THE UNITED REPUBLIC OF TANZANIA

Ministry of Health and Social Welfare

Results Based Financing (RBF)

Design Document

Version:13 November 2014

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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.

RBFis 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.

Charles A. Pallangyo
Permanent Secretary

Acknowledgements

The Ministry of Health and Social Welfare (MoHSW) sincerely expresses its gratitude to all individuals and development partners for their generous assistance in preparation of the Results Based Financing (RBF) design. The completion of this Design document is a result of collaborative hard work involving consultations with different stakeholders including the RBF Team, RBF Task Force members and other ministries specifically the Prime Minister's Office Regional Administration and Local Government (PMORALG).

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

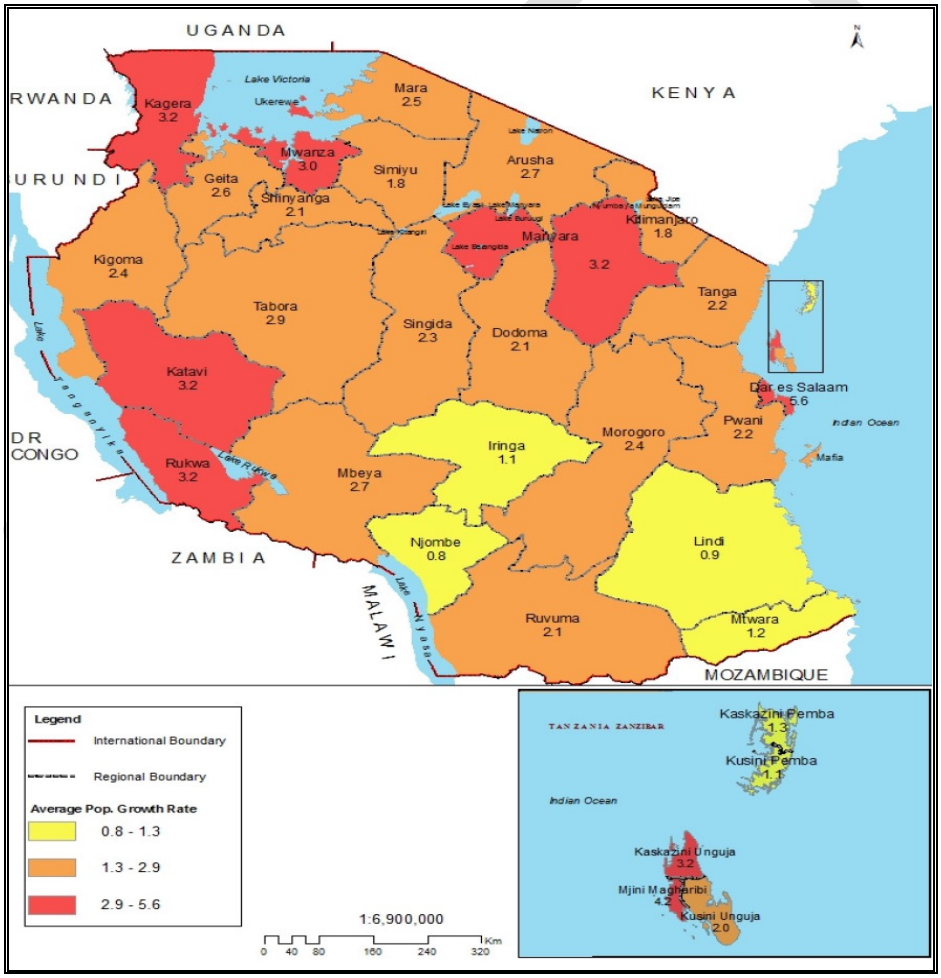
The population of Tanzania mainland is estimated to be about 43,625,354million people with average annual growth rate of 2.7 % (NBS2012). It is the largest country in East Africa, occupying an area of about 945,087 sq. km, and has a common border with 8 neighboring countries. About 75% of the population 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.

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

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.

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.

[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.

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, 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 ofmost 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. 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 TASAF beneficiaries seeking outpatient care
3. Number of children under one year immunized against measles
4. Number of under-five receiving Vitamin A supplementation
5. Number of newusers 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 infantsreceiving 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. Quarterly council health progress report 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. Timely submission of verified data into DHIS2
2. Timely notification of NHIF (purchaser) that verification has been completed
3. Timely submission of regional quarterly report
4. Quarterly report assessment results
5. RMSS-C implementation rate
6. CHOP quarterly report submission
7. HRH Data collection support

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. The infrastructure assessment report, and the tool on which it was based, can be found in Annexes1and 2.

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.

The assessment will be conducted using the assessment tool attached as Annex 3.

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 will 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		

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 CHMTs and RHMTs. The minimum readiness criteria are having an active bank account for receiving financial incentives, adequate staffing (at least one skilled personnel at a dispensary level), 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. The Readiness Assessment tool is attached as Annex 4.

A minimum score will be set by the Regulator for participating in RBF. However criteria of having skilled personnel must be fulfilled for a facility to be enrolled in RBF. Those facilities which pass will be provided with an initial investment amount (on average 11.5 million TZS) to improve their infrastructure, equipment, supplies and the quality of health services. Those facilities that do not meet the minimum readiness criteria will be targeted by their RHMT and CHMT to work on bringing them up to at least the minimum standard 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

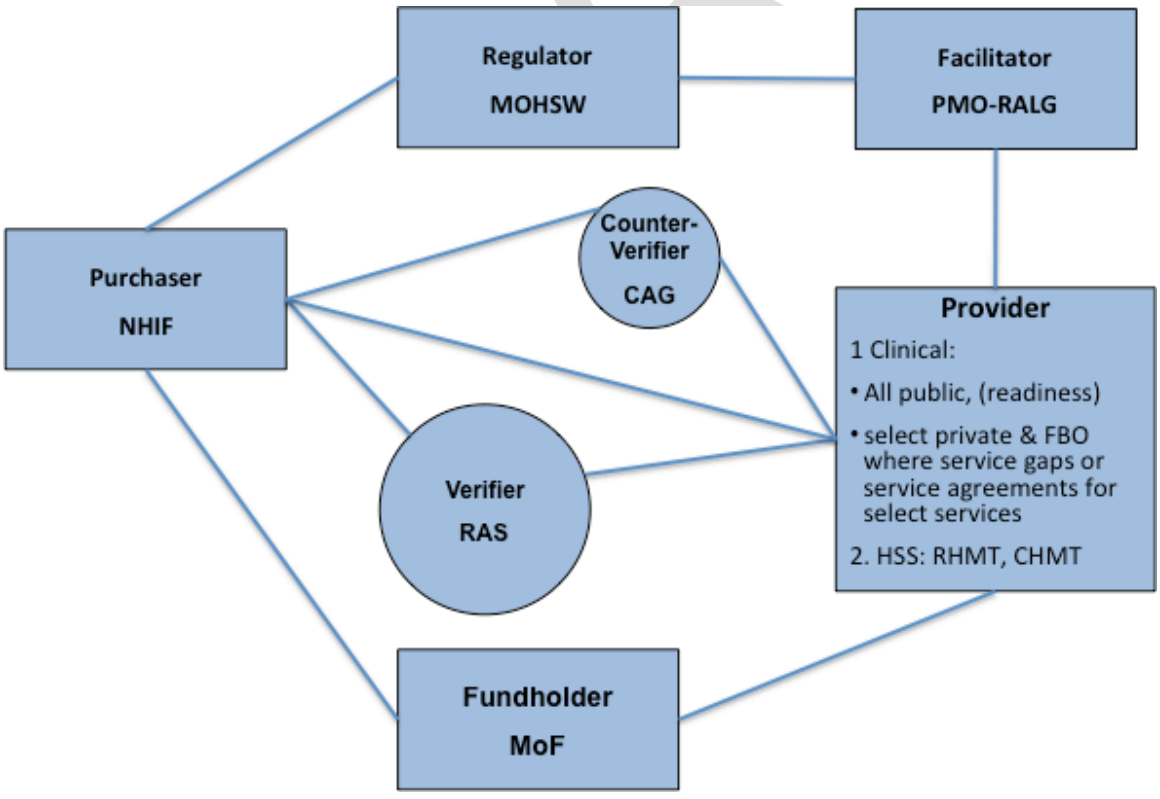
assessment will be required to apply for the re-assessment to the RBF programme through the DMO's office.

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
Fundholding	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 (An identified team within regional capacity)
External verification		Controller Auditor General

Memoranda of Understanding

There will be one master memorandum of understanding 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 MoU will be signed by an authorized signatory for each institution thereby committing them to ensuring the success of RBF.

There will further be individual MoUs 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 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.

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.

MoHSWManagementof 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 Reglulatory 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 scheme;
- Mobilize, monitor and allocate adequate resources for implementation of RBF system;
- Monitoring and evaluation of the RBF system;
- Support the RBF Regulatory 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.

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.

Provision/ 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 innovative strategies including community sensitization, outreach services to reach the contracted targets
- 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, reporting analysis of management data (under MoHSW instructions) to be 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 efficiency use of the resources
- Report to the respective Council the use of RBF funds both for health facility improvement and for health care staff incentives.

Verification/Regional Administrative Secretary 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.

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.

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 Secretariate

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 and quality and quantity data that have been entered in the RBF district database/DHMIS.
6. Ensure all health facility DHIS reports are submitted electronically to MoHSW and PMORALG by the 15th of consecutive month
7. Jointly the CHSB and CMT form the Internal Verification Team (IVT) which conducts verification visits to each health facility at least once per quarter.
8. Ensure each Health Facility use the RBF funds according to guidelines and government financial regulation and financial reports are submitted on time.
9. 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 facilities under RBF system.
10. Advocate RBF to all relevant stakeholders at council level.
11. Ensure availability of drugs, supplies and equipment at all health facilities
12. Mobilizes and manage resources allocated for health care delivery.
13. Ensure communities are responsible in taking care of their own health and also the safety of medicine and equipment in their health facilities
14. Review the CCHP guidelines to accommodate RBF payment received by facilities.

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.

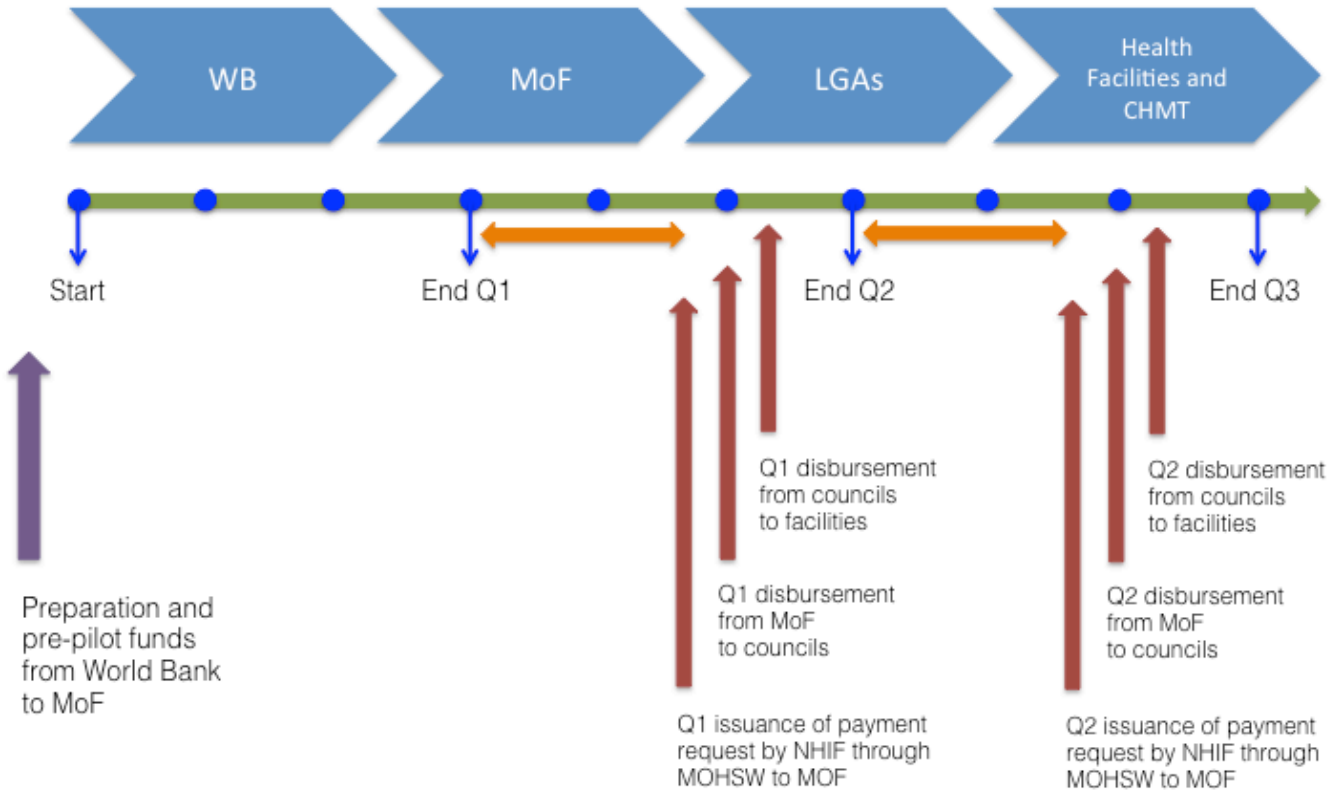
6. Payment Modalities and Guidelines

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.

For supervision and oversight, the funds will flow from the MoF to Councils. The councils will then disburse funds to health facilities and management teams. No disbursement will be made in advance. The amount disbursed by the MoF to councils will be exactly the total payments to be made to the participating 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:



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.

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, according to the set criteria.

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**	**17,852,000**
Health Centre	**19,900,000**	**4,975,000**
Dispensary	**5,000,000**	**1,100,000**
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%

Indicator	Index	Fee TZS (USD)	Baseline 2014
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%
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%

Indicator	Index	Fee TZS (USD)	Baseline 2014
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)							$\Sigma F - \Sigma G$
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.

7. 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 DED development account	5	40
DED disburses to HF accounts	5	45

8. 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:

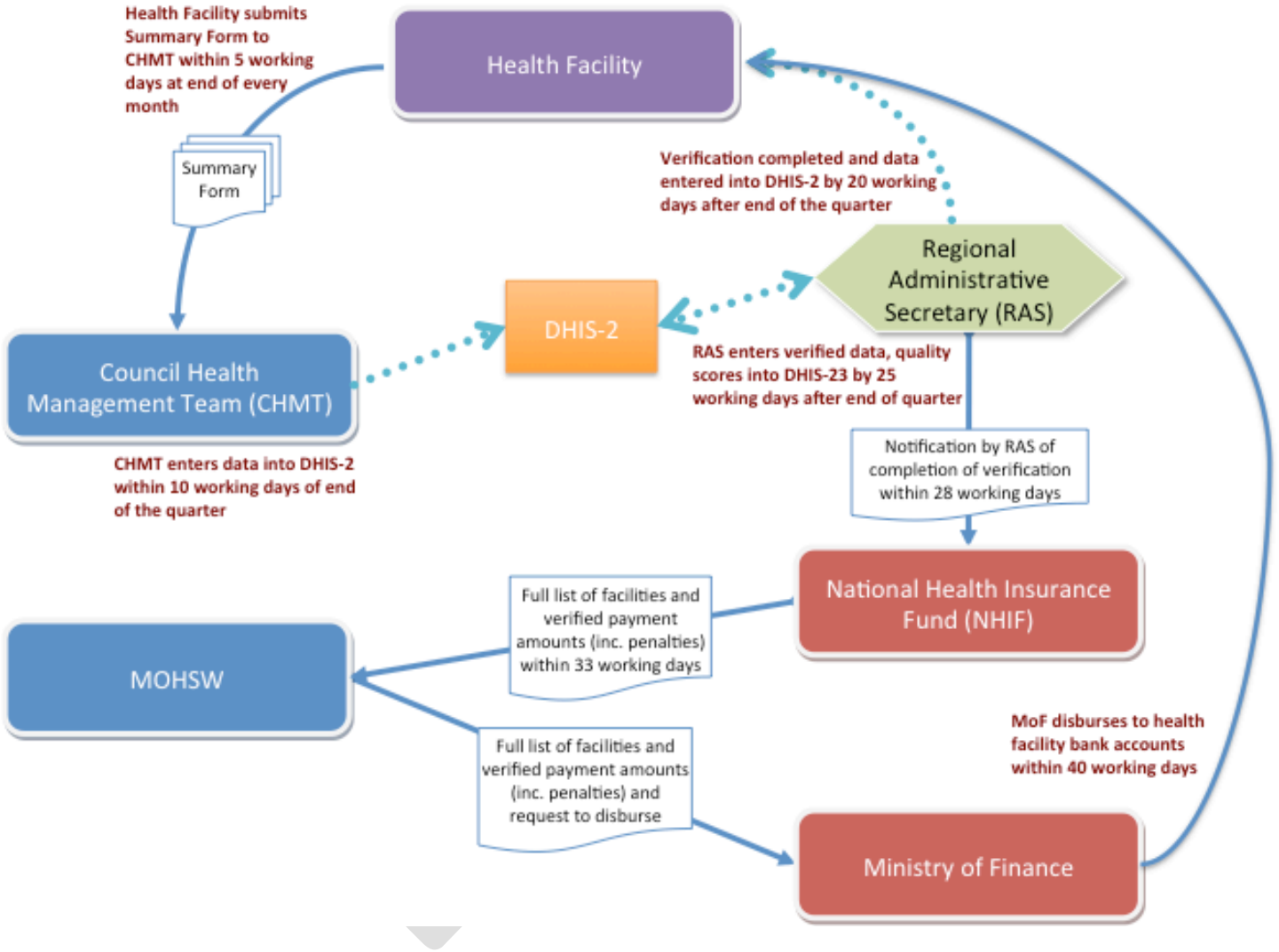
- Regional leaders (RC, RAS, Regional secretariat)
- NGOs present in the region
- District and Council Leaders (DC, DAS, DED, CMT members) Counselors and MPs
- Health Facility Governing Committee members and identified Community Health workers.

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 5 working days at end of every month
Health Facility
Summary Form
Verification completed and data entered into DHIS-2 by 20 working days after end of the quarter
Regional Administrative Secretary (RAS)
DHIS-2
Council Health Management Team (CHMT)
RAS enters verified data, quality scores into DHIS-23 by 25 working days after end of quarter
CHMT enters data into DHIS-2 within 10 working days of end of the quarter
Notification by RAS of completion of verification within 28 working days
National Health Insurance Fund (NHIF)
Full list of facilities and verified payment amounts (inc. penalties) within 33 working days
MOHSW
Full list of facilities and verified payment amounts (inc. penalties) and request to disburse
MoF disburses to health facility bank accounts within 40 working days
Ministry of Finance

9. 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.

10. References

NBS 2012

MoHSW 2013

Mid Term Review

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11. ANNEXES

Facility readiness assessment tool

ADD IN

Master Memorandum of Understanding

ADD IN

ADD IN

Quality indicators for upgraded HC and Hospital

ADD IN

CHMT Indicators

ADD IN

Community Health Worker Indicators

ADD IN