

Dispensary agrees on the results as a true reflection of the health facility

Health Facility In-charge	Quality Assessment Team
Name:…… …….	Name&Signature:……..
Signature & Health Facility Stamp:……..	Name&Signature:……..
	Name&Signature:……..
	Name&Signature:……..
Date:……..	Date:……..

MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING

DISTRICT HOSPITAL & HEALTH CENTRE QUARTERLY QUALITY ASSESSMENT TOOL

TANZANIA 2015

Quarterly Quality Assessment

Frequency of Assessment

The evaluation is quarterly and each of the 23 activities/areas is assessed once per quarter.

Assessment Process

- ✓ The visit of the assessors is scheduled the day when the services assess are available.
- ✓ The provider may be assessed carrying out the activity (for purposes of case observation)
- ✓ The available medical documents at the facility are assessed in some cases (Registers, cards e.tc)
- ✓ The assessment of each activity/area is done in the presence of the Health Facility staff to witness the findings and avoid the conflicts when announcing the results,
- ✓ At the end of the assessment, the results are approved with names and signatures of the of the assessor's head and the health facility's in-charge
- ✓ The team of the assessors takes time to discuss with the Health Facility in-charge and staff **1)** The positive findings and **2)** The issues to be improved upon. After discussion, the team of the assessors, together with the In-charge and other staff, make recommendations including those requiring technical support.
- ✓ A complete copy of the assessment results is given to the health facility; one to CHMT, and the other one is carried for data entry into the RBF database, the analysis, compilation and filing.

Note: It is the responsibility of the health facility to ensure the availability and the accessibility of all required documents by the assessors

Use of Quality Assessment Tool

Checklist of Areas of assessment

The checklist of activities assessment is presented in the form of table, which is composed of 6 columns.

- **1st Column**: Classification of the areas
- **2nd Column**: Dimension or Area to be assessed
- **3rd Column**: Checklist Elements & Verification Method; it allows assessing the quality of the activity/area in execution. These elements are assessed by the analysis of the documents and by direct observation of activity or equipment and supplies
- **4th Column**: Criteria; this explains how to assess each element and to attribute a score to it.
- **5th Column**: Possible maximum score
- **6th Column**: Obtained Score; this is the result of the checklist elements assessment according to the attributed points.
- **7th Column:** Justification of score; explains the reasons for the variance between the maximum score and the obtained score.

Sampling Cases for Validation

The selection of cases to be validated is done randomly.

Selection of Cases

The number of cards to be selected shall depend on the size of the sample needed from the total quantity. If the activities with available quantities services not exceeding the needed cases, the assessor analyses all the cards available.

Random Selection

The random selection method is used to draw the number of cases to be analyzed. Systematic random sampling consists of calculating the step of sampling (K), which is achieved by dividing the total number of cases (N) by the number of cases to be chosen (4) and by rounding it to the nearest unit.

To determine the first file to draw from the register, the assessor randomly draws a figure between 1 and (K) which becomes thus the first file. Then, the assessor adds (K) to first file figure to draw the next file and so on.

If the assessor does not find a case from the drawn file, he/she replaces it by the following case.

For example:

- ✓ Health Facility with 70 consultations FP from the register.
- ✓ Number of cases to be chosen from the register = 4 cases to which we apply the criteria of validation of quality.
- ✓ Step of sampling (K) = 70/4 = 17.5; we use 17 as (K)
- ✓ The assessor randomly chooses a figure between 1 and 17 (for example 8). The figure proposed represents the first card.
- ✓ From card 8, all 17th cards are selected up to 4 cards (for example, the second card is 25th; the third is 42nd, fourth is 59th).

Direct Observation

The number of cases to be observed for each activity is indicated in the tool. This is very important because the assessment is done while the provider is preforming the activity.

Summary of Quarterly Quality Activities Assessment Results of the Facility

This page of the assessment is presented in the form of table, which is composed of 6 columns:

- ➢ **1st Column**: N = Classification of the quality assessment areas
- ➢ **2nd Column**: Assessed areas
- ➢ **3rd Column**: Possible Maximum (total points for each assessed area)
- ➢ **4th Column**: Obtained Points to each area (total points obtained for each area)
- ➢ **5th Column**: Percentage (= Obtained points / Possible Max. points X 100)
- ➢ **6th Column**: Observations (Explanation of the variation)

QUARTERLY OBSERVATIONS AND RECOMMENDATIONS ON THE SERVICE OF THE DISTRICT/HEALTH HEALTH CENTRE

This page is composed by five rows:

- **1st Row:** List of recommendations not addressed from the previous quarter and justifications provided by the facility
- **2nd Row:** Identified strengths during this assessment
- **3rd Row:** Identified weaknesses to improve upon during next quarter
- **4th Row:** Recommendations regarding the identified weaknesses.
- **5th Row:** Recommended Technical Support.

For assessment to be valid, this last page of observations and recommendations must be signed by both the head of the assessors and the In-charge of the assessed health facility

Distribution of Points

The distribution of points for the 23 activities/areas to be assessed will be carried out according to the criteria of national priority and based on problems on the ground likely to be solved by contribution of RBF. The attribution of the points of the elements within each activity/area was given by comparing the importance of one element to another.

General Information

HEALTH FACILITY IDENTIFICATION

Health Facility Name:		Assessed Quarter: …… Year: …..
District:		Region:
Phone No:	Fax:	PO Box:
Status: Public: ☐ Missionary : ☐		Private : ☐ Partner: ☐
Catchment Population:		Number of beds:
Name of In-charge:		Phone No:
P.O. Box:	E-mail:	

23 Activities / Areas of Quality Assessment

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
1	SOCIAL ACCOUNTABILITY	**Transparence in operations and information sharing:** Presence of the following displayed at the notice board; **1)** Price list for services displayed (Inc. free services; **2)** Quarterly Income and Expenditures reports displayed; **3)** Health Facility Governing Committee meetings conducted and minutes displayed; **4)** Working hours displayed for outpatient services; **5)** Mobile/phone number and names for complaints displayed	Presence of all 5 elements = 5 Even one missing element = 0/5	**5**		
2	FACILITY PROGRESS REPORTS (INC. RBF)	**Availability of Facility Progress Report:** Verify previous Quarter Facility Progress Report, including: **1)** Technical Section (Including Business Plan Implementation) **2)** Financial Section	Both elements available in the report = 4 Even one missing = 0/4	**4**		
3	MEDICAL RECORDS	**Availability of Medical Record Department for Patient's Record filing system:** Verify if the facility has the following: 1) At least one trained medical recorder, 2) Rooms for client record keeping with adequate shelving (no files being kept on the floor), 3) Organized filing procedures in place [Numbering/alphabetical labeling], 4) Existence of waiting card system with numbers for patients (for clinics)	Four elements available = 4 1 missing element = Deduct 1 Point per missing element	**4**		
4	PRIVACY	**Privacy in Individual treatment /service delivery rooms have full privacy during service provision** • All service delivery rooms with doors that close	Privacy Assured in rooms and all criteria met = 4 Service room with all			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		• All service delivery rooms with screen to partition the examination area/bed • Windows with curtains or painted or with frosted glass • Divider (screen/curtain) if the service delivery room is shared.	criteria = 4/number of service rooms Privacy not assured = 0	**4**		
5	HYGIENE AND SANITATION	**Presence of clean and functioning disinfected toilet/s for patients, staffs and physically challenged people:** **5a. 1)** Functioning toilet [VIP latrine which is not full OR a flushing toilet with working or improvised flushing system], **2)** Toilets clean inside and out with no stagnant water and no foul smells], **3)** Presence of toilet paper or water. And in case of flushing toilet, a dust bin. **4)** Hand-washing facilities just outside the toilet or with basin inside toilet [soap and source of water]	All element available for all toilets = 4 Element missing for one or all toilets = Deduct 1 Point per missing element	**7**		
		5b. No organic waste, used syringes, needles, used bandages or dangerous products on the ground of the facility that are easily accessible to the public (including waste pit area) and grounds surrounding the HF entirely cleared of weeds and stagnant water drained	Yes = 1 If present = 0/1			
		5c. Presence of: Functioning incinerator, fenced in and ash pit. If no incinerator, it must have waste pit with evidence of use by burn and bury but also fenced in. Presence of placenta pit with slab and cover	Functioning incinerator=2 If it is Placenta pit in use meeting all criteria = 1 If not available =0			
6	WATER SUPPLY	**Availability of reliable supply of safe running water:** Availability in functional areas of a reliable water supply (piped water or well, pump or water tower/tank)	Available water source = 6 Water source not available=0	**11**		
		Availability of functioning running water or improvised water dispensers in all services	Available in all rooms =5 Not available in all rooms=			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
			0			
7	LABOUR WARD	**Delivery room with essential equipment and supplies for quality service delivery:** **A.** Delivery bed functional, Clean, Adjustable, with a footstool,	All delivery bed meeting all criteria = 1 If not all=1/#beds*bed meeting criteria If none meets criteria=0	**14**		
		B.1) One Functional goose neck lamp / light source, **2)** one Functional newborn weighing scale, **3)** One Drum with Sterile gauze and, **4)** One drum with cotton wool, **5)** One Suction machine, **6)** Resuscitation kit (Ambu-bag, tubes), **7)** One Mackintosh (plastic mattress cover) for each delivery bed	All elements Available element = 7 Missing element = Deduct 1 point per missing element			
		B) At least 5 sterilized delivery trays (1 kidney dish or gallipot, 2 scissors, 2 clamp forceps, 1 stitching forceps, 1 dissecting forceps, 1 sponge holding forceps per tray, 2 needles with suture, 1 umbilical cord clamp)	If 2 or more trays found and with all contents= 3 If less than 2 even if all contents are in = 0/3			
		C) PPEs: Three Plastic aprons, Three pairs Gumboots/closed shoes, Three Masks, Three Goggles, At least Two full or nearly full box of Clean (50 pairs), Two full or nearly full Sterile gloves (50 pairs)	All element available=3 Even one missing= 0/3			
8	WASTE MANAGEMENT	**Waste management done as per standard guidelines in clinical procedures rooms:** Availability of: 8.1) *Labor ward and dressing room*: Three buckets, each bucket clearly labeled with today's date, 1 bucket with chlorine 0.5%, 1 with soapy water and 1 with clean water;	3 buckets available = 1 Not available or not meeting criteria = 0/1	**6**		
		2) *Inpatient wards (Including labor ward, laboratory and immunization/Injection room):* At least 1 safety box with sharps not exceeding ¾ full, and no sharps sitting on top of the box	Available and criteria met=2 If partial= 0/2			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		3) *In labor ward, laboratory and minor theatre:* Proper waste segregation using Red, Yellow and Black/Blue bins with color coded bin liners – labeled bin liners ok in lieu of colored	Waste segregation meeting criteria and in all relevant rooms = 3 If partial= 0/3			
9	OBSTETRIC EMERGENCIES	**Availability of appropriate equipment and materials available to treat/manage patients with obstetric emergencies:** Sterilized manual removal aspiration kit available [MVA kits 2]	MVA kits available = 1 Not available = 0	**35**		
		Blood transfusion facilities available [Blood bank with 5 units different groups preferably O group of blood available]	All O groups available=5 O groups missing=0/5 All other groups available=5 All other groups missing=0/5			
		1) Vacuum extractor, 2) Gunlet gloves for manual removal of placenta	2 elements available = 4 One missing = deduct 2			
		1) Suction machine, **2)** Resuscitation kit [Ambu bags different sizes, Sodium bicarbonate, Vit. K]	2 elements available= 6 One missing/incomplete= Deduct 3			
		Infusions: **A)** Three bottles of Ringer lactate, Three bottles of Normal saline 1000mls, **B)** Sets of cannula, Gauge 14 & 18	A&B available = 4 A/B missing = Deduct 2			
		Infusions (cont.): **C)** Giving sets 3, D) Syringes 2cc, 5cc, 10cc [5,5,5]	C & D available = 2 C /D missing/incomplete = Deduct 1			
		Emergency Drugs Availability: **1)** Magnesium Sulphate, **2)** Nifedipine/Hydralazine	Both available = 4 One missing = Deduct 2			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		Antibiotics: **1)** Metronidazole Inj., **2)** Ampicillin inj. OR Gentamycin inj. **3)** Ceftriaxone inj.	These 3 drugs available = 3 Missing drug= Deduct 1			
		Sedatives: (E.g. diazepam)	Sedative Available = 1 Not available = 0/1			
		Family Planning: Post-abortion family planning counseling and method provision conducted (Sample 2 cases)	A case fulfilling Criteria=1 Criteria not fulfilled = 0/1			
10	PARTOGRAM	Use of Partograms accordingly: *Analysis of 3 randomly selected partograms* **1.** Check for completeness filling of Patients information [All areas filled] **2.** Check for filling onset of labor pains, rupture of membranes, gestation, lie and presentation **3.** Half hourly observation documentation of fetal heart rate **4.** Hourly observation and documentation of contractions **5.** Four hourly observation and documentation **a)** Graphs of cervical dilatation, **b)** Descent of presenting part, **c)** Vital signs [Temp, BP] **6.** Action taken [C/S, Vacuum extraction, Normal delivery or referral] [If one or more deliveries are taking place, observe the filling in of a partograph for a woman in labor]	One partogram fulfilling all criteria = 6 This mean 1-point per element among those 6 listed Deduct 1 per missing/not correct & Complete element	**18**		
11	COMPLICATED DELIVERIES INCLUDING C-SECTIONS	**Correct management of complicated deliveries:** For previous quarter, sample 5 complicated deliveries from	Delivery fulfilling A&B=2 Time management			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		the register and review files to assess prompt and correct management of the case **(Complicated deliveries = third degree tear, vacuum extraction, breach delivery, face presentation)** **A)** Action with 30 min from arrival, **B)** Right treatment given	accordingly = 0.5 If not = 0/0.5 Right treatment= 1.5 Partial treatment = 1	**10**		
12	POST-NATAL CARE	**Post Natal care according to national guideline:** On actual day of the Post Natal Visits, request the RCH card number 4 and number 1 (At least 3 cards). If woman selected has suffered baby loss, then only confirm part (a). a) POST NATAL WOMAN *I. Confirm that following have been noted for first PNC visit:* 1) Involution of the uterus, 2) Color of lochia, 3) Condition of the perineum (condition of operation site if delivered by C-section), 4) Family planning counseling on FP methods appropriate for postpartum women, and for women no longer postpartum; timing of return to fertility after live birth; 5) Temperature, 6) Blood pressure, 7) Hemoglobin level, 8) Any engorged breast, 9) Any cracked nipples b) BABY *I. Confirm that following have been noted for first PNC visit:* 1) Condition of the umbilical cord, 2) Feeding option (Breast feeding or artificial feeding), 3) Birth Weight, 4) Temperature, 5) Vaccination status (Polio and BCG Vaccine)	**Mother** A card with at least 7/9 items Recorded during 7th day = 2 A card with more than 2 items not Recorded = 0/2 **Infant** A card with at least 4/5 items recorded = 1 A card with more than 1	**9**		

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
			item not Recorded = 0/1			
13	KANGAROO MOTHER CARE	**Implementation of kangaroo mother care to improve baby's condition:** Availability of: **1)** Room for Kangaroo care with heater [in areas with cold weather], **2)** Table with special weighing scale for premature **3)** Sunflower oil, **4)** Vital signs tray, **5)** Observation charts **6)** Wall clock, **7)** Graduated feeding cups	7 elements available = 7 Deduct 1 per missing element	**15**		
		Review Two cases notes of premature for proper records of vital signs [Temperature, Pulse rate, weight and feeding]	Both cases fulfilling criteria= 8 A case with even one			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
			criteria not met = 0/4			
14	FAMILY PLANNING	Analysis of 4 randomly chosen FP clients Cards to check if they are correctly examined, counseled on FP methods choice *A) Proper history taken:* **1)** Number of children, **2)** Number of deliveries / abortions / miscarriages, **3)** Menstrual history – completely filled as per card *B) Physical examination correctly conducted:* **4)** Physical examination to include the following: a) Abdominal examination, *b)* Legs examination (edema, varicose veins), *c)* Vaginal examination – completely filled as per card), d) Blood pressure, *e)* Cervical screening ***5)*** Hemoglobin, **6)** Method chosen, **7)** Provider Initiated Testing and Counseling, **8)** Given date for next appointment	A card fulfilling at least 6/8 criteria = 2 A card with more 2 criteria not met = 0/2	**24**		
		Conduct exit interview about informed choice of FP methods (select 1 client at random) = 10 Points **1.** What methods were you taught? [Must be able to mention 3 of the following: Condoms, Injectable, Pills, Implants, IUCDs] **2.** Did you receive your method of choice or advised which methods were appropriate for you following examination today? If not, were you provided information on where you could receive the method, or referred to a facility or outreach service where the method is provided? **3.** Today or when you first initiated use of your current method, did the provider discuss with you what to do if	A question answered with **YES** = 2			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		side effects arise during use of the method? **4.** Did you wait for less than <u>one hour</u> at the clinic from time of arrival until being seen by the family planning provider? **5.** Can the client correctly identify the fertile period in monthly cycle?	A question answered with **NO** = 0/2			
		Direct Observation of the Room and Supplies: Contraceptive methods: (6Pts) 1.Pills, 2. Injectable contraceptives, 3. Implant, 4. Intrauterine Contractive device (IUCD), 5. Condoms both male and female, 6. Emergency Contraceptives **A)** Availability of contraceptive with theoretical stock corresponding to physical stock; and **B)** Minimum & Maximum stock levels maintained	One contraceptive method fulfilling both criteria **A** and **B** = 1 A contraceptive method with one unmet criterion = **0.5**			
15	MATERNAL DEATH AUDITS	**Proportion of maternal deaths in HFs that are completely and appropriately audited and action plan in place:** **A)** The number of maternal deaths in health facilities and reported by CHWs in the assessed quarter that are completely and appropriately audited and action plan in place. (Form A) /Number of maternal deaths per register in the facility in the assessed quarter.	If the reported are >= 80% = 3 If the reported are < 80% = 0/3	**15**		
		B) Select randomly 3 audited cases and check if they were **1)** Completely, **2)** Correctly filled and **3)** Action plan in place.	A case with 3 criteria = 3 Even one criteria missing = 0/3			

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
16	PERINATAL DEATH AUDITS	**Proportion of perinatal deaths in the HF that are completely and appropriately audited and action plan in place:** ***A)*** *Proportion of perinatal deaths that were discussed in the previous quarter* Number of perinatal deaths in HF and reported by CHWs in the assessed quarter that are completely and appropriately audited and action plan in place. (Form A)/Number of perinatal deaths per register in the HF in the assessed quarter	If the reported are >= 80% = 3 If the reported are < 80% = 0/3	**15**		
		B) Select randomly 3 audited cases and check if they were **1)** Completely, **2)** Correctly filled and **3)** Action plan in place.	A case with 3 criteria = 3 Even 1 criteria missing= 0			
17	IMMUNIZATION	**Quality of vaccination services as guided by national vaccine management guideline and availability of functional cold chain maintenance of vaccines:** **1)** A functional refrigerator, with temperature indicating between +2C and +8C, **2)** Two LP gas cylinders, 1 connected to refrigerator and 1 full as a spare, OR if the facility has electricity with a gas cylinder or generator as alternative power source or functional solar fridge, **3)** Vaccine carriers, **4)** Updated Temperature monitor chart, with every day's temperature filled, for last 3 months, **5)** Functional thermometer in the refrigerator	Each item fulfilling criteria = 1 If criteria not met = 0/1			
		All vaccines available as per guideline: **1)** BCG, **2)** Polio, **3)** Measles, **4)** Pentavalent, **5)** Rotavirus **6)** Pneumococcal Vaccine (PCV 13), **7)** Tetanus Toxoid **8)** Diluent	If all vaccines & Diluent available = 1 Even one missing = 0/1	**7**		

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		Availability of seats or benches to allow every woman and child to seat	If yes = 1 If no= 0/1			
18	STERILIZATION	**Availability of proper sterilization of instruments:** **1.** Existence of proper means / methods of sterilizing instruments: Steam sterilization (Autoclave) or Dry heat sterilization or Chemical sterilization **2.** SOPs for sterilization displayed on the wall by the equipment **3.** Each pack has an indicator for control of sterility	Each element fulfilling the criteria = 1 Criteria not met = 0/1	**3**		
19	IPD	**Patients provided with appropriate nursing care, plans and documentation done according to nursing guideline:** *Check at least 5 patient's case notes to check presence of nursing care plans with the following headings:* **1)** Patient particulars [Name, Age, Sex and Date], **2)** Nursing diagnosis, **3)** Objective/Goal of care, **4)** Nursing intervention and rationale, **5)** Evaluation	Each case note which fulfill all five headings= 2 A case with even one heading not fulfilled = 0/2	**10**		
20	LABORATORY	**Functional laboratory** *Availability of:* **1)** At least 3 Trained personnel, **2)** Functional microscope **3)** At least availability of reagents for the following test [For Syphilis test, Malaria, Blood grouping and x-matching and typhoid], **4)** Reliable running water [Piped running water]	Each item fulfilling criteria = 1 If criteria not met = 0/1	**4**		
21	TB SERVICES	**Documentation of diagnosed TB cases at the hospital level for patients that have been sent back to the HC and dispensary for continuation of TB management:** Availability of TB reports/documentation for diagnosed TB	All entries done completely and correctly (Columns and rows) = 2	**2**		

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		cases at the hospital level sent back to low level facility in previous quarter (TB UNIT REGISTER NO 3) Analysis of one randomly chosen page of the assessed quarter): number of entries completely filled in all fields	If not = 0/2			
22	PHARMACY	**Availability of tracer medicines, supplies, vaccines and Stock management and according to national guidelines** (Review HMIS book 4 (Ledger book) and verify the *availability and updated ledger of the following tracer drugs at the facility for the assessed quarter)* **Availability of tracer drugs and consumables:** **1)** Artemether (ALU) oral, **2)** Amoxycillin or Cotrimoxazole, **3)** Albendazole or Mebendazole, **4)** Oral Rehydration salts (ORS), 5) Inj. Ergometrine or Oxytocin or tabs Misoprostol, **6)** Iv fluids Dextrose 5% or Sodium Chloride + Dextrose), **7)** Disposable syringes (Autodisposable), **8)** Malaria Rapid Diagnostic Test (MRDT)	All tracer drugs/consumable available = 8 Even one tracer drugs/consumable missing = 0/8	**13**		
		Stock management: 1) Use of bin card, 2) FIFO/FEFO system, 3) Proper filling of Report & Request forms of the assessed quarter	All three elements available = 3 Deduct 1 for Missing element			
		Labeling of shelves according to International Common Denomination = 2	Criteria met = 2 Criteria not met = 0/2			
23	CLIENT SATISFACTION	From Client Satisfaction Form, check the followings: **A.** Patient tracing and **B.** Patient satisfaction part	If 100% of clients traced from those three indicators are found = 10 If less than 100% = From 10 you deduct missing clients X 10/Total number	**20**		

N	DIMENSION	CHECKLIST ELEMENTS & VERIFICATION METHOD	CRITERIA	POSSIBLE MAXIMUM	OBTAINED SCORE	JUSTIFICATION OF SCORE
		Note: 10% of the assessed total quarterly number of clients reported by the HF for: Deliveries, ANC 1st Visits, and PNC visits 3-7 days after deliveries women, then use sampling method found in this tool introduction to pick the actual clients to trace. For the District Hospital: Only patient satisfaction part will be considered and 20 points will be used as maximum on that part	to be traced If some clients are not being existing, they should be deduced from the quantity reported in terms of % of those not found and total reported If 100% of clients traced are satisfied to the maximum= 10 If less than 100% = From 10 you deduct missing clients X 10/Total number to be traced			
TOTAL SCORE				**255**		

Information on Assessments

Region: District: Date of assessment: ……/……/ 20….

#	Activity or assessed services	Possible Maximum	Score of previous assessment	Score of current assessment	Name (s) of the current assessor/s	Function & work location	Starting time of assessment	Ending time of assessment
1	Social Accountability	**5**						
2	Facility Profile Reports (Inc. RBF)	**4**						
3	Medical Records	**4**						
4	Privacy	**4**						
5	Hygiene and sanitation	**7**						
6	Water supply	**11**						
7	Labour Ward	**14**						
8	Waste management	**6**						
9	Obstetric emergencies	**35**						
10	Partogram	**18**						
11	Complicated deliveries including c/s	**10**						
12	Post-natal care	**9**						
13	Kangaroo mother care	**15**						
14	Family planning	**24**						
15	Maternal death audits	**15**						

#	Activity or assessed services	Possible Maximum	Score of previous assessment	Score of current assessment	Name (s) of the current assessor/s	Function & work location	Starting time of assessment	Ending time of assessment
16	Perinatal death audits	**15**						
17	Immunization	**7**						
18	Sterilization	**3**						
19	IPD	**10**						
20	Laboratory	**4**						
21	TB Services	**2**						
22	Pharmacy	**13**						
23	Client Satisfaction	**20**						
TOTAL		**255**						

Summary of Quarterly Quality Activities/Areas Assessment Results of the Facility

QUALITY EVALUATION OF DISTRICT HOSPITAL & HEALTH CENTRE: _____

DISTRICT:_____ _____QUARTER 20_____

N	Dimension	Possible Maximum	Obtained Points	%	Observations
1	Social Accountability	5			
2	Facility Profile Reports (Inc. RBF)	4			
3	Medical Records	4			
4	Privacy	4			
5	Hygiene and sanitation	7			
6	Water supply	11			
7	Labour Ward	14			
8	Waste management	6			
9	Obstetric emergencies	35			
10	Partogram	18			
11	Complicated deliveries including c/s	10			
12	Post-natal care	9			
13	Kangaroo mother care	15			
14	Family planning	24			
15	Maternal death audits	15			
16	Perinatal death audits	15			
17	Immunization	7			
18	Sterilization	3			
19	IPD	10			
20	Laboratory	4			
21	TB Services	2			
22	Pharmacy	13			
23	Client Satisfaction	20			
TOTAL		**255**			

QUARTERLY OBSERVATIONS AND RECOMMENDATIONS ON THE SERVICES OF THE DISTRICT HOSPITAL/HEALTH HEALTH CENTRE

District:_____ HOSPITAL/Health CENTRE: _____ Date:_____
1. **List recommendations not addressed from the previous quarter and provided justifications**
2. Identified Strengths during the assessed quarter

3. **Identified weaknesses to improve upon during next quarter**

4. Recommendations regarding the weaknesses

5. **Recommended Technical support**

Hospital/Health Centre agrees on the results as a true reflection of the health facility

Hospital/Health Centre In-charge	**Quality Assessment Team**
Name:…… …….	Name&Signature:…… ……..
Signature & Health Centre Stamp:……..	Name&Signature:…… ……..
	Name&Signature:…… ……..
	Name&Signature:…… ……..
Date:……..	Date:……..

ANNEX 17: RBF Client Satisfaction Questionnaire

The internal verifiers will conduct patient tracing for 10% of clients registered to have received services of a certain indicators:

1. Health facility deliveries for assessed quarter,
2. ANC: First antenatal visits, with gestation age < 12 weeks for the assessed quarter,
3. POSTNATAL CARE: Mothers who received Post Natal Services within 3-7 days after delivery during the assessed quarter.

CLIENT SATISFACTION QUESTIONNAIRE FOR……HF, …….Quarter 20…

N	Question	Scoring Criteria	Available Points	Obtained Score	Observation
	Get to introduce yourself to the clients, Which facility do you normally visit when you want medical services?	N/A	N/A	N/A	N/A
	Are you able to remember the last time you visited this HF? (If YES, go to next question)	N/A	N/A	N/A	N/A
	We are interested in knowing the quality of care provided by some of our HFs, are you able to share the experience from the visit to the same HF to contribute on health service improvement? (Ensure her that the information shared is between you and me	N/A	N/A	N/A	N/A
1	That time you visited……HF did you wait for more than one hour before being attended to?	If YES = 0 If NO = 1	1		
2	When being attended to, were the medical staffs taking time to listen to you carefully?	If YES = 1 If NO = 0	1		
3	Were you satisfied with the medical care you received at this facility?	If YES = 1 If NO = 0	1		
4	Was the staff at the facility is caring, friendly and welcoming?	If YES = 1 If NO = 0	1		
5	Did the medical staffs at the facility explain matters to you appropriately (like medical test results, diagnosis or drugs provided and possible side effects?	If YES = 0 If NO = 1	1		
6	Have you ever gone back home without medication because they were out of stock?	If YES = 0 If NO = 1	1		
7	Did you find the costs of care / services financially reasonable and affordable to you?	If YES = 1 If NO = 0	1		
TOTAL					

Information collected by ……, On ……/……/20…….

ANNEX 18: Critical Deadlines – From Receipt of RBF Invoice to Payment of Incentives

N	Date	Activity	Responsible Person
1	By 7th day after each month	Health Facility submits Summary Form to CHMT within 7 days after the end of every month	Health Facility In-charge
2	By 15th day after each month	Data entry into DHIS-2 for all health facilities should be concluded	HMIS Focal Point
3	By 30th day of the following month after the quarter has ended	Quantity data Verification and quality assessment should be concluded	RS/Verification Team
4	By the 5th day of 2nd month after the quarter has ended	RBF data entry into database	RS/RHMT
5	By 10th day of 2nd month after the quarter has ended	R-RBFC quarterly meetings	RAS
6	By 15th day of 2nd month after the quarter has ended	Transmission of approved quarterly consolidated invoices to the NHIF HQ	RAS
7	By 19th day of 2nd month after the quarter has ended	Approved quarterly consolidated invoices are forwarded to MOHSW from NHIF	NHIF
8	By 22nd day of 2nd month after the quarter has ended	Approved quarterly consolidated invoices are Submitted to MOF from MOHSW	MOHSW/RBF Technical Team
9	By 60th day after the end of the quarter	All providers should receive their payments	MOF

MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING

REGIONAL SECRETARIAT QUARTERLY ASSESSMENT CHECKLIST

TANZANIA 2015

No	Indicator/Performance Measure	Composite Criteria/Validation Criteria	Weight	Obtained Score	Justification of score
1	*Timely and Completeness of data entry*	The data/results of each verified/assessed facility or CHMT is entered into the database as follows: ▪ Not later than 5th day of May of current year (1st quarter) ▪ Not later than 5th day of August of current year (2nd quarter) ▪ Not later than 5th day of November of current year (3rd quarter) ▪ Not later than 5th day of February of Following year (4th quarter) If all RBF data are entered into database by 5th of the months above = 50 points In case of delay of data entry for even one CHMT/Health Facility, the RS shall lose **0.5%** of their quarterly budget per day of delay per CHMT/Health facility with delays in data entry.	50		
2	*Timely R-RBFC Quarterly meetings*	Meeting held as follows: ▪ Not later than 10th day of May of current year (1st quarter) ▪ Not later than 10th day of August of current year (2nd quarter) ▪ Not later than 10th day of November of current year (3rd quarter) ▪ Not later than 10th day of February of Following year (4th quarter) If the meeting is held by 10th of the months above = 25 points In case of any delay in the holding of the quarterly R-RBFC meetings, the RS shall lose **0.5%** of their quarterly budget per day of delay	25		
3	*Timely transmission of approved quarterly consolidated invoice to the NHIF*	Transmission of the approved quarterly invoices and R-RBFC meetings minutes to the NHIF as follows: ▪ Not later than 15th day of May of current year (1st quarter) ▪ Not later than 15th day of August of current year (2nd quarter) ▪ Not later than 15th day of November of current year (3rd quarter) ▪ Not later than 15th day of February of Following year (4th quarter) If the above documents are transmitted by the indicated time = 25 Points In case there is any delay in the transmission of the above documents, the RS will lose **1%** of funding per day of delay	25		
TOTAL			**Weight = 100**	**Obtained Score=**	

Summary of the Regional RBF Quarterly assessment

ASSESSMENT OF THE REGIONAL SECRETARIAT OFFICE _____**QUARTER 20**_____ **REGION:**_____					
N	**ASSESSED ACTIVITIES**	**Available Points**	**Attributed Points**	**%**	**Observations**
1	Timely and Completeness of data entry	**50**			
2	Timely R-RBFC Quarterly meetings	**25**			
3	Timely transmission of approved quarterly consolidated invoice to the NHIF	**25**			
TOTAL		**100**			

QUARTERLY SUMMARY OF THE OBSERVATIONS AND RECOMMENDATIONS

Region: _____ **Quarter_____ Year: 20_____ Date:_____**
1. Non achieved tasks and justifications
2. Identified strong points during this assessment
3. Identified weak points to improve during this assessment
4. Recommendations

_____ _____

Assessors Team Leader/Name & Signature **Name, Signature & Stamp of the RS**

MINISTRY OF HEALTH & SOCIAL WELFARE

RESULTS BASED FINANCING

REGIONAL HEALTH MANAGEMENT TEAM QUARTERLY ASSESSMENT CHECKLIST

TANZANIA 2015

No	Indicator/Performance Measure	Composite Criteria/Validation Criteria	Weight	Obtained Score	Justification of score
1	Spearhead the verification process of the RBF in the region	Availability of the prove that: ▪ RHMT staff have fully participated in RBF verification processes (Quantity and Quality) ▪ Quarterly assessment of CHMTs by 30th day after the quarter ends. Both criteria fulfilled = 10 Points Even one criteria not fulfilled = 0/10 Points	**10**		
2	RBF data management and Quarterly HFs RBF data timely entered in the database	Availability of: • Prove of RBF data entry into database by 5th of second month after the quarter has ended, • CHMTs, HFs Quantity and quality results available in specific files for all ended quarters, • Printed Quarterly CHMTs, Health Facilities RBF Invoices, filed in a Specific Files for all ended quarters, • RBF/HMIS analysis for CHMTs and HFs, printed as per presented in R-RBFC meetings filed for documentation, For each of the 4 criteria fulfilled = 5 Points For each of the 4 criteria not fulfilled = 0/5 Points	**20**		
3	Participation in R-RBFC quarterly meetings	Availability of: • Minutes of the R-RBFC showing that RHMT was fully represented in the meeting, • Printed quarterly RBF Invoices and original provisional invoices have been presented and discussed and/or validated in the R-RBFC meeting, • Eventual changes suggested to the RBF Final Invoice (missing data, data entry errors etc) are documented in the meeting minutes, • Prepare and present RBF/HMIS data and trends analysis for CHMTs and HFs during R-RBFC meetings, All criteria met = 15 Points Even one not met = 0/15 Points	**15**		

No	Indicator/Performance Measure	Composite Criteria/Validation Criteria	Weight	Obtained Score	Justification of score
4	Management of motivation Agreements	Availability of: • Signed motivation agreements with the existing staff at RHMT • Individual quarterly evaluation results for the assessed for all existing staff • Quarterly staff bonus calculations for the assessed quarter based on the results of the evaluation • Signed payroll by the RHMT staff for the last quarterly bonus payment based on RBF calculation guidelines All criteria met: 10 Points Even one criterion unmet: 0/10 Points	**10**		
5	Timely submission of RHMT quarterly report	Submission of Compiled quarterly financial to PMORALG and MOHSW • Proof from MOHSW & PMORALG that shows the report was submitted by 15th of the following month after the quarter ends = 5 • Report submitted after 15th of the following month or not submitted to both entities = 0	**5**		
6	Quarterly report assessment results	Availability of the results indicating all CHMTs RBF performance status • If the assessment results are ≥ 70% for all CHMTs = 10 • Even one CHMT assessment results are less than 70% = 0	**10**		
7	Regional Management Supportive Supervision for CHMTs (RMSS-C) implementation rate	Availability of: 1) Narrative summary of RMSS-C results is stated in text = 5 2) The summary includes major findings, actions to be taken discussed during the SS, and challenges toward conducting SS itself = 5 Points • 1 & 2 available in the summary = 10 Points • 1 or 2 missing = 5/10 Points • If both are missing in the summary = 0/10 Points **Note:** Confirm with a summary report RMSS-C signed by CHMT	**10**		
8	Regional Management Supportive Supervision for Regional Referral Hospital	Availability of: 1) Narrative summary of RMSS-H results is stated in text = 5 2) The summary includes major findings, actions to be taken discussed			

No	Indicator/Performance Measure	Composite Criteria/Validation Criteria	Weight	Obtained Score	Justification of score
	Management Team (RMSS-H) implementation rate	during the SS, and challenges toward conducting SS itself = 5 Points • 1 & 2 available in the summary = 10 Points • 1 or 2 missing = 5/10 Points • If both are missing in the summary = 0/10 Points **Note:** Confirm with a summary report RMSS-H signed by RRH	**10**		
9	Comprehensive Hospital Operational Plan (CHOP) quarterly report submission	The Regional Referral Hospital (RRHMT) Operational Plan is submitted to the MOHSW. • Plan submitted by 15th of the following month after the quarter ends = 5 Points • Report submitted after 15th of the following month after the quarter ends = 0	**5**		
10	Human Resource for Health (HRH) Data collection monthly report	Availability of proof that data was collected and timely submitted (electronically) to the MOHSW for the last three months; • Data collected and submitted by 5th day of every following month for all three months = 15 • A month with data collected and submitted by 5th day of every following month = 5 • A month with data collected and submitted (electronically) after 15th day = 0/5	**15**		
TOTAL			**Weight = 110**	**Obtained Score=**	

Summary of the RHMT RBF Quarterly assessment

ASSESSMENT OF THE RHMT _____**QUARTER 20**_____ **REGION:**_____					
N	**ASSESSED ACTIVITIES**	**Available Points**	**Attributed Points**	**%**	**Observations**
1	Spearhead the verification process of the RBF in the region	10			
2	RBF data management and Quarterly HFs RBF data timely entered in the database	20			
3	Participation in R-RBFC quarterly meetings	15			
4	Management of motivation Agreements	10			
5	Timely submission of regional quarterly report,	5			
6	Quarterly report assessment results,	10			
7	Regional Management Supportive Supervision for CHMT (RMSS-C) implementation rate	10			
8	Regional Management Supportive Supervision for Regional Referral Hospital Management Team (RMSS-H) implementation rate	10			
9	Comprehensive Hospital Operational Plan (CHOP) quarterly report submission	5			
10	Human Resource for Health (HRH) Data collection monthly report	15			
TOTAL		**110**			

QUARTERLY SUMMARY OF THE OBSERVATIONS AND RECOMMENDATIONS

Region: _____ Quarter_____Year: 20_____ Date:_____
1. Non achieved tasks and justifications
2. Identified strong points during this assessment
3. Identified weak points to improve during this assessment
4. Recommendations

_____ _____

Assessors Team Leader/Name & Signature **Name, Signature & Stamp of the RHMT**

MINISTRY OF HEALTH& SOCIAL WELFARE

RESULTS BASED FINANCING

COUNCIL HEALTH MANAGEMENT TEAM QUARTERLY ASSESSMENT CHECKLIST

TANZANIA 2015

No	Indicator/Performance Measure	Composite Criteria/Validation Criteria	Weight	Obtained Score	Justification of score
1	100% of facilities Monthly HMIS reports timely and completely entered into DHIS-2	Availability of: • Time stamp of data entry in DHIS-2 indicating that entry of data was before 15th day of the month for all facilities in the council including non RBF Facilities. Data entry done for all HFs accordingly= 10 Even one HF not done accordingly= 0/10	**10**		
2	Average (mean) number of tracer medicines available in RBF facilities	Availability of tracer drugs in the facilities per DHIS-2 for the quarter by verifying this figure against the tracer medicine forms (Each HF submit a completed monthly form to CHMT) - If the average is 10 = 20 - If the average is 8 to 9.99 = 16 - If the average is 6 to 7.99 = 10 - If the average is 0 to 5.99 = 0	**20**		
3	Council Progress Reports for all HFs produced submitted to PMORALG and MOHSW on time	Availability of the evidence that the Council Progress Report for the assessed quarter has been submitted to the PMORALG and MOHSW in the previous quarter Report with Technical and Financial component submitted by 15th after quarter end = 5 Delayed report, incomplete or not submitted to both entities = 0	**5**		
4	Health Facilities with qualified staff (Qualified staff is a health care worker who has undergone at least 2 years formal health training)	Total number of health facilities with minimum qualified staff requirement (Dispensary: 1; HC: 5; Hospital: 12) • Documented in HR office • Confirmed by evaluators by phone calls or actual visit of at least 3 HCs 100% of the HFs with qualified staff = 10 50 - 99% of HFs with qualified staff = 5 >50% of HFs with qualified staff = 0	**10**		

No	Indicator/Performance Measure	Composite Criteria/Validation Criteria	Weight	Obtained Score	Justification of score
5	100% of HFs have received comprehensive supportive supervision visit at least once per quarter	Availability of evidence that all HFs have been supervised in the assessed quarter 100% of HFs got supportive supervision in that quarter = 10 50 – 99% of HFs got supportive supervision in that quarter = 5 >50% of HFs got supportive supervision= 0	**10**		
6	CHF enrolment rate increase in the council	Compared with the previous quarter, perform the calculation to check if there was increment of the CHF enrolment in assessed quarter. (Use the total households and CHF enrolment) If the increment is >= 5% = 10 If the increment is <5% = 0	**10**		
7	Compiled quarterly financial report of all Health Facilities enrolled in RBF	Proof from PMORALG & MOHSW of submission of Compiled quarterly financial report (All income and expenditures made by the facilities, RBF & non RBF funds) All compiled report with all information included according to the template = 10 Report not complete or not submitted to both = 0	**10**		
8	Planned preventive maintenance conducted quarterly as budgeted in CCHP for CHMT and all health facilities	Review the number of planned preventive maintenance that was able to be conducted in the assessed quarter as narrated in preventive maintenance in the council in the CCHP quarterly report with the followings criteria: 1. Availability of PPM register with plans and funds allocation for each planned activity = 3 2. Availability of PPM report indicating all planned activities and implementation status = 3 3. If > 80% of planned activities were implemented = 9	**15**		

No	Indicator/Performance Measure	Composite Criteria/Validation Criteria	Weight	Obtained Score	Justification of score
		These three criteria met = 15 Criterion unmet or incomplete = 0/3 or 0/9 for 3rd criterion			
9	Health Facilities Maternal deaths Audit by CHMT	Proportion of maternal deaths in health facilities that are completely and appropriately audited by CHMT and action plan in place: The number of maternal deaths in health facilities and reported by CHWs in the assessed quarter that are completely and appropriately audited and action plan in place. (Form B) – numerator The number of maternal deaths per the register in the facility in the assessed quarter, or the record at the CHMT, whichever is higher – denominator - If the maternal death completely and appropriately audited and action plan in place are >= 80% = 10 - If the maternal death completely and appropriately audited and action plan in place are < 80% = 0	**10**		
10	Health Facilities perinatal deaths Audit by CHMT	**Proportion of perinatal deaths in health facilities that are completely and appropriately audited by CHMT and action plan in place:** The number of perinatal deaths in health facilities and reported by CHWs in the assessed quarter that are completely and appropriately audited and action plan in place. (Form B) – numerator The number of perinatal deaths per the register in the facility in the assessed quarter, or the record at the CHMT, whichever is higher – denominator If the perinatal death completely and appropriately audited and	**10**		

No	Indicator/Performance Measure	Composite Criteria/Validation Criteria	Weight	Obtained Score	Justification of score
		action plan in place are >= 80% = 20 If the perinatal death completely and appropriately audited and action plan in place are < 80% = 0			
11	Council Health Service Board [CHSB] quarterly meeting conducted	Meeting held and availability of: CHSB Meeting Minute at the District Medical officer records /council health secretary office with the following criteria: ✓ Date and time indicated ✓ Agenda available ✓ Signed participants list available ✓ Discussion on the health matters in the council, ✓ Follow up of recommendations and tasks from previous meeting ✓ Action points listed with tasks attributed Minute with all criteria available = 5 No meeting or minute not fulfilling criteria = 0	**5**		
12	Management of motivation Agreements	Availability of: • Signed motivation agreements with the existing staff at CHMT • Individual quarterly evaluation results for the assessed for all existing staff • Quarterly staff bonus calculations for the assessed quarter based on the results of the evaluation • Signed payroll by the CHMT staff for the last quarterly bonus payment based on RBF calculation guidelines All criteria met: 10 Points Even one criterion unmet: 0/10	**10**		
TOTAL			**Weight = 125**	**Obtained Score=**	

Summary of the CHMT RBF Quarterly assessment

ASSESSMENT OF THE CHMT **_____QUARTER 20_____**

DISTRICT:_____ **REGION:_____**

N	ASSESSED ACTIVITIES	Available Points	Attributed Points	%	Observations
1	100% of facilities Monthly HMIS reports timely and completely entered into DHIS-2	10			
2	Average (mean) number of tracer medicines available in RBF facilities	20			
3	Council Progress Reports for all HFs produced submitted to PMORALG and MOHSW on time	5			
4	Health Facilities with qualified staff	10			
5	100% of HFs have received comprehensive supportive supervision visit at least once per quarter	10			
6	CHF enrolment rate increase in the council	10			
7	Compiled quarterly financial report of all HFs enrolled in RBF	10			
8	Planned preventive maintenance conducted quarterly as budgeted in CCHP [For facilities enrolled in RBF]	15			
9	Health Facilities Maternal deaths Audit by CHMT	10			
10	Health Facilities perinatal deaths Audit by CHMT	10			
11	Council Health Service Board [CHSB] quarterly meeting conducted	5			
12	Management of motivation Agreements	10			
TOTAL		**125**			

QUARTERLY SUMMARY OF THE OBSERVATIONS AND RECOMMENDATIONS

Council: _____ Quarter_____ Year: 20_____ Date:_____
1. Non achieved tasks and justifications
2. Identified strong points during this assessment
3. Identified weak points to improve during this assessment
4. Recommendations

_____ _____

Assessors Team Leader/Name & Signature **Name, Signature & Stamp of the CHMT**

ANNEX 22: Guidelines for Regional RBF Committee

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH & SOCIAL WELFARE

GUIDELINES FOR THE REGIONAL RESULTS BASED FINANCING COMMITTEE (R-RBFC) IN TANZANIA

TANZANIA 2015

The RAS will form a Regional RBF Committee, which will be responsible for assisting the RAS in ensuring that verification is smoothly implemented. The Regional RBF Committee will comprise of a minimum of 12 members. The composition should include the following persons:

1. MEMBERSHIP

- Regional Administrative Secretary, Chair
- RHMT, Regional Medical Officer, Secretary
- RHMT, Regional Health Secretary
- RHMT, HMIS Focal Person
- RHMT, Regional RCH Coordinator
- Regional Auditor
- Regional Local Government Officer
- Regional NHIF Manager
- Regional Nursing Officer
- Regional Pharmacist
- Regional Monitoring and Evaluation Officer
- A representative from existing Health NGOs working in the region (Maximum 3).

2. MAIN ROLES AND RESPONSABILITIES OF R-RBFC

The R-RBFC is tasked with validating the decentralized level RBF performance frameworks and incentive payments.

i. Validating the Health Facilities, CHMTs and RHMT performance frameworks and incentive payments

ii. Facilitating the implementation of the RBF system activities at the Regional, council and community levels

iii. Receiving, reviewing and forwarding reports and invoices to be submitted to the National Health Insurance Fund for payment

iv. Ensuring that all the implementing providers get paid their incentives at the rightful time as indicated in their agreements; i.e. Not later than 60 days after the end of the quarter in which they were earned

v. Ensuring that there is a trend analysis of the indicators in quarterly meetings and bottlenecks identified and addressed

vi. Facilitates the internal and external audits and verifications

vii. Settlement of all disputes arising during the implementation of the RBF system

3. MAIN ROLES AND RESPONSIBILITIES OF THE MEMBERS OF THE R-RBFC

3.1 Regional Administrative Secretary

- Chairperson for the R-RBFC
- Calls for planned and emergency meetings,
- Provides leadership and ensures that all the members play their roles in the committee
- Ensures that quality and quantity assessments are conducted in timely manner,
- Spearhead the process of validating the RHMT, CHMTs and Health Facilities RBF performance frameworks and incentive payments,
- Ensures that final/validated RBF invoices are signed,
- Ensures that final reports and invoices approved by the R-RBFC are sent to the NHIF according to the agreed timelines
- Reports proceedings of R-RBFC to other relevant bodies (stakeholders) in the region
- In collaboration with other members of the committee, to come up with strategies for improvement of performance,
- Settlement of all disputes arising during the implementation of the RBF system

3.2 RHMT, Regional Medical Officer (Secretariat)

- Secretary to the R-RBFC,
- Circulates Minutes of the R-RBFC to all members of the R-RBFC and the National Health Insurance Fund,
- Generates schedule of meetings,
- Documentation of challenges and success for problem solving and future planning;
- Reports on quantity verification, quality assessments at the R-RBFC meetings,
- Reports on technical support visits conducted or action taken following the findings/recommendations of quantity verification and quality assessment,
- Ensure that all CHMTs and Health Facilities receive copies of approved invoices to be aware of the amount of incentives they are waiting for.

3.3 Regional Auditor

- To ensure that RBF funds are utilized according to the financial regulations
- Report on financial audits in the meeting,

3.4 Regional NHIF Manager

- Representative of the purchaser in the meeting,
- To ensure that all providers have signed performance agreements,
- To ensure that all providers receive their incentives timely,

3.5 RHMT, HMIS Focal Person and Regional Monitoring and Evaluation Officer

- Works with the verification team in planning and conducting quantity and quality data verification

- Makes timelines/schedules of various committees/entries for reports/final invoices
- Ensures that all collected RBF data are timely entered into the database
- Facilitate the process of submitting all the consolidated RBF invoices and RBF data on indicators in the R-RBFC for consideration
- Prepare and present RBF/HMIS data and trends analysis during R-RBFC meetings
- Explain trends in performance indicators based on clinical, epidemiological and other socio-economic factors prevailing in the Region/Council/health facilities
- Identifies shortfalls in equipment, human resource, data collection tools and capacity building
- Participate in Technical support supervisions to the CHMT levels,

3.6 RHMT, Regional Health Secretary/RHMT, Regional RCH Coordinator/Regional Nursing Officer

- Participate in CHMT RBF assessments
- Conduct technical support supervision in the Councils and identify capacity building needs at the CHMT level, facility and community levels
- Facilitate the process of conducting follow-up technical support visits in the Councils and Health Facilities based on findings/recommendations from the verification teams
- Provides advice on all clinical and public health aspects of the RBF system in the region

3.7 Regional Pharmacist (Pharmaceutical advisor of the committee)

- Reports on the management of drugs at the Health Facilities and CHMT Pharmacies in the region. This includes providing updates on:
    - Shortage of drugs at any Health Facility and CHMTs within the last quarter
    - Ordering of drugs according to schedule,
    - Use of government funds and other available funds to procure emergency drugs,
    - Usage of stock control cards and appropriateness of entries,
    - Expired drugs and management of expired drugs
    - Submission of reports on expired drugs
- Participation in RBF Verification Team

3.8 Regional Local Government Officer

- Representative of PMOLARG,
- Plays a role in lobbying and mobilizing resources,
- Identify gaps and show how they could be bridged,
- Play a role of ensuring social equity,
- Evaluates the RBF indicators and how they affect the broader social and economic aspects within the region,

3.9 Representative of existing Health Donor/Non-Governmental Organization (NGO)/Representative of missionary health facilities

- Representative of the NGOs in the region,
- Plays a role in lobbying for and mobilizing and resources,

- Identify gaps and show how they could be bridged,
- Ensuring social equity by acting as a voice for the unprivileged in the Region,
- With all other health partners in the Region, actively participate in RBF Implementation.

4. MINIMUM QUORUM

For the R-RBFC meeting to take place, at least 8 of the members should be available. The minimum quorum of the R-RBFC meeting consists of the Chairperson and at least other 7 members. The meeting should not take place when the quorum is not met.

5. FREQUENCY OF MEETINGS

Scheduled meetings are held at least four times a year, but may be frequent depending on local arrangements. Each quarterly meeting (mandatory) must be held as follows:

- Not later than 10th day of May of current year (1st quarter)
- Not later than 10th day of August of current year (2nd quarter)
- Not later than 10th day of November of current year (3rd quarter)
- Not later than 10th day of February of Following year (4th quarter)

Note: Approved invoices with the cover letter and the Minutes of the meeting via regional NHIF office, should be submitted to the NHIF Headquarters by the 15th day of the second month after the end of the quarter.

6. PROCEDURES

The Secretary of the R-RBFC on behalf of the chairperson will issue a notice of meeting. The agenda and invitations for the meeting should be made at least 5 days before the planned day of the meeting through a letter or by e-mail. Minutes of the previous meeting and all relevant documentation related to the Agenda of the meeting should also be attached.

7. THE MEETING

Duration: 2hours to 2hours 30 minutes maximum

Chairperson: Regional Administrative Secretary (In his/her absence, a selected officer from RAS Office chairs the meeting)

Secretary: RHMT, Regional Medical Officer

Timekeeper: To be appointed for each meeting

The minutes of the previous meeting will be discussed and approved at each meeting. The draft Minutes of the current meeting should be sent by regular mail or e-mail to all members at least two days after the meeting.

7.1 Agenda and Allocated Time

Agenda Item	Time Allocated
a. Opening	(5 minutes)
b. Correction and Adoption of the Minutes of the Previous meeting	(15 minutes)
c. Follow-up on Action Taken after the last meeting (Matters arising)	(15 minutes)
d. Debrief the members about last quarter's RS performance	(10 minutes)
e. Report or Presentation on CHMTs and RHMT Performance	(15 minutes)
f. Presentation on the verification reports of RBF in the Region (HMIS/RBF Quantity indicators and Quality Assessments)	(40 minutes)
g. Presentation and discussion on the Quarterly Consolidated Invoices	(15 minutes)
h. Discussion on other activities for the next Quarter including follow-ups on Technical Support activities to improve Quantity and Quality Assurance	(20 minutes)
i. Any Other Business and Closing	(10 minutes)

7.2 Template and Format for Minutes of R-RBFC Meeting

Minutes are primarily produced to provide an accurate written record of the business conducted or decisions made or issues resolved by a meeting. They can therefore be said to be a summarized true record of the deliberations of the R-RBFC meeting. The Minutes should have the main heading showing: (i) the name of the R-RBFC which met; (ii) the venue at which the meeting was held; and (iii) the date and time when the meeting was held.

The Minutes should also have the list of members present and absent at the meeting, with their titles; reasons of being absent; and items discussed.

Draft Minutes should be in Word while the Final Approved Minutes should be in PDF and signed by both the Chairperson and Secretary. The font type should be Times New Roman throughout the document with the main heading in font size 14 and the other parts of the document in font size 12, spacing of 1.5.

7.2.1 List of Participants

No.	Name of Member	Name of organization	Title/Position	Email address	Mobile phone #
1.					
2.					
Etc					

7.2.2 Layout/Main Headings

The layout or main headings of the R-RBFC should follow the main agenda items of the meeting. This should be:

a. Opening
b. Correction and Adoption of the Minutes of the Previous meeting
c. Follow-up on Action Taken (Matters arising) after the last meeting
d. Debrief the members about last quarter RS performance
e. Report or Presentation on CHMTs and RHMT Performance
f. Presentation on the verification of RBF in the Region (HMIS/RBF Quantity indicators and Quality Assessments)
g. Presentation and discussion on the Quarterly Consolidated Invoices
h. Discussion on other activities for the next Quarter including follow-ups on Technical Support activities to improve Quantity and Quality Assurance
i. Any Other Business and Closing

7.2.3 Signing of the Minutes

At the end of the Minutes, there should be a space for names and signatures of Chairperson and Secretary for signing the approved Minutes. The signing should be done after the next meeting when the Minutes have been confirmed as a true record of the proceedings by the R-RBFC.

Chairperson: ..... Date: .....

Secretary: ..... Date: .....

ACTION POINT SHEET (MATTERS ARISING)

An Action Point Sheet is a list of tasks emanating from the resolutions and decisions made at the R-RBFC. It indicates the list of identified actions, responsibility for each identified action, and deadlines or completion dates. It is relatively easy to prepare and can be circulated even before the minutes are completed. It serves as a reminder to members who have been assigned tasks based on the resolutions and decisions made at the R-RBFC. The Action Point Sheet is not only a summary of the required actions but it is also a monitoring tool for the Chairperson to follow up on the implementation of agreed tasks. The following is an example of an Action Point Sheet:

Action Point Sheet

Identified Issues	**Responsible Person**	**Deadline**
1.		
2.		
3.		
…		

ANNEX 23: Staff Responsibility Points

Employees' individual staff Responsibility Point for Management Team

N	Cadre	Relative Point
1	RMO/DMO	100
2	Regional/District Health Secretary	80
3	HMIS FP	70
4	Other RHMT/CHMT members	60
5	Data Entry Clerk	40
6	Other Non-Technical Staff	30

Employees' individual staff Responsibility Point for Hospital

N	Cadre	Relative Point
1	Facility-In charge	100
2	Medical Doctor	80
3	Assistant medical officer	70
4	Clinical officer	60
5	Assistant nursing officer	60
6	Nurses	60
7	Health Secretary	50
8	Medical recorder	30
9	Medical attendants	30
10	Health lab technologist	60
11	Assistant lab technologist	50
12	Pharmaceutical technologist	60
13	Dental therapist	50
14	Assistant social welfare	50
15	Worker/social welfare assistant	30
16	Assistant environment health officer I	30
17	Mortuary attendant	30
18	Dobie	20
19	Security guard 2	20
20	Other Staff	20

Employees' individual staff Responsibility Point for Health Centre

N	Cadre	Relative Point
1	Facility-In charge	100
2	Medical Doctor/Dental surgeon	80
3	Assistant medical officer	70
4	Clinical officer	60
5	Assistant nursing officer	60
6	Nurses	60
7	Medical recorder	30
8	Medical attendants	30
9	Health lab technologist	60
10	Assistant lab technologist	50
11	Pharmaceutical technologist	60
12	Dental therapist	50
13	Assistant social welfare	50
14	Worker/social welfare assistant	30
15	Assistant environment health officer I	30
16	Mortuary attendant	30
17	Dobie	20
18	Security guard 2	20
19	Other staff	20

Employees' individual staff Responsibility Point for Dispensary

N	Cadre	Relative Point
1	Facility-In charge	100
2	Clinical officer/clinical assistant	80
3	Nurse – OPD	70
4	Nurse – RCH	70
5	Pharmaceutical assistant	60
6	Lab assistant	60
7	Medical attendant	50
8	Security guards	30
9	Other Staff	30

ANNEX 24: Quarterly Individual Evaluation Form for Staff

N	Name of Staff	Responsibility	Responsibility Point	Attendance Point	Total Individual Point
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
….					
Total Points: Sum of Total Individual Point for all staff					
Quarter Indices: 25% of Total facility incentives/ Total individual points for all staff					

ANNEX 25: Example of how to Calculate Individual Staff Performance Bonuses

The following are the steps for calculating individual staff incentives

1. Obtain the quarterly indices
2. Multiply the quarterly indices with the total individual points to obtain the amount earned by each staff

25% of total facility incentive			TZS:				
N	Name of Staff	Responsibility	Responsibility Point	Attendance Point	Total Individual Point	Quarterly Indices	Individual Incentives
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
….							