



Royal Tropical Institute
KIT Development Policy & Practice

Payment for Performance (P4P) Evaluation

2008 Tanzania Country Report for Cordaid

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Final version

Executive summary

Cordaid's development strategy aims at improving access to health care and subsequently improving the health status of the population through strengthening southern partner organizations. Working towards this aim, Cordaid has been implementing a three year (2006-2008) performance based financing scheme known locally as Pay for performance (P4P) in Tanzania. Historically, Cordaid has been supporting the health programmes of five RC Dioceses in Tanzania: Arusha, Bukoba, Rulenge, Sumbawanga and Kigoma, through resource allocation to a total of sixty four health facilities. The continuation of the support is now aligned with an output based approach which replaced the prior input based financing.

The aim of the formative evaluation was to assess the current status of the P4P project with a focus on the institutional architecture, management practices and effects on the health worker motivation and performance. The methodology included discussions and semi-structured interviews with relevant stakeholders and the collection and analysis of health and financial data. Recognising that it is difficult to attribute effects to P4P by merely comparing data before and after implementation, non-P4P health facilities were also included to compare results.

Current arrangements involve Cordaid (as fund holder) channelling the funds through the Diocesan Health Offices with payments made to the accounts of the supported health facilities. Verification is undertaken by an independent consultant hired by Cordaid. As there is no national fund holder and no independent verification agency, the essential pre-requisites for institutionalizing the model are not yet fully in place. The specification of targets and outputs were not agreed independently with each health provider. This means that they are obliged to accept the conditions rather than be instrumental in determining their own priorities, yet expected to perform to meet the prescribed targets. Ownership is therefore excluded by virtue of limited engagement which undermines provider autonomy; one of the core principles of the performance based financing approach.

A reappraisal of the current role of the Diocesan Health offices (DHO) and their interface with the MOH District level governance structure is necessary. Given the recent signing of a national service agreement between the MOH and CSSC on behalf of the faith based organizations, a reappraisal of the management structures for the three principal agents; regulator, fund holder and providers is recommended to establish clear lines of responsibility for governance and operational management of P4P at district level. This review should also appraise the structures and support for independent verification and community involvement with P4P.

With respect to health service organization including management and planning of health system delivery, the program is still nascent. P4P has not had a notable effect on improving health systems due the relatively low level of resources and limited technical assistance at diocese and facility level. Management teams talked of the need for review of policies (HR, administration, organograms) while staff also requested training on HMIS, M&E and quality of care tools. All of these are essential components of a performance based financing system, which will require additional technical and financial assistance.

One of the key concerns at the facility level is the choice of indicators as a means of measuring performance in the P4P approach as they are focused on quantitative aspects of health service delivery and do not include performance measures on the quality of health services. Nor do the indicators selected reflect preventative aspects of health care provided,

crucial for the provision of integrated health care. The payment for performance depends on a uniform target set for each indicator rather than based on baseline or contextual circumstances like population catchment or available staffing. It is recommended that contracts will be signed between the fund holder and the health facility (at the decentralized level and in accordance with the local context) whereby the indicators for performance and its corresponding targets will be re-negotiated. Indicators reflecting perceptions of the quality of care provided and those promoting access to preventative health care are also recommended for inclusion in the package of indicators.

Despite the absence of provider autonomy, health workers at facility level reported increased levels of motivation (self reported and via direct observation) and in many instances P4P promoted empowerment staff whereby they were more actively involved in day to day planning at facility level. This concurs with the findings from other HR studies which stress the value of intrinsic rewards as an effective means of improving performance and ultimately the quality of healthcare provided. This may even take place in the absence of extrinsic incentives, however in this case P4P proved to be a catalyst in this process.

In terms of community involvement, there was limited participation by community representatives. Firstly, the project is facility focused with no resources allocated to establishing community participation structures or direct investment in community health interventions. Secondly, using existing health facility committees for P4P purposes assumes that these entities are functioning while in most cases they are not active. It is therefore not appropriate at this point to attribute any community demand for services or community sensitisation for health directly to the P4P project. However, it is recommended that community health committees be invigorated through regular review meetings with future involvement in the verification at household/community level based on the Rwanda model.

With regards to the financial costs of P4P, one of the key objectives is to provide sustainable and equitable healthcare that is cost effective and efficient through adopting appropriate health financing mechanisms that are tailored to Tanzania context. In the context of P4P in Tanzania, it is not possible to determine the actual transaction costs of the project due to gaps in vital financial information. In order to verify if the project is indeed cost effective, more financial information is required and the evaluation would recommend a review by the end of the next project period.

To conclude, P4P has shown potential to act as leverage for initiating innovative and proactive management actions that will motivate improved health worker performance. In order to build on this potential, health facilities should be fully involved in development of the business plan including how the base and bonus funds are deployed. It is also timely to consider the development of a transition plan to cultivate ownership of P4P by the district health councils. The introduction of a 'bonus for results' approach at national level, supported by the Norwegian partnership presents an opportunity to link in with the mainstream development of performance based financing. Cordaid is now well placed to play a lead role in provision of technical support to the district councils for P4P implementation and monitoring. This would anchor P4P within the MOH institutional structures and ensure a more sustainable approach in the longer term.

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Acronyms

CCHP	Comprehensive Council Health Plan
CDH	Council Designated Hospital (formerly DDH)
CHF	Community Health Fund
CHWP	Council Health Work Plan.
CHSB	Council Health Service Board
CHMT	Council Health Management Team
CSSC	Christian Social Services Commission (Tanzania)
DDH	Designated District Hospital (recently renamed as CDH)
DHO	Diocesan Health Office
DPT3	Diphtheria, Pertussis and Tetanus (3 rd antigen)
DC/DHC	District (Health) Council
EED	German Evangelical Church
ELCT	Evangelical-Lutheran Church of Tanzania
FBO	Faith Based Organization
GAVI	Global Alliance for Vaccination Initiative
GoT	Government of Tanzania
HSSP	Health Sector Support Project
HMIS	Health management information system
IHDRC	
JEEHS	Joint External Evaluation of the Health Sector (Tanzania)
MOH&SW	Ministry of Health & Social Welfare (Tanzania)
MTR	Mid-term review
MTUHA	Swahili acronym for HMIS
NHIF	National Health Insurance Fund
NHSP	National Health Strategic Plan (Tanzania)
NSGRP	National Strategy for Growth and Reduction of Poverty
OPRAS	Open Peer Review and Appraisal
PBF	Performance based financing
PHSDP	Primary Health Services Development Program
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
P4P	Pay-for-performance
PPP	Public – Private Partnership
SA	Service agreement(s)
SWAp	Sector Wide approach
TA	Technical assistance
VA	Voluntary Agency
VCT	Voluntary counselling and testing (for HIV)
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1 Scope of the evaluation

In the context of “linking and learning” within Cordaid’s program Access to Health, the health systems team initiated a process for a multi country formative evaluation to promote knowledge management and learning with and among partners. With this aim Cordaid invited the Royal Tropical Institute (KIT) to coordinate and deliver a review on performance based financing in collaboration with WHO, its local country partners, national consultants and key stakeholders in country.

The study (*see Annex 1, ToR*) has three components whereby all stages involve the lead consultants from KIT in collaboration with Cordaid head office program staff and a WHO Health systems advisor. The four components include; (i) a desk study on performance based financing in order to take stock of it’s current global status and identify relevant lessons and outcomes from the various country initiatives, (ii) country field visits in collaboration with incountry partner agencies and national consultants to five countries in order to undertake a review of the projects and (iii) to synthesise the findings from the respective countries (DRC, Burundi, Rwanda, Tanzania and Zambia) and (iv) synthesis the results in terms of current perspectives and practice in relation to PBF. The evaluation design was agreed with Cordaid and standardised research instruments were developed for collection of both quantitative and qualitative data. These tools were later modified in line with the country context and parameters such as, feasibility of collecting information in country, relevance to the local context and time available for data collection.

Table 1 Tanzania Cordaid supported diocesan health facilities

Tanzania – Cordaid supported diocese	Population	No of HFs
Bukoba Diocese	530,000	7
Rulenge Diocese	610,000	11
Kigoma Diocese	250,000	6
Arusha Diocese	390,000	21
Sumbawanga Diocese	470,000	19
Total	2,250,000	64

Cordaid has been implementing a three year (2006-2008) performance based financing scheme known locally as Pay for performance (P4P) at selected health facilities in Tanzania since January 2006 (see Table 1). The total budget of Euro 1,85 million (2006-08), plus additional top up allocations in 2007, translates as 0.5 per capita for the target population of 2.25million. Historically, Cordaid has been supporting the health programmes of five RC Dioceses in Tanzania: Arusha, Bukoba, Rulenge, Sumbawanga and Kigoma, through resource allocation to a total of sixty four health facilities, the continuation of the support is now aligned with an output based approach as opposed to input based financing. “Cortaid’s strategy is to contribute to improving access to health care and subsequently improving the health status of the population through strengthening partnership with local organizations and aiming at comprehensive programme support¹”.

The aim of the formative evaluation was to assess the current status of the P4P project through a study of the current management practices and results of the project. The study therefore looks at the operational and institutional functions of all the stakeholders involved and links it with the national government and non government health sector developments. (MOH, CSSC, donors).

¹ Cordaid Tanzania Annual P4P report (2007)

1.1 The payment for performance approach (P4P)

P4P in Tanzania

The current developments in health financing and the recommendations of the 2005 Tanzania Annual Health Sector Review² support the principle of shifting resource allocation from institution (input) based financing to performance (output) based financing. In fact, Tanzania health sector has experience with various approaches and modalities of health financing, some of which were focused on performance based bonuses. Current supply side incentives deployed to incentivize health workers already exist within the country, eg; GAVI provide performance linked financial boosting for EPI coverage, GFATM provide salaries and top ups to vertical program staff, Selected Accelerated Salary Enhancements were in operation (2004-06) supported by DANIDA but were not considered a success as it targeted only senior level management staff, while there were challenges of accountability and transparency therein. However, there has been no prior adoption of a comprehensive performance based financing modality to include the separation of purchaser and provider functions, with associated business plans that include performance targets with verification and control systems. Cordaid's initiation of a P4P approach was therefore ground breaking in its efforts to establish a performance financing model targeting selected health facilities.

In many countries including Tanzania, it is not appropriate to wait for the ideal conditions³ and standards to be in place before introduction of performance based incentives. Indeed, by virtue of introducing an individual or collective performance reward system, it can prove to be an impetus towards overall health systems improvement. This is the premise that is also adopted in Tanzania where many skill deficits still exist in the health sector and many districts continue to be under resourced thus leading to shortfalls in skilled staff and other hardware and software supplies.

Within such resource constrained environments, performance based financing is intended to boost the motivation of health providers with a positive impact on both the utilization and quality of health care to its population.

1.2 P4P how it works

Dissatisfaction with the gap between investment and outputs resulted in introduction of alternative funding modalities in the late 1990's that have potential to elicit more autonomy and independent management for health providers and ultimately improved services for the users.

Objectives of payment schemes include:

- Increase equity, accessibility, and quality of health care
- Efficient organisation of the services

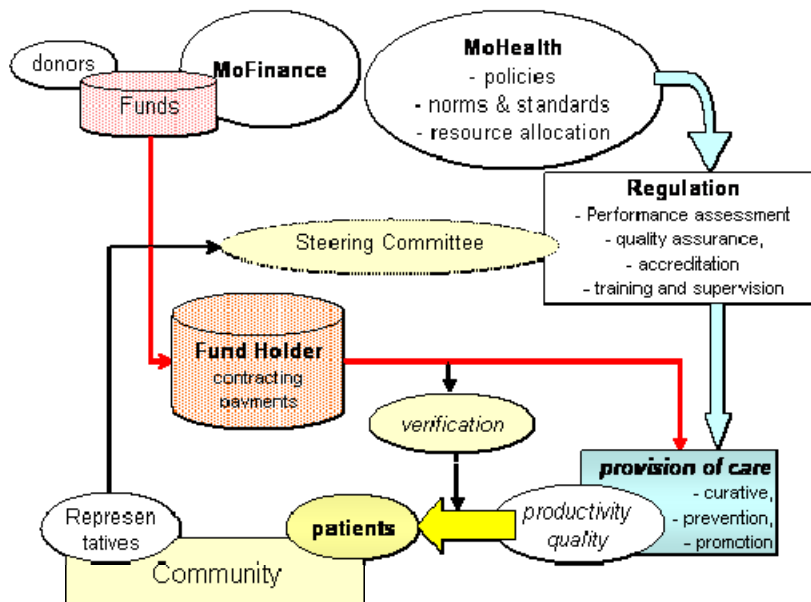
The diagram illustrates the roles and responsibilities of the regulator (MOH), fund holder (NGO or Ministry of Finance or other) and the health providers (public and private). Pay for performance is deployed as a modality to incentivise public and private providers, by making links between motivation and incentives or sanctions. It is informed by the principles of (i) autonomy in

² Review of Tanzania Health Sector Reform Project (2007)

³ Studies advocate for certain pre-conditions to be in place for the better functioning of P4P, including staffing levels based on MOH norms, functioning HMIS and other M&E tools (supervision), financial audits and management systems to accommodate the performance based approach.

management and planning by service providers with separation of functions of regulation, financing, and service provision (ii) involvement of the community in management of the services and (iii) use of standardised instruments including business plan, contracts and monitoring tools. It promotes enhanced participation through a consultative process between the fund holder, regulator and health providers, the inputs, outputs and processes are articulated in a business plan.

Figure 1 Performance Based Financing recommended structure.



This plan (see Figure 1 above) captures the steps for delivery of agreed results; it is thereby expected to improve productivity and quality of care, through creation of more conducive conditions for the health providers, with direction from the regulator(MOH) and additional resources from the fund holder (donor) with overall increased accountability through rigorous performance monitoring, usually a selection of curative, preventive and quality of care indicators.

1.3 Tanzania national context

Tanzania Ministry of Health and health sector structure;

The Tanzanian government under the auspices of the Ministry of Health operates a decentralized health system with three distinct levels; (i) primary (dispensaries and health centers), (ii) secondary level hospitals and (iii) tertiary level referral hospitals. The districts are under the auspices of the district health council (total of 129 districts), and have the full responsibility for planning and implementation of health services to complement the central MOH authority for policy, regulation and monitoring of the national health sector.

The health coverage plan includes the dispensary, health centre and secondary/tertiary hospitals as higher level referral centers. The dispensary provides healthcare for the village level (average of 3-5 villages) covering average population of 3000 – 5000, with health centers at ward level (grouping of villages) for a population of up to 50,000 though some health centers have lower population catchment areas. The secondary referral hospital (DDH)

covers a catchment population of 250,000 on average. Regional hospitals serve as a referral point for district hospitals and usually cover a population of > 1 million. Health infrastructure coverage varies between urban and rural areas with an estimated 90% of the population within 5km of the nearest health facility, however major inequities in access by the poor and vulnerable prevail. This has now become the political goal of the current President under a new initiative to promote the construction of a health post in every village and a health centre in every ward. The Primary Health services development plan has been adopted by the Ministry of Health and will be implemented with government funds with effect from the 2008-09 financial year.

Ministry of Health development plans and strategies;

Tanzania has witnessed a proliferation and subsequent endorsement of policy and strategy documents that promote poverty reduction and associated globally agreed targets (eg, MDGs); *The Tanzania Development Vision 2025* advocates for a high quality livelihood for all Tanzanians with attention to poverty reduction. In the medium term the goals are laid out in the *National Strategy for Growth and Poverty Reduction (2005-15)*, this strategy advocates to improve the quality of life and social well-being of the population, and includes indicators for reduction in child and maternal mortality and HIV prevalence. In addition, the Government is committed to attaining the Millennium Development Goals by 2015 which is articulated in a “roadmap for maternal and child health” to achieve the MDG 4 for child health targets and MDG 5 for maternal health targets.

More specifically within the health sector, the *National Health Policy* (2003) articulates the main goal of improving the health and well being of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. In line with these broad policy objectives; the *Second National Health Strategic Plan* (2003-2008) is focused on “reform towards delivery of quality health services and clients satisfaction” which includes all three levels; primary, secondary and tertiary referral care. The district has oversight of health service delivery as expressed in the Comprehensive Council Health Planning (CCHP) and implementation. A new Primary Healthcare policy has recently been adopted; “Primary Health Services development program (2007-2017), which is focused on expansion of primary healthcare infrastructure and on strengthening of community based health interventions⁴.

A review of the Health Sector Support Project (HSSP) was undertaken in 2007 and the recommendations inform the current Phase III plan that is under development, which is proposed for 2009-2015. This six year plan will bring the health sector into line with other global and regional development goals; including the PRSP and MDGs. The strategy encompasses development of the public private partnership implementation framework and expansion of the current primary healthcare infrastructure. ⁵;

Though there is wide variability across regions in Tanzania, the MOH provide coverage estimates of faith based organizations as follows; 40% of the total

⁴ The PHSD is linked to a new initiative endorsed by the Tanzania President, for PHC expansion, within the 2008-09 financial commitments.

⁵ The national health infrastructure in Tanzania mainland, includes a total of 5,552 health facilities for the delivery of curative and preventive healthcare services. The facilities are comprised of 5,526 for primary/first referral/district healthcare, 18 secondary referral /regional hospitals and 8 tertiary referral hospitals.

hospital coverage, health centers (12%) and dispensaries (26%). FBOs are responsible for 49% of the Nursing schools as indicated below;

Current approximation of actual public – private service delivery is as follows⁶:

- Hospitals - public (96), private for profit (37) and FBOs (87)
- Health Centres - public (341), private for profit (439) and FBOs (101)
- Dispensaries - public (1383), private for profit (733) and FBOs (763)
- Allied Health Colleges - public (45), private (7) and FBO (8)
- Nursing Schools; - public (27), private (2) and FBOs (28)
- Research Institutes Public (1), private (1) and FBOs (1)

Recent developments within the health sector have focused on moving forward with public private partnership development plans. There is a National PPP Steering Committee composed of key stakeholders; MOHSW, Prime Minister's Office Regional Administration and Local Governments (PMORALG), Association of Private Health Facilities in Tanzania, Christian Social Services Commission, Tanzania Public Health Association with DANIDA as the major donor. The committee has been instrumental in the development and signing of the Health Service Agreement between the government, (MoHSW and PMORALG), and CSSC as representative of FBOs. To date, only three District hospitals in the entire country have signed service agreements but it is anticipated that more service agreements will be signed in the coming year.

The *Service Agreement (SA)* as based on the Lesotho model of public private mix of health services was ratified in November 2007 for all district councils to adopt through a phased - in approach. The district councils will establish local agreements with FBOs based on a selective services contract by district. All private including faith-based facilities can be contracted by local authorities (district councils) to provide a negotiated package of healthcare services. The SA includes cost per service based on the per capita costings of the national health insurance fund (NHIF) as a benchmark. However, it's felt that this is not representative of real costs so service level costings are now in progress. It is anticipated that the SAs will be scaled up over a 10 year period to all 129 districts in the country, in line with the National Health Policy objective to promote and sustain public-private partnerships in delivery of health services

Future national plan for performance based financing approaches

The Norway Tanzania partnership initiative is focused largely on achieving MDG4 & 5, this has been a catalyst for working through government structures using joint financing mechanisms towards these goals. Several key objectives are agreed within the partnership including allocation of additional basket fund resources to district councils (estimated at \$5m per year equiv to \$0.20 per capita) and introduction of results based financing which is based on the model of P4P, whereby district councils will be allocated financial lump sum awards to allocate to health facilities against agreed performance targets. While 80% of the total fund is dedicated to results based financing, the remaining 20% will be used for improvement of M&E systems, with particular attention to HMIS in all target districts.

Using the essential principles of P4P, it is proposed by the MOH that the allocation will be disbursed to all district councils in the 08/09 financial year. District councils were requested in June 2008 to include the allocation in the annual budget requests and prepare for delivery of the plan. However there are a number of challenges to implementation due to the accelerated approach that has been adopted by the MOH. While Ifakara Health Research & Development

⁶ Second Health Sector Strategic Plan (HSSP), (2003-2008).

Centre (IHRDC), were funded by NORAD, to develop an implementation framework for this performance financing model, the MOH have decided to move ahead with first phase implementation without a framework. It is anticipated that this will result in lack of standardization on allocations and monitoring of performance awards. The MOH responded to this issue in interview, suggesting that the first phase will include a formative learning process to determine an appropriate strategy for Tanzania and effect iterative improvements accordingly.

The major principles and proposed design were outlined in an initial paper written by an external consultant; it includes an allocation per level of health facility including, Hospital (TSH 9m), Health Centre (TSH 3m) and dispensary (TSH 1m). The original fund focused on achievement of MDG 4 and MDG5 to include all MCH activities. However, based on MOH decisions in collaboration with local government, the allocations are not earmarked exclusively for MCH but for integrated healthcare delivery. The essential aim is to promote quality healthcare for all users.

Health financing developments in Tanzania:

To date there is no official health financing policy in Tanzania, although there are several documents that guide implementation of equitable use of basket funds, community health fund and cost sharing approaches. The MOH anticipate that they will develop a comprehensive financing policy in collaboration with international donors by 2009. By implication, there is no official policy guideline on performance based financing while the recent Norwegian partnership "Bonus for results" served as an entry point in this regard.

The financing of national health services in Tanzania is sourced mainly from the government taxation, user fees, National Health Insurance Fund, Community Health Fund combined with overseas development assistance. In 2007, health expenditure constituted 4.5% of gross domestic product (GDP) and 10% of total government sector expenditure, which is below the Abuja target of 15 percent. The total per capita health expenditure per annum is \$11 of which \$6 is accounted for by out of pocket expenditure. This is well below the more recent estimate of US\$ 34, as advised by the Macro Economics commission (2000) and the \$43 per capita projection to meet the MDGs.

In addition to the government contribution to the health sector, the donor contribution for health infrastructure capital costs and technical assistance, includes \$ 0.5 per capita as a Health *Basket Grant* (funded by *Danida, GTZ, Dutch, Irish Aid, DFID and World Bank*) and deployed towards the improvement of health services in key priority areas covering administrative, curative, preventive, and rehabilitative services. Basket funds are administered by the district councils under the *Comprehensive Council Health workplans (CCHWs)* that are inclusive of both government and non government HFs. These workplans are used to determine the allocation of resources by health facility for the financial year. In addition, other donors operate outside the basket fund or SWAp, including USAID, JICA and GTZ who provide direct funds to NGOs and government district level health services. For the purpose of achieving pro-poor allocation of resources, the Ministry of Finance applies a standard formula for basket funding; 70% allocated per capita with additional allocations based on the following measures: (Poverty Index (10%), Mileage Index (10%) and < 5 child mortality (10%). This allows for more equitable distribution of the funds in line with poverty reduction goals, with attention to populations with higher levels of vulnerability and disease burden.

- **Cost recovery strategy**

The Arusha declaration (1993) advocated for diversifying health financing mechanisms in order to complement government allocation to the health sector. Cost sharing was thereby introduced as one modality for resource generation for health facilities. Reviews suggest that there is not sufficient evidence on access by the poor but one study indicated that 40% did not seek healthcare due to lack of money for treatment⁷.

User fees are applied in both public and private sector health facilities with exemption systems theoretically in place. Government health facilities apply a lower rate than FBOs; (eg, OPD TSH500- 1000 (\$0.50- 0.80)⁸, as most recurrent costs are met by government. The faith based agencies adopt higher user fee rates to meet recurrent costs. Examples range from OPD (TSH 1000 – 4000) to IPD rates of TSH 5000 – 10,000 per day (\$4 - \$7).

Figure 2 Hospital User fees (Diocesan Hospital)

OPD Fee (Clinical Officer) 1000 TSH
OPD Fee (MD) 1500 TSH
OPD Fee AMREF MD) 2000 TSH
Cesarean Section – 35,000
IPD – 1000 per day per bed
IPD – 1000 per day (food)
IV infusion (Dextrose 500mls) – 1200
Drug charges range between 100 – 40000 TSH depending on drug

Variable rates apply for specialist services, laboratory and drugs across the diocesan health facilities. The exemption system as advocated by MOH, advises free treatment for all children < 5 years, pregnant women, elderly and chronic diseases. FBOs report⁹ that on average 70% of users pay the full fees with 25% partial payment and 5% unable to pay¹⁰. There are no equity funds in operation at faith based supported services and few FBOs apply the exemption systems for the poor. This of course has adverse implications for those households who cannot afford the services; we will explore this issue later in the results section.

The *Community Health Fund (CHF)* was designed to channel out of pocket payments into a pooled scheme which was seen as better value for money while endorsing a pro-poor approach. It was initially piloted in 1996 and scaled up in 2001 following an evaluation; currently a total of 92/129 districts have signed agreement for establishment of the CHF funds with uptake ranging from 20-30% of households subscribing to the fund but interviews with DMO and MOH sources reported wide variability in household coverage at district level. The CHF applies to government health centre and dispensary services only with selected FBOs currently negotiating a district level agreement to be included in the CHF coverage. The current annual contribution is reported as within a range of Tsh 5000 to TSH 10,000 per household.

The architect of the CHF within the MOH pointed out that the fund is in fact a cost sharing fund, so the community is expected to contribute towards health care costs. The CHF is therefore presented to communities as a cost sharing

⁷ Tanzania Demographic Health Survey (2005), reported barriers to access for maternal health services.

⁸ Current exchange rate is \$1 equals TSH1200 (August 2008) & Euro 1 equals TSH 1700 (August 2008)

⁹ Cited in Annual Health sector review (2006), District health service delivery.

¹⁰ *ibid*

option where government pay an equal match to that collected, thus increasing the total revenue for district health councils. In practice, the consumer pays the fee at the local designated health facility and receives a card upon payment with the option to use government health centers/dispensaries.

Based on interviews with MOH and donors, they point to several problems related to the implementation of the CHF including:

- (i) Both district and central MOH key informants stated that people are not sensitized to the gains and do not perceive the value of social protection and risk pooling. It is also not evident to households that the non-CHF payers are obliged to pay *TSH3000 per service*, which is more than the previous user fee rates.
- (ii) Households may not be able to afford to pay in some cases, there has been no systematic socio economic study undertaken, so it's not clear whether users are willing to pay. Also, most adults calculate that if they have 2 visits per year is it worth TSH5000 per visit as a pre-payment.
- (iii) Most of the patients who use the HFs are exempt in line with the MOH policy (eg, <5 years, pregnant women, chronic diseases, elderly) while adult users may only use the services once or twice per year.
- (iv) Operationally, there are several management challenges to implementing the CHF including; business regulation, actuary control, costing of the benefits package, verification, and administrative management. To date, there is no transparency at district level regarding how the CHF income is allocated with HFs reporting that they do not receive any resources from the fund.
- (v) Transaction costs and scale of economy to operate this fund have not been considered; currently the district councils are responsible for managing the fund but ultimately it requires an umbrella organization to manage such funds (eg, NHIF or ALAT) which would allow an appropriate scale of economy.

The *National Health Insurance Fund (NHIF)* covers all formal public sector workers through a non-voluntary subscription which entitles them to free healthcare in public health facilities. The NHIF was only introduced in the 1990s as Tanzania is a relative newcomer to promoting alternative health financing mechanisms due to its socialist history. In relative terms, the NHIF accounts average of 20% of health facility income nationally, but findings from this study suggest proportional revenue of 5% at hospital level. Based on interviews with hospital and district managers, they reported major challenges primarily with the administration of claims including;

- Weak administrative systems which do not accommodate the complexity of claims so health facilities experience delays in reimbursement for treatment costs.
- Using branded drugs rather than generic drugs increases recurrent costs of HFs which cannot always be reimbursed by NHIF.
- Subject to adequate administrative systems in place (as seen in the Lutheran mission hospital), they reported processing and returns on claims in one month.

Diocesan health management structures;

Christian Social Services Commission (CSSC) are the national body who represent the interests of faith based organizations and act as an intermediary between the private non-profit faith based agencies and government. They undertaken the following roles;

- Advocacy – representing the interests of ecumenical faith based agencies to central level, while also attending to the decentralization of decision making to regional and district levels. Examples include advocating and lobbying for an inclusive approach within the PPP and the service agreement for all faith based agencies. In future this will extend to monitoring of the service agreements at district level jointly with government ministries. (MOH and Local Government)
- Capacity building; recently CSSC have developed a plan for support to FBOs and diocesan staff for financial management capacity building and linked to the costing of health facility services with technical support from TRAG (Dutch based private consulting firm) on a phased basis.
- Monitoring of services and development of learning networks for documentation of lessons learned from FBOs; Examples include documentation of experience of Church Based health insurance fund by the Lutheran church.
- Support to zonal coordinators as policy and planning advisors to district councils on the implementation of the service agreement. In 2007, CSSC appointed zonal coordinators, who work 33% LOE to support advocacy and representation at regional zonal level. In addition, health policy advisors have now been recruited to serve more actively as collaborators with the regional and district authorities. Lead Agents pre-existed these new appointees and serve as liaison officers representing multi-denominational interests but have recently been replaced by more technical representatives.

CSSC encounter ongoing financial constraints to meet their operational functions. In the past they were largely funded by German church which enabled them to deliver on certain projects. In 2006/07 this funding terminated. Currently, they have defined the need for a “basket fund” whereby several donors will commit longer term funds using the same reporting and monitoring procedures. Cordaid, EED and Danida have agreed to the pooled fund arrangement. It is planned to commence adoption of the fund in 08/09 financial year.

At regional and district level, diocesan health management oversight is provided by the Bishop (as Head of the Diocese) as the chair of the Diocesan Health Board (DHB) which is the highest health policy and decision making body in the diocese. They have powers of decision making in relation to fund allocation and operational management of all health facilities under their jurisdiction. They are supported in this work by the diocesan health offices that provide technical and administrative support to the health facilities. The hospitals however have relative autonomy in their day to day management with oversight by a hospital management committee (with senior managers from the hospital and nursing school (where they exist) and a hospital management team (composed of Hospital manager, administrator and matron, treasurer of diocese) who oversee the day to day operational management.

- **Burden of disease; a brief profile**

With respect to the national *mortality and related burden of disease*, Tanzania has experienced a plateau effect in MMR, with the DHS (2005) reporting MMR of 578 per 100,000 live births, (MDG target of 193/100,000). Of concern is the low level of institutional deliveries with the Tanzania DHS (2005) reporting a national rate of 47% against a target set of 80% (2015). Total fertility rate is 5.7 with a Contraceptive Prevalence rate of 26% while 42% unmet need exists for contraceptives (DHS, 2005).

Meanwhile, Under-five mortality has declined by 24% to a current rate of 112 per 1000 while infant mortality rate has reduced by 31% to a current rate of 68 per 1000 live births. National programs have contributed to improvements in preventive indicators such as EPI, with coverage of 71%, but anaemia (6-59months) is high at 72%. With respect to disease burden, malaria, diarrheal disease and respiratory infections continue to be the top three childhood diseases. Malaria prevalence in endemic areas accounts for 40% of total morbidity at health facilities with only 16% of children < 5 years sleeping under a net (LLIN). The current HIV infection rate is 5.7% with ranges of 2%-16% among the 21 regions in the country.

1.4 Methodology

The Tanzania field study was conducted over a 3 week period by two public health consultants (1 international and 1 national) with experience in performance based financing and health systems strengthening. The study involved a comparison of mission based health facilities (where the P4P was provided by Cordaid since 2006 through diocesan partners) with government health facilities where there is no P4P existing and where only government revenue is in place to support service delivery. The field study involved preliminary meetings with stakeholders at central and district level followed by visits to both mission and government health facilities per diocese.

Out of a total of five diocese supported by Cordaid, three were selected based on criteria of (i) remote populations with limited resources and (ii) dioceses that were accessible (by air). A total of 18 health facilities¹¹ were visited (3 mission HFs and 3 government HFs) per diocese; an appraisal of the functioning of the health facility was undertaken, adopting a routine of (i) health staff and management interviews (ii) study of HMIS to extrapolate data (2005-2007) (iii) client satisfaction interviews were conducted randomly with a convenience sample of health facility users (iv) staff motivation questionnaire was administered in all health facilities to staff followed by focus group discussion. (v) Interviews were held with district and diocesan representatives, health facility staff and community representatives where available.

Methodological constraints:

- The major constraints included (a) field logistic challenges with delays in flight connections from the capital to the districts (b) long travel times to reach the diocesan offices and health facilities. Generally, health facilities were reviewed within a range of 4-6 hours with dispensaries averaging 4 hours, health centres (6 hours) and hospitals (6-8 hours). In some health facilities, data was not available and/or not reliable, in which case the evaluators focused on qualitative content

¹¹ A total of 18 health facilities were visited over three dioceses. Kigoma diocese received shorter visits due to a total timeline of 3 days; in some health facilities, it was not feasible to collect the HIS data as the person responsible was not there or books were missing. The data from some HFs is therefore limited.

including; management team discussions, client interviews, community representative interviews. The motivation survey was also administered at each facility complemented by focus group discussion with a cross section of health staff.

- One of the most significant limitations of this study is the absence of a community enquiry. Due to time limitations and sheer distance between health facilities there was no opportunity to travel to the villages and meet community members directly. While requests were made to health facilities to organise for community members to be present on the day of the visit, few were able to accommodate the logistics of the visit. In most cases interviews were held with the local parish priest or councillor who was close at hand, this does not allow for a wider perspective on household level perceptions and consumer satisfaction with services, although all relevant household studies were availed of for analysis.
- The original quantitative data instrument was developed by KIT and includes a wide range of service delivery and organizational indicators; it relies on the national health information system (HMIS) to provide the secondary data. Due complex system of MTUHA in Tanzania, with a total of 12 registers including 3 summary registers, extrapolation and cross checking of raw data is labour intensive and time consuming. Apart from data recording, there is virtually no data analysis at facility level; it was therefore not feasible to collect comprehensive data sets as previously anticipated. The consultants therefore reduced the data collection to provide for key indicators including those measured for P4P (at mission HFs) and selected proxy indicators for utilization and quality of care at each health facility.
- Financial data was not attainable at some of the diocesan offices. The evaluator obtained comprehensive financial data in 1/3 of the diocesan offices. The other offices were not able to supply the requested data, the gaps were therefore supplemented by Cordaid HQ financial officer.
- At district level staff is responsible for compiling the aggregate data from all health facilities based on the comprehensive council health workplan results for each health facility. This however is variable in quality and in all cases, districts were unable to provide performance data, with limited capacity by the district staff to collate and analyse the data.
- At central level, meetings with key stakeholder including MOH, donors and CSSC were held where possible. However due to competing schedules for the MOH with the advent of the new health sector strategy in progress and other priority national meetings, it was not feasible to hold a formal debrief workshop following the field visits. A meeting was however conducted with the Head of the Health Sector Reform Secretariat (HSRS) who holds the mandate for health financing and health service management. Debrief meetings were also held with the CSSC Director, WHO Health Financing Advisor, World Bank Health sector advisor and select donor representatives.
- In discussion with Cordaid at the preparatory phase of the evaluation and as reflected in the original terms of reference, this is a learning evaluation whereby Cordaid country staff and partners are invited to participate where possible in the evaluation process. As part of the cross fertilization between Cordaid supported country programs, an exchange of partner staff was agreed. This however proved not to be feasible at the point of the country evaluations so there were no Cordaid staff present for the Tanzania evaluation. A member of CSSC (Faith based umbrella organization for social services) was requested to

participate in each diocese; this was also not feasible and only one member participated for 4 days of the evaluation in Rulenge. This denied staff the opportunity to engage in the review process and gain a direct appreciation of the challenges and lessons emanating from the evaluation review.

- Based on the above methodological constraints, the evaluators focused more on the structures, processes and qualitative analysis, while reducing data collection to a short list of indicators. Additionally, they adopted a systems approach to determine not only the P4P approach but how the health system functions based on the policies, guidelines and the essential health package as prescribed by the MOH for adoption by both public and private health providers in Tanzania.

2 Findings

2.1 P4P – how it works in Tanzania

Historically, Cordaid has supported Catholic mission in Tanzania for decades through provision of financial and human resources to diocesan health offices, who function as a coordinating office with oversight responsibility for allocation and monitoring of the resources in support to designated health facilities. Additionally, Cordaid supported Dutch medical doctors as technical assistance to hospitals. Project and financial reports were submitted to Cordaid on an annual basis with limited accountability and oversight of the actual outputs and outcomes of the project by Cordaid, which was primarily activity focused, including trainings and running costs.

In 2006 the new financing scheme, P4P – Pay for Performance, was introduced. This scheme includes a performance dimension and is focused on "*output based financing*" instead of the previously "*input based financing*". The main objective of the current project is to strengthen Diocesan Health Services, which includes the following results;

- Improved access to health services
- Improved quality of health service
- Strengthened organizational performance

The total target population is estimated at 2.25 million¹² with average per capita investment of \$0,50 by Cordaid. The P4P project currently includes a total of 64 church health facilities in five dioceses, comprising of 13 hospitals, 12 health centres and 39 dispensaries.

Institutional context

Overall health sector regulatory responsibility lies with the District Council Health Board (DCHB) as the government institution mandated with the management of all public health facilities, with the District Medical Officer as the chief signatory for the district health authority. The operational management responsibility for diocesan health facilities lies with the Diocesan Health Board (DHB) in each diocese with the diocesan health office having an administrative and technical function to support the health facilities under their jurisdiction. The Christian Social Services Commission (CSSC) is mandated with responsibility for oversight of the social services sector including policy and advocacy support to national faith based organizations including all Catholic diocesan entities. The dioceses and respective health facilities are accountable to and thereby partners of the District Council Health Board and the Council Health Management Team. The Comprehensive Council workplan is the annual plan which includes all health related activities proposed by government and non-government entities within the district, this plan is used as a basis for allocation of appropriate resources and delivery of health services accordingly.

¹² Population estimates are based on Tanzania population census (2002) plus 2.8% population growth rate. However the population figures quoted in national and local reports can be contradictory and do not always reflect accurate estimates.

Table 2 Budget allocation by health facility for P4P

Facility	Guaranteed funding		Performance based	Total budget (max. funding)
	Monthly / Tsh.	Yearly / Tsh.	Yearly/Tsh.	Yearly/Tsh.
Hospital	1.500.000,-	21.000.000,-	21.000.000,-	42.000.000,-
Health Centre	500.000,-	7.000.000,-	7.000.000,-	14.000.000,-
Dispensary	250.000,-	3.500.000,-	3.500.000,-	7.000.000,-
Health Office: With effect from January 2008, 25% of the performance payments to all health facilities (for management of the scheme, data collection, reporting, audits etc)				

Based on the 2007 review and in line with inflation, CORDAID agreed to an increase for hospitals from 18M to 21 M bases & bonus. Health centers from 6M to 7M and dispensaries from 3M to 3.5M in 2008. The above table reflects this increase per level of HF.

The annual allocation to health facilities (see Table 2 above) is set at 50% as *guaranteed financing (base fund) with 50% earmarked as bonus allocation*. Cordaid apply a range for use of P4P funds by health facilities including;

1. Staff motivation (incl. housing, training, uniforms, incentives etc) to a maximum of 50% which is the bonus allocation based on achieving the targets.
2. Equipment, drugs and supplies (incl. non-medical equipment) to a maximum of 30%
3. Infrastructure (such as latrines, incinerator, waiting mothers' shed) to a maximum of 20%
4. Running cost (including maintenance and communication) to a maximum of 10%

The DHOs are eligible to 25% of the performance bonus allocation, as realised by health facilities in the Diocese. The bonus or performance incentive is tied to pre-set targets (Table 3) that are reported on a six monthly basis and verified by an independent consultant hired by Cordaid¹³ prior to the allocation of the performance linked financing. To date, four verification visits have been undertaken by the consultant who is the only Cordaid technical person routinely visiting the health facilities. The total incentive per facility is thereby; % of total performance times the maximum incentive per health facility with the following selected performance targets;

¹³ Cordaid contracted an independent international consultant who resides in Tanzania, who conducts the verification independently. By August 2008, she has visited all 64 health facilities.

Table 3 Selected Performance Indicators for P4P Tanzania

Performance Indicator	Target	Health Facility
OPD utilization	0,6 visits per capita	HC and Dispensaries
IPD utilization	40/1000 population	Hospitals only
Supervised deliveries	10/1000 population	Hospitals
	20/1000 population	HC + Dispensaries
New VCT clients	10/1000 population	All
Drug management	Amoxicillin caps	All
	PPF	All
	Ergometrine inj.	All
	SP	All
	DPTHB vaccine	All
	Syringes 5 ml	All
	Surgical Gloves 7.5	All
	Field Stain powder	All
	HIV test kits	All
	X-ray films	Hospitals

Source: Cordaid Service contract for health facilities, revised version (2007)

Table 4 Minimum HR levels & P4P participation (Cordaid, 2007)

Level facility	Medical	Nursing	Paramedical
Hospital	2 MO/AMO	2 NO 2 NM	2 Lab Assistant or 1 Technician & 1 Ass.
Health Centre	1 CO	2 NM	1 Lab Ass
Dispensary	1 CO	1 NM	1 Lab Ass

Source: Amended Cordaid service contract with Diocese (2007)

While recognising the gaps in meeting the national MOH staffing norms, Cordaid made a decision to introduce minimum staffing levels, guided by the current staff complement in each of the 64 supported health facilities. The table above shows the prescribed staffing norms.

The measurement of the performance targets uses the Health Management Information System or MTUHA as its known locally. All indicators have the same weighting when performance is calculated. The health facilities are eligible to a performance bonus every six months upon achieving the proportionate part of agreed target. The Diocesan health coordinators are responsible for delivery of six monthly narrative and financial reports to Cordaid, The select performance targets are thereafter verified by an international consultant hired by Cordaid on part time contract. The submission of the verification report triggers the allocation of the performance bonuses based on the % target met. Health facilities should therefore be in receipt of the bonus payments on a six monthly basis according to the official contracts signed.

2.2 Relevance/ appropriateness of P4P

2.2.1 Strategies and approaches

Tanzania has not yet witnessed an official health financing policy, with no consensus on performance based financing articulated within national strategy documents. There is however growing national interest in results based financing with the advent of the Norwegian partnership initiative in 2007/08. The opportunity for Cordaid to pioneer this approach in Tanzania is thereby

timely with potential to innovate and tailor the approach to the local context in the future.

As there was no full scale assessment study undertaken to ascertain the state of readiness of the health facilities and management structures in line with PBF pre-conditions, this phase could in effect be perceived as a pilot to determine the feasibility. P4P was informed by the Cordaid Rwanda experience which had proved to be a success, which was to be replicated in Tanzania. Initial steps included a baseline study using HMIS secondary data and a planning workshop held in Mwanza in October 2005¹⁴, which outlined the rationale and essential elements of the project; the official P4P project thereby commenced in January 2006. Given this relatively short timeline from inception to implementation, there was no consultation and feedback from the assumed regulator (MOH, District health council), from the community and most significantly from the health providers, who were the primary beneficiary.

The institutional arrangements as it stands operate outside the MOH structures with no direct links with the district health councils as the official regulatory body for the public health system. Equally, there was limited involvement of CSSC as a possible key stakeholder in its position as a national body for faith based social service organizations. Current arrangements involve Cordaid (as fund holder) channeling the funds through the Diocesan health offices with payments made to the accounts of the supported health facilities. Verification is undertaken by an independent consultant hired by Cordaid who has invested significant effort and assumed an extended role in her technical assistance, in the absence of other technical support. As there is no national fund holder and no independent verification agency, the essential pre-requisites for institutionalizing the model are not yet fully in place.

The **critical gaps** that currently exist in the design and implementation framework include;

1. Lack of ownership by health providers; most of the senior managers stated that they were not directly involved in the conceptualisation stages and design of P4P intervention. Few of them were invited to the planning and monitoring workshops. Following the initiation workshop, each health facility was provided with an implementation guideline. Subsequent review meetings held invited a small number of health managers but the quota was low.
2. Limited national level engagement by the program to liaise with MOH and key stakeholders (WHO, World Bank, DANDIA, NORAD), in order to dialogue on the approach, participate in national level discussions on its suitability for the local context, issues of scale up and adaptation to the institutional arrangements within the MOH structures.
3. There has been limited engagement with the District council to date in how P4P could be more integrated by linking it to the resource planning for the district.
4. Community participation has limited inputs by community representatives in P4P, in part due to the non-functioning of most of the health facility committees. Community feedback is therefore notably absent.
5. With CSSC as the oversight body for faith based social service organizations, there is potential for more engagement and support by CSSC for the technical assistance to P4P. The plan for increased engagement with CSSC in terms of financial resources and human resources is in progress in 2008. and this is encouraging.

¹⁴ See Cordaid report on Mwanza workshop (October 2005)

Based on the above elaboration of the critical gaps, we can conclude that the basic conditions for Performance based financing approach (P4P) are not yet in place, it is therefore not feasible to expect positive or adverse effects, when the key elements of the P4P are not yet established, including the following;

- There was no business plan negotiated and developed; the current service agreement or contract as developed by Cordaid HQ resides with the diocese and not with the health providers, providers therefore have not negotiated their contract, and by implication they have not been contracted to meet the performance targets.
- The expected results and target indicators are uniform for all health facilities which create inequities in relation to the achievements against the original baseline measures, and were not a product of adequate negotiation with the health providers.
- The regulator of the health system (MOH/District Health Council) does not have an institutional or structural role in the P4P approach.
- Current verification is not streamlined according to the required conditions for user and provider inputs at health facility and community level respectively, users of the service therefore do not participate in the process with no assessment of client satisfaction.
- There is no steering committee to guide the P4P process and engage in decision making and determine relevant changes to the process at local level.
- Current target indicators are exclusively supply focused with limited attention to preventive health indicators (eg, ANC, health education/outreach) which would address disease control and appropriate health seeking behaviours.
- There is no quality control built into the P4P, with no tools developed to measure quality of care with the exception of tracer drugs which is used at both primary and hospital facilities.

The formulation of the current P4P requires rethinking to align it with the recommended PBF structure including clear roles of regulator, fund holder and provider. While the fund holder is currently Cordaid, this also requires consideration in line with nationalizing the role and transferring responsibility to a local entity (eg, CSSC, DHO or District council). Consideration should be given to adoption of the main principles of PBF as outlined under "how PBF works" and to develop the framework in line with the local context, based on discussions and analysis with local stakeholders.

Recent development including the public/private service agreement and the Norwegian Bonus for results development plan, all have major implications for Cordaid's support to P4P in the longer term. With the advent of district wide "bonus for results" which is still awaiting an implementation framework, it is expected that the district health council will take charge of the regulation and monitoring. The time is now opportune to redefine the structures and reach consensus on the modality of P4P within the Tanzania context.

2.2.2 Pre-conditions for Pay for performance

Here we not only address the issue of fulfilment of pre-conditions for P4P but also include some aspects of wider health systems strengthening, which are of particular consequence to Tanzania include the following;

- **Human Resource staffing levels;** Based on the minimum levels of skilled staffing as recommended in the MOH Human Resource strategy (2007), most P4P health facilities do not have the required numbers of qualified staff. In many cases, health centre and dispensaries do not have trained midwives so have to rely on unskilled birth attenders or

referral to other health facilities. Cordaid have addressed this issue during the review meeting in 2007, followed by a recommendation for minimum staffing levels as a criteria for participation in the P4P (see Table 4), this has not been enforced and may in fact not be the most appropriate strategy, given the overall HR constraints faced by the health sector at large. The issues related to human resources are elaborated further in discussion on human resources.

- **Diocesan Health Offices;** The DHO staff (average of 2 staff per office) are major stakeholders in the P4P, serving as intermediary in finance, administration and technical support between Cordaid HQ and the health facilities. The move to output financing has meant a reduction in Cordaid support with staff losses in some offices. They currently receive a Cordaid contribution of 25% pro rata of the total performance bonus budget, plus ad hoc contributions from health facilities (based on % of total HF income). Cordaid report (2007) states that “obviously the Diocesan Offices were not well prepared for the sudden change and were not able to manage the reduced allocated budget”. This issue was raised by all the DHO staff interviewed and clearly does not position them for adequate oversight of the P4P in line with the roles and responsibilities currently expected.
- **Reliable health information;** the availability of reliable health and demographic information is one of the biggest gaps, which in turn limits the opportunity to use the data for planning. The standard of recording, data analysis and reporting is variable across districts and across health facilities. Some of the hospitals visited (Kananga, Rubya) had established a good standard of data collection using the registers and summary sheets, with oversight by the Chief Medical Officer. Other facilities relied on untrained staff to record the information with limited understanding of the purpose and process involved. Staff reported that they would welcome training in HMIS as most of the recording was centralized, whereby ward and OPD staff were not aware of or involved in the compilation and in the analysis and use of the results. Overall, data analysis was non-existent with exception of select vertical programs (EPI, HIV) which has technical support from national program advisors and donors but even in this case, data was limited
- **Quality assurance;** There is no standardised quality assurance system in place. There was no evidence of quality assurance tools for hygiene, infection control or other monitoring tools such as monitoring of rational drug prescribing. Despite the lack of established standardized QA tools, the mission health facilities visited all maintained acceptable standards of hygiene, infection control and waste disposal with general cleanliness of the environment; this is in contrast to most of the government health facilities that exhibited a low standard in all key quality assurance indicators that were directly observable. Such markers of QA were in evidence but the HF visits did not allow for direct observation of quality of consultation practice or adherence to emergency protocols to determine practitioners standards. Practices such as over prescribing of drugs and perverse incentive effects were difficult to observe and ascertain during a short visit.
- **Community feedback mechanisms;** Currently, there are no routine patient exit surveys or client satisfaction survey conducted at facility level and in the community respectively. This means that the health staff do not actually measure the quality of healthcare provided and are not cognisant of the user’s perceptions or feedback on the health care standards.

2.3 Inputs

2.3.1 Funding by source

At national level, budgetary allocations under the health sector sourced from recurrent and capital items to Ministries of Health and Social Welfare and Prime Minister's Office – Regional Administration and Local Government. As Tanzania is a decentralized system with deconcentrated arrangements, the funds are allocated to a total of 21 regions and 129 District/Local Government Authorities. The comprehensiveness of CCHP¹⁵ demands that the activities reflect priority areas of the Essential Health Package (EHP); all sources of funding are taken into consideration and all health care providers regardless of the ownership. As Faith based health facilities receive the major proportion of their income from external sources (church, private donations and user fees), the government have historically allocated limited budgets to diocesan health facilities. With the introduction of a service agreement, it is expected that both hospitals and primary health facilities will be entitled to guaranteed funds from the basket fund as expressed in the public private partnership agreement.

Key findings for financial inputs;

The major sources of income of the health facilities are included here with analysis of the proportion of revenue per income source disaggregated by diocese:

- Basket funding (made available by development partners through the district councils)
- Staff grants (made available by the Ministry of Health)
- Receipt in kind (the value of drugs and medical supplies; made available through Ministry of Health)
- Revenues from user charges (inpatient fees, outpatient consultation fees)
- Reimbursement from the National Health Insurance Fund (NHIF)
- Donations (if any)
- Cordaid P4P income
- CHF
- Vertical projects (mostly in kind, like malaria)

Cordaid approved budgets for the P4P project includes the following allocations;

Cordaid approves a contribution of 0.5per capita or a total budget of Euro 1.85 million, for the P4P project (2006-08). This provides funding per diocese as follows:

Table 5 Health Facilities by diocese with budget (2006-2008)

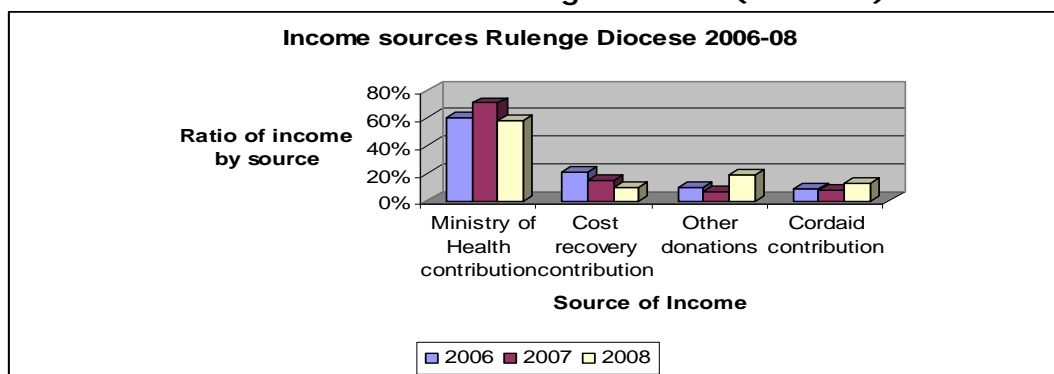
Cordaid supported diocese	Population	No of HFs	Total budget
Bukoba Diocese	530,000	7	320,000
Rulenge Diocese	610,000	11	410,000
Kigoma Diocese	250,000	6	165,000
Arusha Diocese	390,000	21	500,000
Sumbawanga Diocese	470,000	19	460,000
Total	2,250,000	64	Euro1.855m

¹⁵ Health Basket and Health Block Grants Guidelines for the Disbursement of Funds (2004), Preparation of Comprehensive Council Health Plans, Financial and Technical Reports and Rehabilitation of PHC Facilities by Councils; Joint Ministry of Health and Presidents Office Regional Administration and Local Government, Dar es Salaam, Tanzania

Additional fund allocations were made for each diocese in 2007, based on reported inflation costs and diocesan offices, which were unable to meet their overhead costs¹⁶

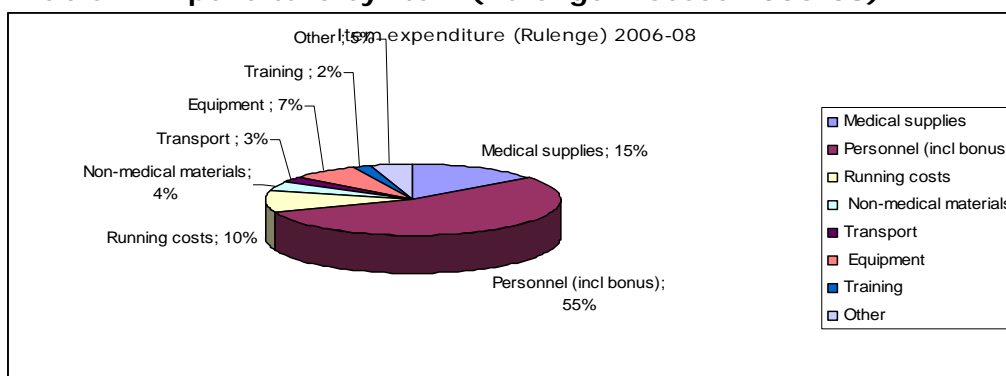
- | | |
|-----------------------|--------------------------|
| a. Arusha Archdiocese | Tsh 90 Million (E56,250) |
| b. Sumbawanga Diocese | Tsh 90 Million (E56,250) |
| c. Rulenge Diocese | Tsh 75 Million (E46,875) |
| d. Bukoba Diocese | Tsh 60 Million (E37,500) |
| e. Kigoma Diocese | Tsh 30 Million (E18,750) |

Table 6 Income sources for Rulenge Diocese (2006-08)



Rulenge Diocese (Pop, 610,000) received a total of TSH 3.1 billion (2006-08)¹⁷ from all the sources of revenue; MOH contribution accounts for the largest proportion of 63% of total revenue from 2006-08 budgets, with a small decrease in the 2008 committed budget. Hospital management teams reported delays in MOH funds, also with variance in the amount of grant allocations by year. Cost recovery accounts for average of 15%, with a notable decrease by year since 2006, this is due to the introduction of flat rates user fees in selected hospitals since February 2007. Other donations account for average of 12% with Cordaid contribution averaging 10%.

Table 7 Expenditure by Item (Rulenge Diocese 2006-08)



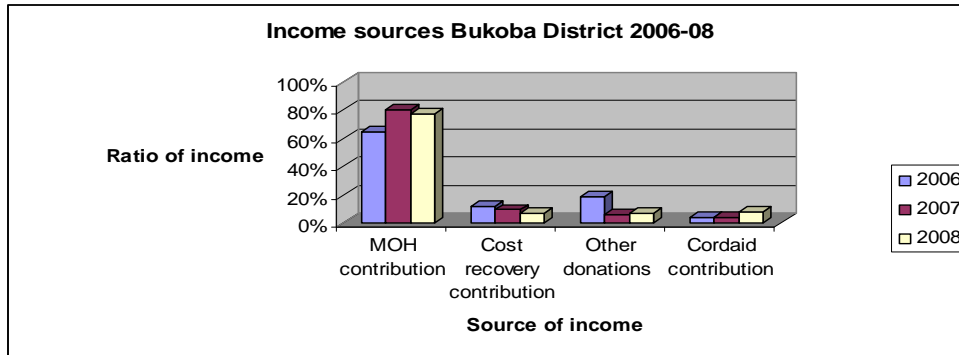
Total expenditure for Rulenge Diocese shows that personnel costs accounts for 55%. Equipment, medical supplies and non medical supplies total 26%, with running costs at 10%. Infrastructure and other costs account for 14%. Rulenge administration have managed to remain within the allocation range as advised by Cordaid but the health managers suggested that its not always the most efficient use of limited resources. For example, essential drugs and medical supplies can be purchased with funds from other donations, whereas personnel

¹⁶ This additional allocation was based on a request for each diocese to submit a proposal and to be invested in promotion of P4P and therefore could not be used for other purposes. Most offices have used this to boost their supervision and monitoring activities.

¹⁷ All 2008 income indicated is committed budget and not indicating disbursement totals.

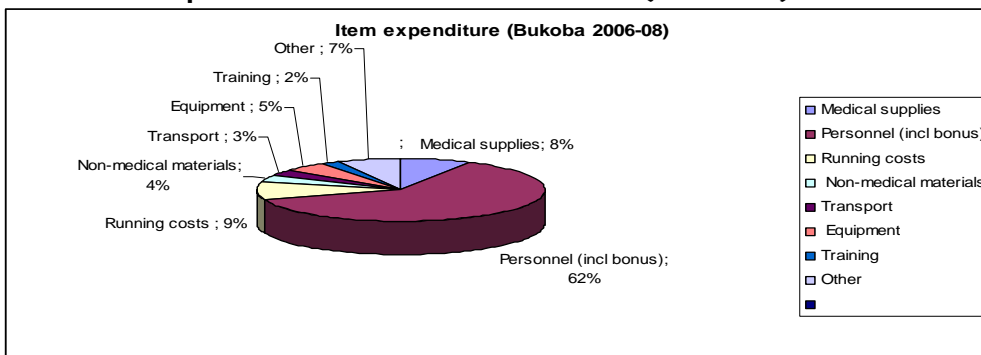
and top ups of salaries are often more difficult to justify from other sourced funds. They request Cordaid to review the allocation range for this purpose to allow for more flexibility on the relative allocation of funds.

Table 8 Income sources for Bukoba Diocese (2006-08)



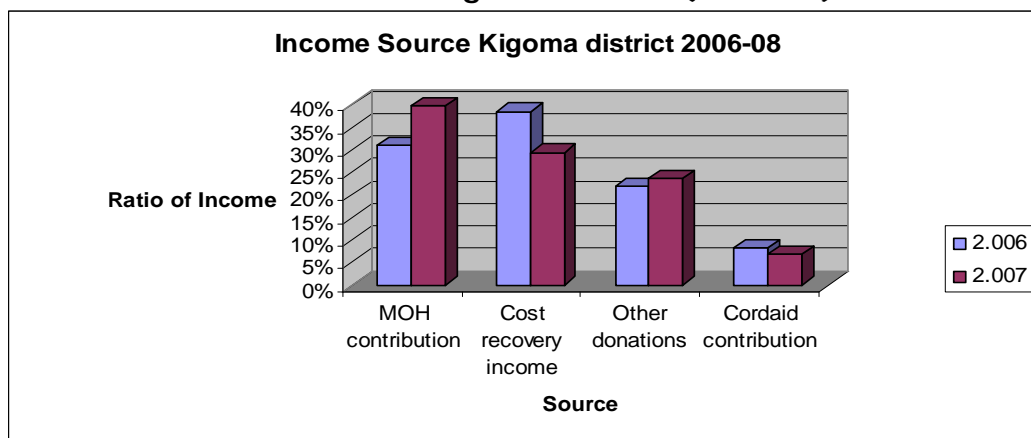
Income sources in Bukoba Diocese (Pop, 530,000) received total revenue of TSH 2.7 billion (2006-08), this includes, MOH (average 78%) with a small decrease from 2007 revenue. Cost recovery is indicated as accounting for average of 7% of total revenue with a similar decrease as in Rulenge due to the introduction of flat rate users fees. Cordaid contribution is currently at 8% (2008) with an increase allocation for 2008 based on the additional commitments made in the review meeting of October 2007. Other donations account for 7% of income.

Table 9 Expenditure for Bukoba Diocese (2006-08)



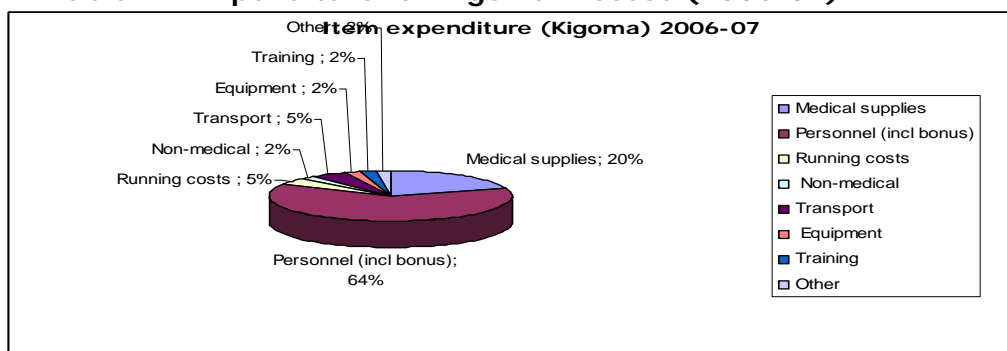
Bukoba Diocese shows a total cost for personnel (incl P4P bonuses) of 62%. Medical supplies/non medical and equipment accounts for 17% while running costs are charged at 9% with infrastructure and other costs accounting for 12%. Training accounts for only 2% of total costs for the entire project period of three years. Bukoba staff expressed dissatisfaction with the lack of flexibility in allocation of funds, and suggested that if they had the choice they would allocate 90% to staffing with options for (i) incentives for staff retention (ii) performance bonuses based on merit and (iii) in kind incentives such as celebrations, internet access.

Table 10 Income sources Kigoma Diocese (2006-07)



Kigoma Diocese (Pop, 250,000) receives a total of TSH1.1 billion (2006-07) financial years. MOH contribution accounts for an average (2006-07) of 35% of total revenue with an increase in the 2007 allocation. Cost recovery accounts for 34% with a reduction in income but Kigoma diocese facilities did not opt for flat rate user fees so no other reason is given for this decline. Other donations accounts for an average of 26% which may be largely attributable to Kananga hospital that fund raise independently. Cordaid contribution is averaging 8%. Donations as evidenced in the income graphs show wide variance across the dioceses, as health facilities are left to their own discretion regarding pro active fund raising. They requested assistance with proposal writing and identification of potential sources of funding so they can ensure additional resources in future.

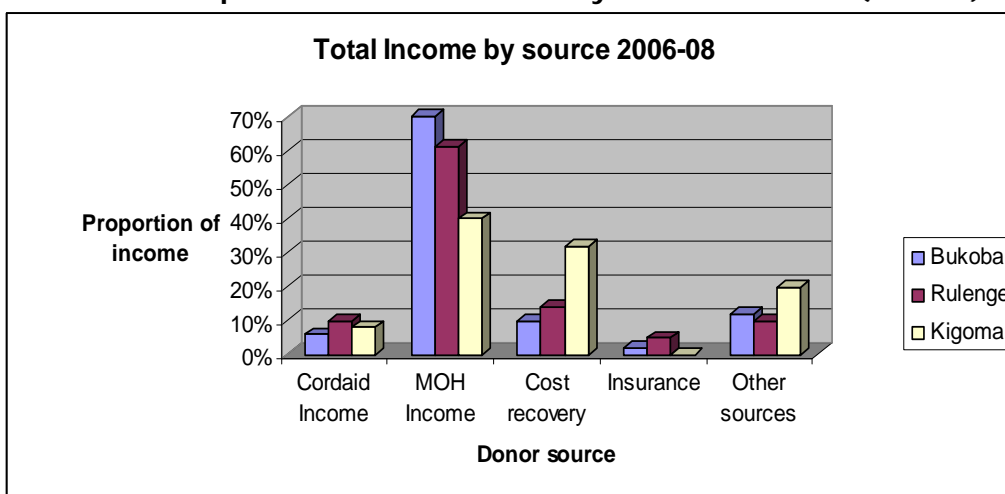
Table 11 Expenditure for Kigoma Diocese (2006-07)¹⁸



Kigoma Diocese reports a total expenditure of 64% on personnel (incl, bonus payments). Medical/non medical supplies and equipment account for a total of 24% while running costs account for 5% with infrastructure and other costs totalling 7%. Training accounts for 2% of other costs. Kigoma Diocesan office reports a major cut back in their income since the introduction of P4P, previously they had six project staff and are now reduced to two staff, with minimal support for office running costs.

¹⁸ Kigoma have not submitted 2008 expenditures for the first half of the year.

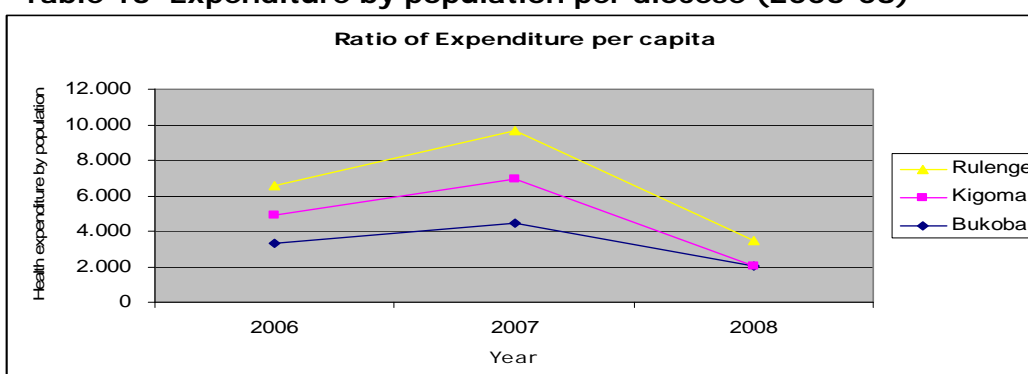
Table 12 Proportion of total income by diocese/source (2006-08)



Based on analysis of the proportion income by source for the total project period (2006-08), MOH contribution accounts for the majority of income across the three year period, with the highest contribution in Bukoba Diocese (70%) and lowest in Kigoma (40%). Cost recovery is conversely highest in Kigoma at 32% of total revenue (2006-07) while lowest in Bukoba (10% of total revenue) which is in part accounted for as previously stated by flat rate user fees at hospitals. Rulenge by contrast with Kigoma (32%) averages 14% of total in the project period.

Cordaid income accounts for average of 8% with a slightly higher income in Rulenge (10%). This includes all contributions from Cordaid including the 2007 supplement. National Health Insurance as confirmed in interviews with the health facility managers accounts for the lowest proportion of revenue with Rulenge (5%) and Bukoba (2%) of total revenue. Kigoma is not reporting any insurance (NHIF) revenue for the project financial years.

Table 13 Expenditure by population per diocese (2006-08)¹⁹



Expenditure for the total P4P project period by target population is consistent with reports of increase from 2006 to 2007 for all dioceses. As stated Cordaid provided additional support to all dioceses in mid-2007 to off set the gaps in resources available, particularly at diocesan offices. Half yearly expenditure is reported for 2008, so per capita expenditure is calculated accordingly.

¹⁹ The expenses for 2008 are based on the first half (Jan – June) only.

2.4 Summary of financial status of P4P

- Currently hospitals receive resources from the MOH through (i) staff grant for qualified staff salaries (seconded staff only), (ii) basket fund for recurrent costs and (iii) other government revenue including in kind support for vaccines, drugs (national program). Faith based supported Health centers and dispensaries receive an estimated 10-15% share of the basket fund plus other external sources (donor assistance, cost recovery and donations as a means of revenue). The allocation of other government funds for primary health facilities has been addressed in the new service agreement contracts to promote more equity of revenue distribution by health facility.
- Diocesan health facilities are not yet eligible to apply for Community health fund status; this is currently denying access by patients who are CHF members who wish to use diocesan HFs. Rulenge Diocese is in the process of applying to the district council for eligibility, which will be granted. Meanwhile, patients who use the diocesan HFs are obliged to pay the full user fees as set by the health facility.
- The NHIF accounts for average of 3% of total revenue. NHIF relies on sound administrative capacity at facility level to ensure efficient claim management; strengthening of financial capacities is currently addressed at central level by CSSC with support from TRAG, this is one of the skills areas that would benefit from TA at health facilities.
- P4P project accounts for an average of 8% of total revenue for all targeted HFs. Incentives account for an average of 4% of total cost of the project. The low proportion for incentives is also explained by the gap in bonus payments since July 2007, the HFs will therefore receive the July 07-July 08 incentives this year.
- Consideration for cost containment by the user led Cordaid to pilot a flat rate user fee in health facilities who volunteered its adoption. Commencing in February 2007, a flat rate was introduced in three hospitals and one health centre using a recommended 25% of the previous variable use fee rates established at the respective facilities. Flat rate user fees (demonstrated by Memawage HC rates 2006-2008) have led to reduced income from cost recovery since the introduction which is not compensated by the low risk money applied per health facility (TSH 1 million per year). The review is urgent in order to address the income gap.
- Verification costs are written into the cost of an international consultant (50% level of effort per year), to undertake HMIS audits of the health facilities to check against the reported performance target data²⁰. To date, the total cost for verification for 2006-07 accounted for three visits to 47% of the HFs (Euro 7500), The August 2008 verifications visits to all 64 HFs are not taken into account in this study.
- Transaction costs; it was difficult to ascertain the overhead transactions costs for the P4P due to (i) Diocesan administrators only track the immediate office expenditures in their annual reports, excluding verification costs (ii) Cordaid HQ staff salary costs pro rata need to be estimated to provide the real transaction costs. (iii) The budget codes are not standardized across the diocesan offices and in line with Cordaid spending codes, it was therefore difficult to identify transaction costs against other receipts eg, personnel and monitoring lines. In order to obtain more accurate transaction cost estimates, Cordaid will

²⁰ This is proposed twice yearly in line with the six monthly allocations of the performance bonus, but there has been a gap in the verification for 2007-08 so the verification has now been completed by August 2008 for all sixty four health facilities.

need to track the full costs of management and administration of P4P for the entire project period, this will be a very useful exercise by end of 2008 financial year.

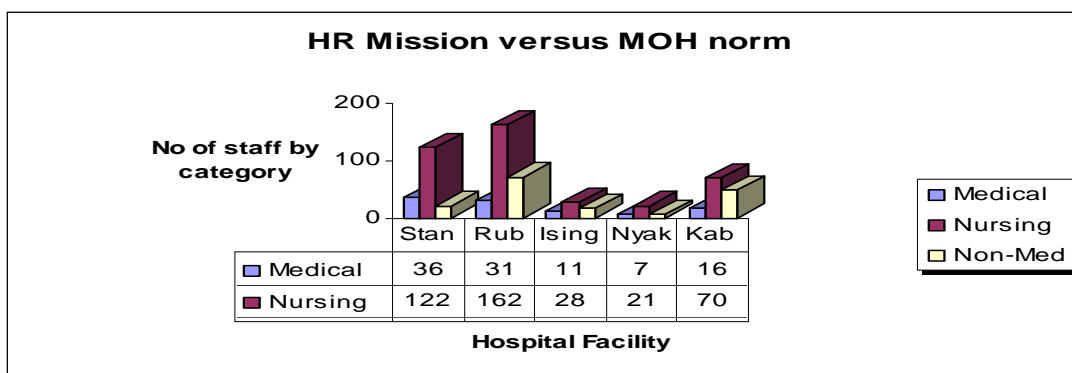
- Predictability of fund flow was investigated at diocesan health offices that are the intermediary channel for P4P funds, with subsequent payment into the health facility account by the DHO administration. All three offices reported that the Cordaid base funding is timely but the bonus funding is invariably late and has not been received since July 2007, due to a delay in the verification of performance targets. Other sources of income including MOH are often late due to delays at district office level in allocations and variance between commitment and actual disbursement; we did not do an audit on this feature as it would require in-depth financial analysis of fund flows.

2.5 Human resources

According to the Tanzania Ministry of Health Human Resource Strategic Plan (2007-12), both public and private health facilities in the country are experiencing an average of 61.7% shortfall in staffing requirements based on the established MOH norms²¹. Tanzania reports PHC HR shortfalls for dispensaries (65.6%) and health centers (71.6%). The HRH health sector budget increased from 3.47% (2006) to 5.3% (2007) of the total health sector budget, but remains insufficient. The staffing deficit is expected to increase in the future as the New Primary Health Services Development Program (PHSDP) builds more dispensaries at village level and health centres at ward level. The district health service delivery review (2006) stated that HR management is one of the areas with least progress in the past years with limited evidence base to inform decisions (eg, limited knowledge on inequity in distribution of staff within the across districts, no workload analysis and limited monitoring of employment practices within the district health systems). Insufficient evidence base for future planning and resource allocation is thereby a major constraint.

The diocesan health facilities are relatively autonomous in terms of HR management functions with responsibility for recruitment and management of staff with the exception of qualified staff seconded from government service. The evaluators were unable to extract comprehensive HR data from district health offices, in order to draw comparisons between FBO and government staffing levels. The following table however (Table 14) provides a comparison of diocesan hospital staffing levels compared to current MOH HR norms. As evidenced most hospitals do not meet the required levels of qualified staff (medical or nursing) with exception of Rubya hospital, this is accounted for by the presence of a nursing school where most graduates receive post registration training. However, CSSC report only 20% graduates nurse retention by diocesan health facilities, which raises the issue of retention strategies by the training institutions²². There are notably higher ratios of unqualified staff compared to the recommended MOH levels.

Table 14 MOH HR norms versus actual (4 Diocesan hospitals)



The HR gaps were noted by the evaluators across all mission health facilities with increasing numbers of staff leaving the diocesan hospitals to work in government service. Most health managers noted that the situation has become more acute in the past year and attributed this to the increase in government salaries and pension security which attracts staff. The acceleration

²¹ The norms are informed by WHO HR standards and considered ambitious, so are rarely accomplished even in better resourced countries; particularly for lower level health facilities.

²² FBOs account for a total of 49% of professional training colleges (especially for nursing and midwifery), yet they report that only 20% of graduates are hired and/or retained by the diocesan health facilities.

of staff migration is aided by civil service reform, whereby government have agreed to increased recruitment, this has led to a total of 1500 new posts in the health sector in 2007-08 financial year²³, one possible adverse effect is therefore the reduction of qualified staff at diocesan health facilities.

Table 15 Rubya District hospital nurse attrition rates (2007-08)

Rubya District Mission Hospital – Qualified Nurse Midwife Attrition study²⁴

No of beds; 162 – June 2007- August 2008 (Total # NM – 82)

Staff cadre	No of staff	Destination	Comments
Nurse Midwife	34	Government services	Most trained in Rubya NS
Trained Nurse	4	Government service	All trained in Rubya NS
Nursing Officer	5	Government Service	

Total No of exit staff 43

Based on interviews with staff and management, the evaluators focused on (i) staff conditions and incentives (ii) regulation of HR employment and (iii) performance appraisal of staff.

(i) Staff conditions and incentives were a priority for discussion where four key issues emerged for attention:

- Staff incentives and other intrinsic rewards (eg, staff housing) as provided by mission facilities do not compensate staff adequately for such differentials between government and faith based agency salaries and longer term security as provided by generous government pension.
- Additionally staff reported that inflation increases in the past year have resulted in unprecedented price increases in basic food commodities and fuel eg, price of sugar per kilo from TSH 600 (2006) to TSH 1400 (2008). The staff was unanimous in identifying that the current bonus is inadequate, especially given the cost of living increases.
- Health workers in both government and diocesan health facilities highlighted that even if they receive promotion, they may not be paid the promotion increment for > 4 years. This undermines their morale and motivation to perform in the new job.
- Job security is a major issue. While government staff benefit from a pension based on a contribution of 5% by employee with a 10% top up by government, the diocesan employees pay 10% with a 5% government top-up, while accruing < 50% of the total pension compared to their government counterparts. This accounts for the migration patterns of qualified staff from faith based services to government services.

The MOH response to the issue of job security, points to the need for the diocesan senior management to address the discrepancies within the salary structure through payment of qualified staff in line with the government

²³ This issue of civil service reform and associated staff attrition from government service was never mentioned by diocesan health staff. The MOH indicated that this was one of the primary reasons that has led to migration of FBO employees to government in addition to the more attractive pension.

²⁴ Diocesan Nurse Training schools exist in three diocese (Kabanga, Rubya and Rulenge) . Rubya NT has an average intake of 150 students per year but the majority leave after graduation while < 20% remain within the diocesan health facilities.

awarded salaries and pension benefits and in line with that allocated by government to seconded staff. Additionally, it is recommended that the salaries are paid direct to the staff bank account, rather than central treasury control of the salary allocations within the diocese. Frequently, staff receive reduced salaries as diocesan offices use the salary budget to cover all staff within the HF (unqualified too) so most qualified staff do not receive their full salary as per contract. This issue requires attention by CSSC in cooperation with FBOs to identify the specific HR challenges and how to overcome them.

(ii) HR regulation;

Staff in both government and mission services experience lack of a regulated HR structure for recruitment, retention and promotion linked to staff performance. More specifically, health facilities need to improve their own internal HR management with the aim of best practice towards finding and keeping staff with appropriate skills levels.

"The hospital organogram has not been reviewed for over 10 years. Job Descriptions are available for all cadres of staff but have not been updated for ten years; One of the major problems is the lack of clear roles and responsibilities in particular at senior levels both within the operational unit of the hospital and externally to the board of governors and diocesan treasury" Hospital manager (Diocese).

At the regulatory level of the district health council, there are still no clear operational guidelines for recruitment, retention and secondment of staff from public to private, it therefore rests at the discretion of the DMO at district council level to use initiative and create a balance of manpower levels across the various health structures. The DMOs acknowledged the problem and indicated that they are willing to offer secondments of senior staff to mission hospitals for restricted time periods as a short term solution to the HR crises. In practice, there are a number of medical doctors seconded from the district to serve in mission health facilities but this does not address gap of medical staff.

(iii) Performance reviews;

An Open Performance Review and Appraisal system (OPRAS) was developed in 2004 for staff appraisal but this has not been implemented systematically in the public health facilities and there is no comparable system in operation within the private health sector.

"A Health Policy document was developed in 2004; this outlines the organizational structures, minimum package for operational delivery of services. However this has not been updated since P4P was introduced so does not indicate the additional contributions to hospital funds and incentive systems".

Hospital Manager (Diocesan Hospital)

This has major implications for health worker motivation levels and links with P4P, due to the importance of staff appraisal and review of performance using standard indicators. Currently, non performing health workers may be receiving higher incentives than those who are performing at a high level.

2.6 Efficiency

2.6.1 Efficient organisation of the program/project in support of P4P

Here we explore the current design of P4P and examine the efficiency of the systems and structures that support its implementation with links to the wider health system functioning;

Investment in appropriate design and implementation process is implicit;

The current P4P design was adapted from the Cordaid Rwanda model which had proved to be successful in that context. The introduction of this model in Tanzania within a very different context with exclusively mission health facilities where resources (HR, financial) are limited, has presented major challenges. As noted earlier, the pre-conditions for P4P were not in place and has led to constraints following the introduction of a relatively ambitious set of indicators, in terms of ability to meet targets, role of DHO office who witnessed staff cut backs since 2006 and the overall capacity to institutionalise the process. Cordaid provided an implementation guideline which outlines the steps involved for implementation of P4P. This was well received by the health facility staff but they expected more technical assistance in the implementation stages to overcome problems encountered. Technical support is limited as Cordaid do not have in country health systems program advisors and rely on one program officer in The Hague to provide project oversight. This creates deficits in technical assistance and advisory support which is required in order to strengthen certain key areas such as, HMIS, M&E, quality assurance, financial and administrative management and selective components of health systems.

Creation of provider acceptance of the need to reform and full collaboration is critical;

In the case of the P4P project, there were implicit assumptions made that the performance incentives would be acceptable to all health workers. The contract agreements and recent updated revisions (October 2007) are not negotiated directly with the health facilities and copies are retained at the diocesan level and in some cases by the Bishop as manager of the diocesan mission. This is an essential component of engaging the health providers at all stages of the P4P process, ensuring ownership.

Management of the monitoring and evaluation with providers,

There are no strategic plans developed jointly so planning is at the discretion of health facilities. The evaluators were only able to access one health plan which was dated 2004 and not updated subsequently. There were no internal documents developed at diocesan HF level to guide the P4P approach towards efficient system development. Additionally, some hospital managers noted the need for clear policy guidelines including organogram structures and HR policies. Also, review processes are ad hoc and rely on the discretion of the health facility management. Apart from quarterly supervision visits by the DHO coordinators and annual P4P review meetings coordinated by Cordaid at central level, there are no other official monitoring visits or review processes undertaken by the line management staff or district authorities.

Capacity building for P4P at local level:

“We were not involved in the design and planning stages of P4P but were provided with the guideline documents in late-2005 and were told to commence implementation by January 2006. We would welcome more involvement in planning the program” - *Senior Hospital manager (DDH)*

Diocesan offices reported that all coordinators were invited to attend a preparatory workshop in Mwanza, October 2005 to inform the design of Cordaid support for health services within five dioceses, following a feasibility assessment by a consultant in early-2005. Four dioceses were represented by the the DHO staff and treasury with an under-representation of health managers from the diocese. CSSC were not involved in the design stages or indeed later in the implementation stages; they were however aware of the project through discussions with diocesan representatives and attended the review meeting in October 2007. The health management of the supported facilities however were not consulted on the design of P4P and only two participated in follow up review meetings. Limited participation and inputs from health providers was a major concern expressed by the workers in both the planning and monitoring stages of the project, this may also be linked to prior consultation and acceptance of P4P approach during the initial feasibility stages in 2005.

Capacity building within the P4P project is limited to a small number of training workshops in each diocese as decided by the individual health facilities in collaboration with the diocesan health office; (examples were given of training in use of MTUHA HIS records). Training on key areas of delivery for health systems strengthening in line with the pre-requisites for P4P such as HMIS and M&E systems is not meeting the needs.

2.6.2 Aid effectiveness

When considering aid effectiveness in the context of P4P, we explore key elements including alignment with national health plans, harmonisation of efforts both within the diocesan structure and between diocese and government structures. With reference to communication and coordination structures, most of the diocesan health institutions have governance committees in place. When interviewed, representatives reported that most of the hospital boards, health centre committees and dispensary committees were not functioning. Quarterly meetings are proposed in the official documents but these are not actually held in most cases. Hospitals reported that decisions are made in ad hoc meetings by the hospital management team. A full appraisal of the current organizational capacity is required to discern the level of communications and coordination both within the health facilities and with the wider stakeholder community.

Currently there appears to be a distinct divide between the operational management of the district council supported health services and that of the diocesan supported HFs. The structures and functions are separate and the point of correspondence is at annual meetings, to discuss the activities for the council workplan; diocesan health coordinators reported attending the annual planning workshops but are only invited for two days of the 5 day event. Such a short exercise excludes the possibility of comprehensive discussions and of district health teams participation in integrated planning of the P4P.

Alignment with the wider donor community and streamlining of resources to support the government to institutionalize performance based financing is not yet in place. It is timely in view of the current Norwegian Tanzania partnership initiative which has dedicated resources for nation wide “bonus for results”

initiative. Equally, the introduction of service agreements between district councils and FBOs will offer the opportunity for redefining roles and responsibilities of the respective partners within a service contract arrangement; this is an entry point for Cordaid and the diocesan partners, supported by CSSC to engage in discussions on the modalities of future performance financing schemes. It is therefore an excellent window of opportunity to move ahead with efforts to harmonise approaches to health system strengthening and align the resource package at district level, given the forthcoming discussions on development of a service agreement.

2.6.3 Monitoring and evaluation.

We explore here the functionality of the monitoring and evaluative systems in the context of their use for P4P reporting, verification and analysis of results;

Health Information systems; P4P measurement relies on a reliable health information system, but this is not available, with errors, omissions and unreliable reporting, how can this form the basis of performance target measurement. A recent study by Norad²⁵ consulting team in preparation for the results based financing program, found that recording of data for MCH and OPD was generally done well (with exception of surgery and laboratory registers) but the gaps occurred in completion of the quarterly and annual summary sheets and subsequent data analysis. Cordaid verification reports point to similar gaps in under/over reporting and omissions and errors in recording of data on entry and in summary registers. In part this can be accounted for by low level of skills as there has been no national training for HMIS for health workers since 1994-97, which means that the past decade health workers have not had any training on use of HMIS. P4P therefore requires a significant investment in management and use of HMIS as a first step to obtaining accurate information and using the data for planning.

Control and verification; The Cordaid verification system consists of visits to a sample of HFs to conduct a mini-audit of the performance indicators that are uniquely supply focused. A Cordaid consultant visits the HFs and inspects the Muthua books to verify that the reported indicators are correct against the summary registers. In 2007, the Cordaid consultant visited a total of 30 HF out of 64 HFs (47%). In October 2007, a review meeting concluded that more rigorous monitoring is required, subsequently and with effect in 2008, the consultant has now visited all 64 HFs across five dioceses to verify the data reported, she also provides support to staff on management of P4P as the only P4P advisor who visits the HFs periodically. While this is a good start, the verification visits need to conduct every three months and followed up with inservice technical support to address the problems identified during verification. Verification is also not linked to the wider HMIS system thereby risking the fragmentation of the HMIS with an over emphasis on select curative indicator tracking. Most importantly, is the need to extend the verification system to include community feedback and inputs from users to discern perceived quality of care by providers.

Reporting: The DHO is requested to submit half yearly reports on performance targets and results of the project. The six monthly reports also include financial statements of each health facility, both on the use of P4P

²⁵ Norwegian Tanzania Partnership Initiative; Baseline assessment report (Paul Smithson et al (2008)

funds and on total income and expenditure (including government, patient fees and other income)

On an annual basis, the DHO is requested to provide the following reports:

- 1) Annual reports of each hospital included in the P4P scheme
- 2) Consolidated report on the financial statements of all Health Centers and Dispensaries
- 3) Report on the DHO covering all activities & income sources (including local contributions)

The DHO staff did not perceive additional reporting burden since the introduction of P4P but critical analysis is missing in the reports including links between wider health system development and P4P effects, and this requires more technical assistance. The reporting system requires further standardisation to ensure that all health facilities provide results in line with the aims and objectives of P4P. More attention to a results based approach to service delivery should include; alignment with district council workplan indicators, balance of curative and preventive/promotive activities in line with the Essential Health package and attention to innovations in health financing of the facilities.

3 Results of P4P Evaluation

3.1 Catchment Populations;

"Health facilities should take initiative to collect and update the information about their catchment /service population.....Information about catchment /service population should be available in the health facilities at the start of each year; it should include the annual population growth; it should be recorded in the annual Mtuha book (book 2) and should be visible on the wall at the MCH clinic of the health facility."

Cordaid Review meeting recommendation (October 2007)

The above recommendation was made in 2007 following 20 months of Cordaid P4P implementation. While undertaking the program evaluation ten months later (August 2008), it is evident that there is at yet no resolution to the problems described²⁶. Although not a pre-requisite for concluding on P4P outputs per se as absolute numbers can provide evidence of the trends, the issue of population denominators was raised by district and diocesan managers as well as by health providers. The evaluators studied some examples of the major discrepancies that exist between catchment population figures based on district health council allocation and the catchment population, based on wards served by the health facility. A number of health facilities were requested to complete a checklist of the wards (OPD and IPD) and villages (outreach) served by their facility. The results as seen in Table 16 demonstrate the major discrepancies that exist when reporting against population denominators.

Scenario 1; Catchment population at Kananga Hospital, Kasula District.

Hospital catchment/service areas in Tanzania are based on geographical boundaries, "divisions" and for District Designated hospitals (DDH) the boundaries are the district. Typically, the mission (or voluntary agency) hospitals act as referral centres for health centres and dispensaries within their catchment area. DDH are the referral centre for all health facilities including VA hospitals. In reality many mission hospitals have superior services and specialist surgical services compared to the DDH government hospitals. The MOH norm for secondary hospital catchment is 250,000. Where two or more hospitals exist within a given district catchment, the district council divides the total district population by the number of hospitals.

In this example, with three secondary hospitals in the district, the hospital catchment population (219,000) is calculated based on 33.3% of the total district pop (657,000). This however does not tally with the estimates provided based on the population cover by ward (#7) (See Table 16 below) whereby a total population estimate is 116,641 (based on 2002 population census plus 2.8% growth rate). This leaves a discrepancy of 102, 359.

Allowing for OPD and IPD users from outside the catchment area (estimated at 20% of total users), the denominators for coverage (EPI, ANC) are not based on reliable estimates. In this instance if the district council denominator is used, the coverage indicators will be lower than if using the hospital ward catchment population figure of 116,641. The current calculation of performance targets uses a ratio of per 1000 population, this results in wide variance across the four quantitative indicators depending on which population denominator is used.

²⁶ "Annual population growth is still not well understood, figures vary from 1.1% to 4.3 % in different parts of the country, whilst the National Population growth is 2.8%. (Mtuha book 2)" quote from Cordaid review meeting, presentation by Erica Musch, October 2007/Dar Es Salaam.

Table 16 Kananga Hospital coverage by Ward**Kananga Hospital coverage by Ward - District/Households and average household size.**

Ward	Population	Households
1. Nyamyusi	16,076	2796 (6.0)
2. Msambara	16011	2655 (6.0)
3. Ruhita	18680	3446 (5.4)
4. Titye	9482	1843 (5.1)
5. Kigondo	8473	1530 (5.5)
6. Murufiti	14260	2360(6.0)
7. Kasulu Mjini	33668	5938 (5.7)
Totals	116641	20,588 (6.0)

This scenario was discussed with district medical officers who explained that the issue of determining population catchments is well recognised but they don't have a solution, so they continue to use geo-stratified allocations in line with No of Health facilities/total population for hospital level. For Health centres the differentials are not as wide, they use the MOH norm of 50,000 per health facility with dispensaries designated 10,000; again this does not tally with the real population figures which in the case of low density populations is far lower while peri urban areas exceed the upper limit of the recommended range. This has implications for P4P in line with use of utilization and coverage targets as a means of determining health facility performance. Further discussions are required with district authorities to reach agreement on more precise population catchments for the respective diocesan supported hospitals.

- **Performance Targets for Cordaid P4P**

Current performance targets are outlined below based on revision to original targets established as baseline from 2004 HMIS data. The evaluation methodology focuses more on the comparisons between mission (P4P) and government health facilities (non – P4P) to determine if P4P is making a difference to the utilisation and quality of care provided to the users.

At hospital level:

1. IPD admission rate²⁷ target 40 per 1,000 population
2. Institutional delivery rate target 10 per 1,000 population
3. VCT clients target of 10 per 1000
4. % of selected key hospital consumables continuously available

At health center and dispensary level:

1. OPD user rate (first attendance) (target 0,6)
2. Institutional delivery rate target of 20 per 1,000
3. VCT clients target of 20 per 1000
4. % of selected key first line consumables continuously available

²⁷ For 2006 ten health facilities had under-reported and ten health facilities had over-reported. For 2007 this was 11 health facilities under-reported and 8 over-reported. The differences varied between under-reported + 1142 patients and over-reported – 846 patients. The lowest was + 8 patients (under-reported) and – 2 patients (over-reported). (cited in Cordaid P4P 2007 review report)

3.2 Outputs

3.2.1 Performance in terms of productivity

A decision was made by the evaluators not to use some of the data collected for the purpose of analysis and drawing comparisons due to (i) incomplete data sets, (ii) unreliable data from some sources. It was not feasible to obtain a "complete picture" of aggregate data per district, in order to provide a benchmark for comparison of performance, as data is not analysed and if available is presented as raw data per activity.

The health facilities per diocese used for analysis of performance outputs include the following:

Rulenge Diocese

The three types health facilities for project and non-project/District council that were evaluated in Rulenge Diocese were; Isingiro and Nyakahanga DDH/DC Hospitals; Rwanbaiza and Nkwenda DC Health Centres, Rwenkende and Kyerwa DC Dispensaries

Bukoba Diocese:

The three types health facilities for project and non-project/District council that were evaluated in Bukoba Diocese included; Rubya and Ndolage Lutheran Mission DC Hospitals; Mwemage HC and Kiabara DC Health Centres, and Kishuro mission and Buhembe government dispensary.

As P4P project has used a rate of 1000 per population to assess the trends in the four performance target indicators, the evaluation is not making any comparisons with the baseline (2004) or subsequent performance indicator measures (2008). This analysis is focused on comparison of diocesan supported facilities where P4P is operational with non-P4P health facilities in the same district. For the purpose of analysis of select indicators, nominal data is presented. This will provides trends in outputs per year for the respective hospitals. While making inferences about possible changes due to P4P, we are aware of that in most cases, it will not be possible to exclusively attribute changes to P4P, given the multiplicity of influences and complex nature of health outputs and outcomes.

Table 17 Inpatient Admission per year (Mission and Gov)

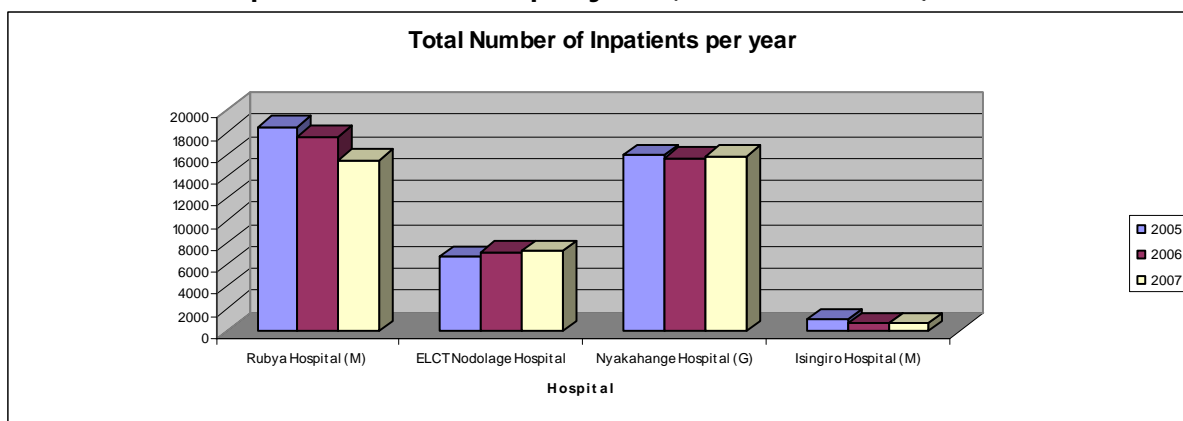
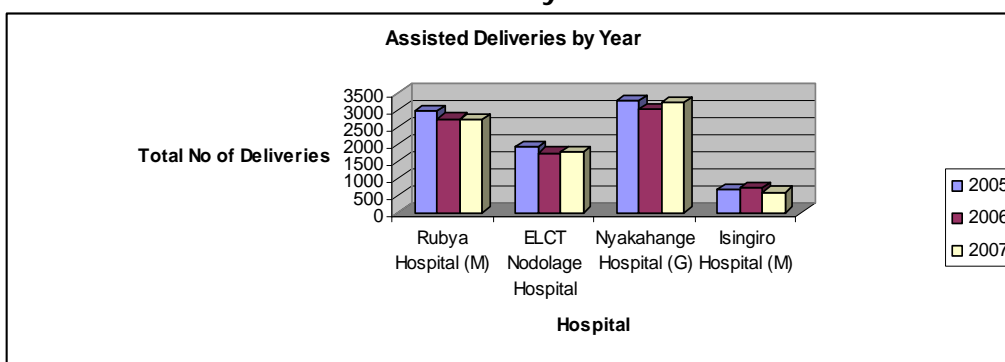


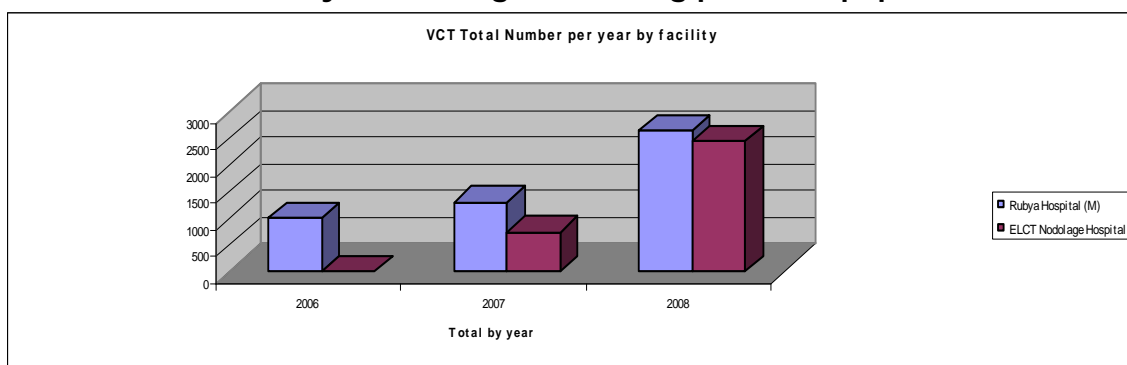
Table 17 illustrates the utilization rates for inpatient activity, it suggests that Rubya hospital has had a reduction in total patient admissions over the three year period; this may be accounted for by the presence of three hospitals in Muleba District with patients moving over to government hospitals where treatment is affordable. While Rubya (Muleba District) is achieving the target set of 40/1000 population, issues of inappropriate referral rates due to poorly functioning primary care facilities and average length of stay for inpatients needs to further explored. Isingiro is showing low IPD but the reliability of the data collected is in question here. By comparison non-P4P facilities are showing consistency in inpatient admission rates, with Ndolage hospital (ELCT) also in Muleba district, serving as a regional centre for specialist services.

Table 18 Institutional Deliveries by Year.



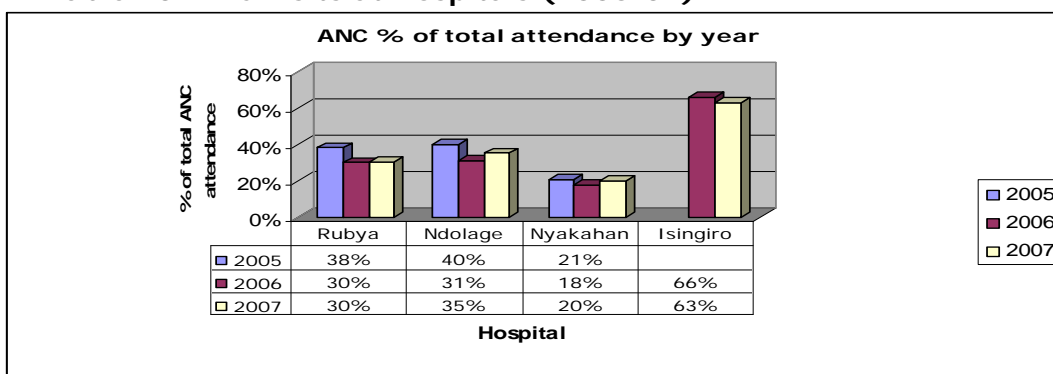
The national rate for Institutional deliveries based on the TDHS 2005 is 47%, while urban areas report facility based deliveries of 70%. Cordaid verification reports indicate that “deliveries are in general better recorded than IPD and OPD. Book 12 (maternity book) is relatively clear and well recorded by staff at the maternity”. We can therefore assume that this is a relatively reliable measure of the total number of deliveries per year by health facility. The trend in P4P hospitals as shown in Table 18 above indicates a decline since 2005 in P4P health facilities, with Isingiro mission hospital well below the target. Government and ELCT hospitals indicate consistency in year by year trends. While institutional deliveries is an important measure for maternal health care, issues of emergency obstetric care provision and overall quality of care comes into question when addressing reduction in maternal mortality and morbidity.

Table 19 Voluntary counseling and testing per 1000 population



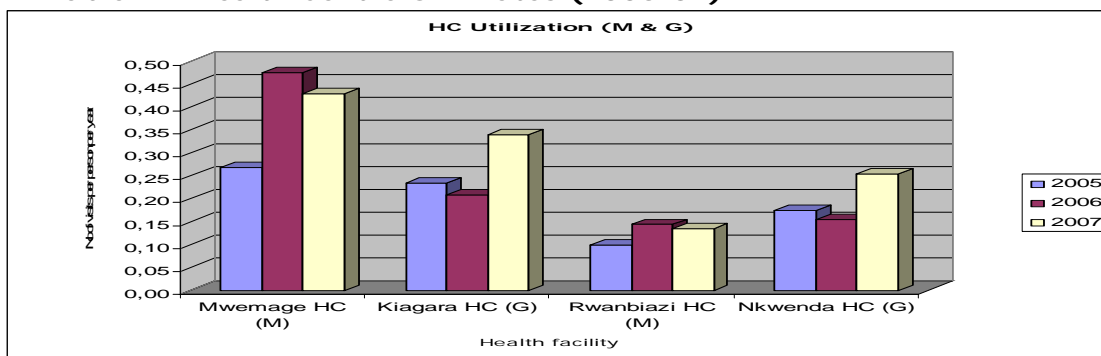
Most significantly in relation to VCT services, there is a notable increase in VCT from 2006 - 2008 for Rubya hospital as a P4P facility but by comparison with a non-P4P, there was a doubling of VCT utilization in Ndolage ELCT hospital. This is also reflected in other districts nationally, due to an increase in VCT services coupled with a national campaign in 2007, which was endorsed by the President and mobilized the population to use the VCT services. This indicator was applied to hospitals and health centers only from late- 2007. However, it is not useful for the purpose of performance monitoring as most health facilities will have exceeded the target, from baseline trends in 2006/07 for the reasons indicated here.

Table 20 ANC visits at Hospitals (2005-07)



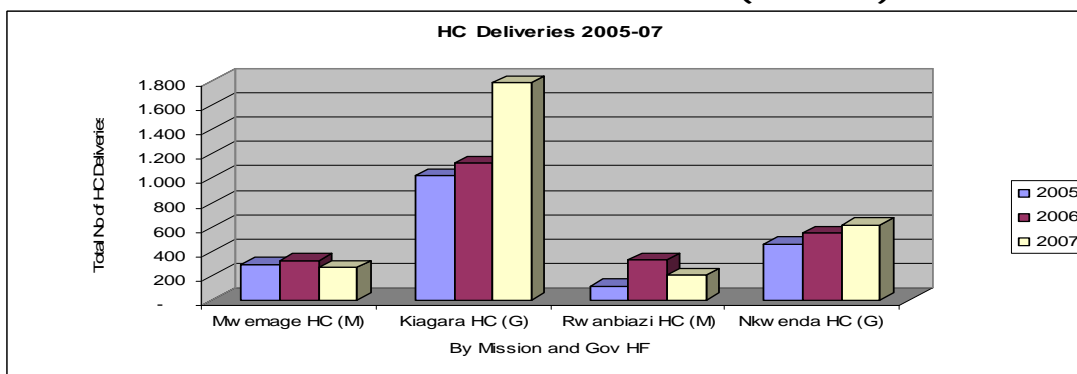
As a proxy indicator for non-P4P health prevention activities we have selected ANC. The TDHS 2005 suggests high ANC attendance with a reported rate of ANC attendance (94%) with 62% having 4 visits for ANC. Based on ANC attendance (4 or more visits), coverage as shown in Table 20 above is well below the expected target as set by the DHS data, across health facilities, while Isingiro recording may be inconsistent. The P4P facilities are not performing well on ANC with a marked reduction in Rubya hospital from 2005 to 2007. Meanwhile non - P4P facilities also demonstrate low rates in ANC attendance. Given the importance of tracking preventive health interventions as a measure of identification of management and risk prevention in pregnancy, such indicators are of utmost importance in this regard.

Table 21 Health Centre OPD rates (2005-07)



The P4P project uses the standard utilization target of *0.6 visits per person per year* for rural health facilities. Comparing P4P and non-P4P facilities, none of the HFs reach the national target of 0.6, but the utilization rates have actually improved remarkably in the non-P4P facilities. The utilization rate for Memawage Health Centre (M) has increased since 2005, though its not possible to compare this figure against the P4P verified trends, as catchment population figures differ between the Cordaid P4P indicators and the evaluation figures. However, based on the above table there has been a notable increase in utilization from 2005 (0.27) to 2006 (0.47) with a small decline in rates from 2007 (0.43) despite the introduction in flat rate user fees in February 2007. Nkwenda Gov HC has low attendance due to shortage of drugs and water shortage, while the fee of (TSH3000), for non CHF members may also be a deterrent in using such facilities.

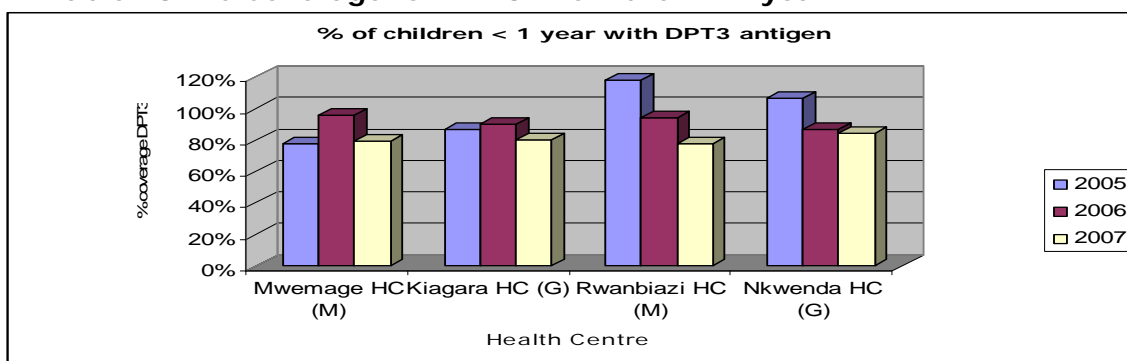
Table 22. Health Centre Total No of deliveries (2006-08).



Institutional deliveries are compared using total numbers due to the variance in reported denominators for pregnant women/catchment and service populations. Based on trends using actual numbers of deliveries, there is a notable decline in P4P facilities in the 2006-07 comparisons. The non – P4P shows an increase in institutional deliveries from 2006 to 2007. The presence of trained midwives largely accounts for the high productivity level at Kiagara HC, with a new maternity ward.

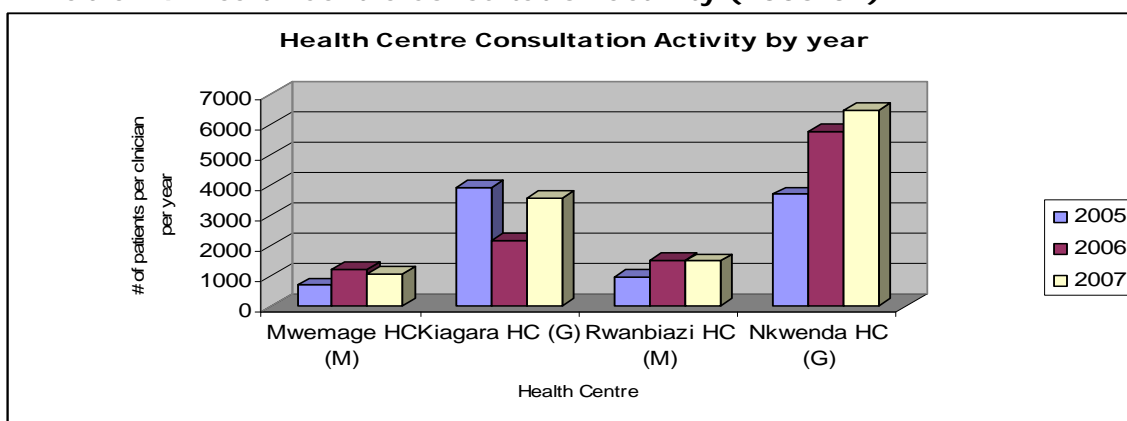
In respect to ANC attendance, maternal the proportion of women receiving ANC is remarkably high which may be due to women attending from outside the catchment area. We have therefore not used ANC to represent health centre level preventive activity. However, as with hospital ANC we question the quality of ANC provided. We have therefore looked at DPT3 as a proxy for EPI coverage for children < 1 year as a non – P4P preventive indicator.

Table 23 HC Coverage for DPT3 in children < 1 year



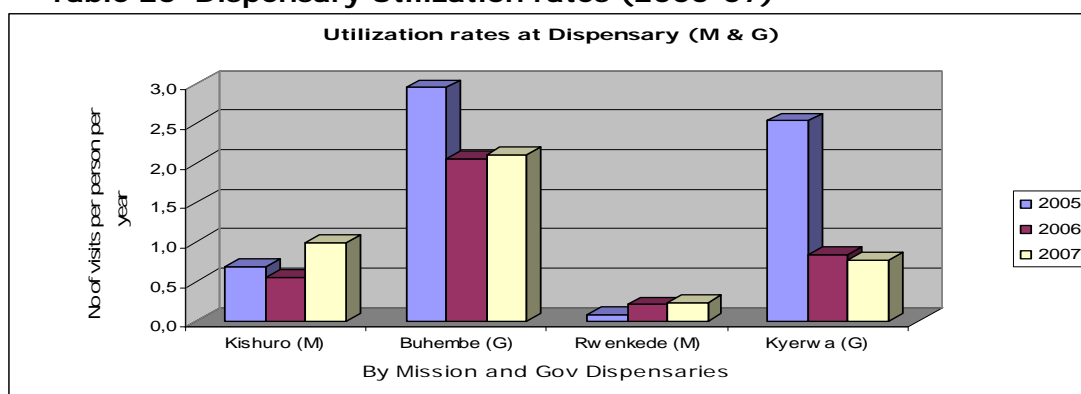
Based on the TDHS 2005, a total of 71% of children 12-23 months are fully vaccinated. By 2007, given the investment in EPI, we would therefore expect to find high coverage for DPT3 as a proxy for completion of the six antigens. Based on the above table, all health centres report high coverage rates but the higher than expected coverage may be due unreliable service population denominators. However, most health centres reported high level of activity for EPI consistent with the district and central MOH interviews whereby EPI has indeed received adequate resources as a national program. We would therefore not advise this to be used as a preventive indicator in P4P projects.

Table 24 Health Centre Consultation activity (2005-07)



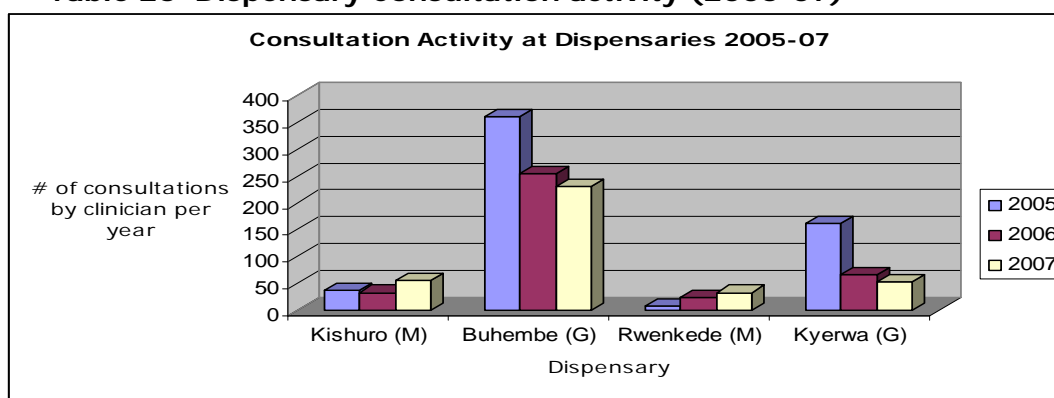
The P4P health centres demonstrate relatively low productivity rates with higher total activity for consultation at non-P4P HCs. This does not provide us with indications of quality of consultation where Mwemage scores higher than Kiagara in overall conditions and quality of consultation. In Rwanbiazi HC, there are only 2 qualified clinical officers, while in Nkwenda (G) the productivity is high, the quality of care is low with lack of essential equipment and supplies noted during the visit, this is further elaborated in the quality of care section later in the report. Rwambaizi is not involved with CHF and as with other FBO health facilities, members in the catchments area can not utilise the services by using their cards until an agreement is concluded with the district health council. The membership of CHF is currently under negotiation.

Table 25 Dispensary Utilization rates (2005-07)



Based on the target of 0.6 visits per person per year, there is a wide variance across the P4P and non-P4P dispensaries, due to (i) users from outside the catchment area attending (Buhembe and Kyerwa government HFs) (ii) construction of new dispensaries and subsequent division of catchment population by district health council (Kishuro (2007-08) and (iii) movement of qualified staff. A notable decline in attendance at Kerywa DC from 2.54 visits per person per year (2005) to 0.78 (2007) could be attribute to lack of qualified staff and thus users travelling to other nearby health facilities. The increase of attendance at Rwenkede from 0.08 (2005) to a 0.23 (2007) followed the posting of a clinical officer to the facility on a permanent basis.

Table 26 Dispensary Consultation activity (2005-07)



The productivity of consulting staff and daily consultations are highly variable at dispensary level as explained due to qualified staff movements. The non-P4P dispensaries have higher productivity but again this must be compared with quality of care indices to determine the quality of treatment for the user. In the case of Bukoba district, both the P4P (Kishuro) and non-P4P (Buhembe) had high standards of care while Kishuro had 3 clinicians with only 2 at Buhembe.

3.2.2 Performance in terms of quality of care

Quality of care study focuses on two major aspects;

- (i) Observed quality of care at the facility level by the evaluators
- (ii) Client interview to elicit perceptions of quality of care

Table 27 Quality of Care Score Index for Health facilities;

(i) Observed quality of care at the facility level by the evaluators

The Quality of Care Score Index was used as a means to establish benchmarks to compare the mission and government health facilities using common quality assurance indices (infrastructure, privacy, laboratory function, patient flow, action plans and communications systems). Additionally, the evaluators studied the MOH HR norms and compared them to the current staffing levels complemented by discussions with the management regarding staff capacities and skill levels. This enables us to provide insight into the current level of functioning of both P4P and non-P4P health facilities.

Quality of Care Score Index (Scale of 1-3)	Hospital				Health Centres				Dispensaries			
	M	M	G	M	M	G	M	G	M	G	G	M
Conditions for Q/C	Rubya DDH	Ndolage (Lutheran)	Nyakahanga	Isingoro	Mwemage	Kiagara	Rwanbiazi	Nkwenda	KishourO	Buhembe	Kyerwa	Rwenkende
1) Building is correct, functional/ well maintained	3	3	2	2	3	1	1	1	2	3	1	1
2) Patient flow in the HS is correct	3	3	1	1	3	2	1	1	2	3	1	1
3) Privacy and comfort of patients is guaranteed	2	2	2	1	2	0	2	1	2	2	1	1
4) Functionality of the laboratory	3	2	2	2	2	1	1	1	2	0	1	1
5) Action plan for Q/c, Q/a available	0	0	1	1	0	0	0	1	0	0	0	0
6) Communication system is available and working	3	2	2	1	1	1	1	2	2	2	2	0
7) Right skills-mix and right-size of human resources in place (according to nat. norms)	1	2	1	1	0	0		1	2	2	1	1
Total quality of care score index	2	2	1,5	1,2	2	1	1	1	2	2	1	1

- A quick analysis of the overall results demonstrates that the mission hospitals have higher scores on functional buildings, privacy and patient flow if compared to government health facilities. Direct observation confirms that most mission facilities have high standards of environmental hygiene, infection control and organization of the service areas. In contrast, government health facilities are frequently facing space shortages (overcrowding of OPD and wards), water shortages (in many cases no water supply), few cleaning products and limited attention to making the public facility conducive for the users. There are some exceptions (Buhembe Dispensary) whereby government facilities were better managed.
- The software supplies in the form of action plans, communications systems and skills mix (HR) are however equal for both mission and government facilities, which suggests that both mission and government hospitals have similar challenges in terms of improving planning, communication and HR skill mix.
- The dispensary level shows least divergence in scoring, where Kishuro and Buhembe (G) scored a total of 2 but Buhembe government dispensary actually scored higher for functional building (3) and for patient flow (3). This government dispensary exemplified remarkable

management and overall staff commitment to work with limited resources. The efforts were primarily due to (i) good management (ii) adequate resources and (iii) good access by patients which maintains high utilization. The staff reported that this is the main incentive for them to perform as they are very busy with current utilization of 2.37. This example demonstrates that in the absence of P4P, it's also feasible to ensure minimum standards for quality of care for the users.

(ii) Client satisfaction and quality of care;

P4P is based on the premise that with improved staff motivation levels, the quality of care will improve and thus client satisfaction with healthcare will be enhanced. The Bukoba District community study undertaken, in 2007²⁸, used extensive household interviews to assess quality of care and satisfaction levels of the client were elicited focusing on malaria and maternal health.

The results of this survey based on user's perceptions show similar findings for Cordaid supported HFs (84% satisfied) while non-Cordaid (government HFs) reported 74% satisfaction levels. Equally, there was no difference in reported waiting times which suggests that efficiency of consultation is of similar quality at Cordaid (35% satisfied with waiting times and Govt (28% satisfied. Findings related to the question of competency of provider care yielded no significant difference between the two groups with 77% of Cordaid HFs users reporting to be very satisfied compared with marginally more users of non –Cordaid (80%) perceiving their provider to be very competent. Similar results were obtained for measures of friendliness across the two groups. Access to the HFs (80% were satisfied with the opening hours for both groups) with >86% of clients accessing the services by foot to reach the HFs.

This evaluation study did not have the time to undertake community based interviews with users, but patient exit interviews were conducted where ever feasible. The interviews were standardized and focused on three key questions (a) satisfaction with the service you received today (b) factors that you were not satisfied with (c) cost of service. (See Annex 2 for SSQ)

Results of the patient exit interviews in diocesan and government facilities revealed a number of key findings as follows;

- Clients in most cases were more satisfied with mission supported facilities including the quality of care, consultation and treatment. Some patients traveled from outside the catchment area to mission facilities, as it was recommended by their families and neighbors to do so "A 27 year old man traveled 65kms to reach the mission hospital and paid 10,000 TSH for treatment, he is happy as quality of care was good". Patients were less satisfied with government facility healthcare but government hospitals were more popular due to the lower or exempted fees so patients were often referred from mission health centers to government hospitals for reasons of affordability.
- Waiting times for OPD were between from two to five hours depending on the condition, but patients reported in some mission facilities, that they do not mind waiting if they receive good care. However, some patients reported waiting for 5 hours with fever and pain, the patient

²⁸ Report Of the Out-of-Packet-Expenditure (OOPE) and Client Satisfaction Study in the Diocese of Bukoba, Kagera Region, North-West Tanzania conducted in 2007. The Tanzania Essential Strategies Against HIV and AIDS (TANESA)

flow in many OPD areas was challenged by poor administration procedures as patients flow includes, registration, consultation room, laboratory, consultation room, pharmacy and finally back to the administration for payment. Also, lack of adequate numbers of consulting staff and overcrowding, particularly in hospital OPDs contributes to long waiting times in government health facilities. We conclude that there are no major differences in waiting times in P4P/non-P4P, determining factors include efficiency of patient flow management and adequate numbers of clinicians on duty.

- Cost of treatment was a major issue at diocesan health facilities; most patients interviewed felt that the costs were too high but were left with no option but to pay. One mother with a two year old child paid 6000 TSH for medical consultation and treatment for child at an OPD health centre. One elderly man explained that “he is not a frequent attendant at the mission hospital and he prefers going to the government hospitals, since it’s affordable, just comes for an eye clinic”
- Inpatient services were variable in quality and attitudes of staff according to patients interviewed. One mother reported that “she attends for the child’s treatment since the prices for adults is very expensive. She is happy with the staff attitude, but not satisfied with the hospitals condition reporting “no nets, no place to wash children’s clothes and the mattresses are worn out”

A total of 8 community representatives were interviewed (Total 18 HFs) as they were not always available to coincide with our visits. Few of the community representatives with one exception were conversant with P4P and had limited knowledge of the rationale for its use. They were vocal in highlighting the lack of resources and challenges faced by their local health facility although not directly linked to P4P, but associated with the overall functioning of the health facility. The six main issues expressed by most the leaders interviewed as community representatives were:

- High user fees of Tsh 2,000-3,000/= charges by diocesan facilities was frequently reported, as fees are beyond the means of most households in remote rural villages. This resonates with the overall recognition of the high user fees charged, this issue was raised by Cordaid, thus the effort to encourage flat rate user fees as a means of promoting equity of access and affordable services.
- The shortage of drugs and medical supplies [syringes and gloves] was noted by most members. This was not reflected in many of the mission based facilities and was most noted at the government health centre and dispensary levels.
- All health committee representatives were unanimous in highlighting the staff shortages; they have noted that this is becoming more serious at mission based HFs and are not aware of any solutions by the district council. Housing for staff was seen as one possible solution to attracting and retaining staff.
- High transport fees and cost sharing for ambulance fuel and staff/patient escort during referrals, this was noted by most community members interviewed. In many instances, the local priest uses his car to transport referral cases as there is no ambulance or other mode of public transport.
- One health centre committee member requested that the CHF is introduced to overcome the exorbitant user fees. However, members reported that monies collected from CHF are not yet allocated to the facility by the council
- Lack of blood transfusion services, shortage of water at health centres (most government HCs do not have a regular water supply),

To summarise, the community representatives' interviews note the commitment of the diocese and health workers to ensuring healthcare, they also noted the limited resources available but were not happy with the high user fee rates. Recognition of the staff shortages and attrition of qualified staff was also noted but they do not feel optimistic for a solution to this in the short term. P4P was not well understood by many of the community representatives with the exception of one community member who has supported the process of data collection at the villages and felt that members should also receive a bonus or in kind reward for their efforts to support the health facility.

3.2.3 Performance in terms of multi-stakeholder involvement

Specification of the process and objectives of the P4P reform need to be clearly agreed and communicated to all stakeholders at local, district and central levels.

Based on this recommended institutional arrangement for P4P, all key stakeholders should participate equally and be consulted at all stages from assessment to implementation and monitoring processes. In the case of this project, only the diocesan health offices were involved in the preliminary planning with Cordaid staff. Staff at health facilities expressed a wish to be more involved in the planning process and consulted and involved in the decision making leading which would culminate in a locally agreed contract reflecting their priorities. Meanwhile, the government district health offices do not play a role in the current P4P system although with the advent of the PPP initiative, joint monitoring of all mission health facilities will be undertaken between DHO staff and district council staff. This has already commenced in Bukoba diocese and is proving to be positive.

As yet, P4P is not firmly linked with CSSC, whose role is to facilitate churches social services; including health and policy lobbying at central level. With the signing of PPP service agreements, this has stimulated discussions on the role of CSSC in the P4P initiative as a direct link is made to how they support existing and new developments of FBOs. CSSC Director recognises that they need to build their own capacity internally and have initiated staff development plans and financial management training, as supported by a Dutch Consultancy firm. Additionally, the appointment of a Cordaid funded consultant to support local counterparts in monitoring and verification processes for P4P is the start of mentoring staff in this role. There is more scope for discussions on complementarity with Cordaid in support to P4P.

At central level, in interviews with the MOH, UN (WHO, UNICEF), World Bank and donors, there was limited knowledge and awareness of the P4P project. One WHO spokesperson indicated that it was his first time learning of the project. They did however express a high level of interest in knowing the results of the evaluation study and in gaining insight into the model with a view to streamlining approaches to performance based financing in Tanzania.

3.2.4 Performance in terms of Human Resource Development

What benefits has P4P provided to staff;

To contextualize on the benefits of P4P, its most critical to note that the staff have not received any financial bonus since July 2007, approximately one year previous to the evaluation interviews. In some cases new staff had not even heard of P4P and had never received a bonus. In most cases, staff have only received a maximum of 3 bonus payments (June 2006, Dec 2006 and June

2007) since the inception of P4P The amounts vary according to the level of the health facility, number of staff and criteria for allocation of the bonus.

So given the realities, what impact has P4P on the performance of health workers, management and diocesan offices to date?

Most health staff agreed that despite the low level of reward, P4P has enabled them to communicate better and fosters decision making, by allowing them to decide on the allocation of the bonus. Typically, P4P committees have been set up to decide on how the bonus will be allocated, and meet when the money is transferred to the health facility account by Cordaid. In addition to individual bonus awards, the bonus fund has also been used to provide training, renovation of work place and residential houses and uniforms.

However, the allocation of staff motivation bonus per provider shows inequities in distribution per level of health facility. For example, one DDH reported that with a total of TSH 19,000 paid to staff in a six month period, each staff member received an average of TSH 2300 per month (\$2). A health centre in the same district with 25 staff receive 4000 TSH (\$3) per staff member per month. A nearby dispensary with 3 staff, each receive TSH9000 (\$7) per month. The staff at dispensaries and health centres appreciated the "motivation bonus" but in most cases perceived it as a top-up to their salary rather than a performance bonus per se. Hospital staff considered it to be "something better than nothing" but relative to total monthly salary (eg MD \$550 per month, Senior Nurse (\$300 per month) plus housing provision in most cases.

II Results of Provider Motivation survey at health facilities;

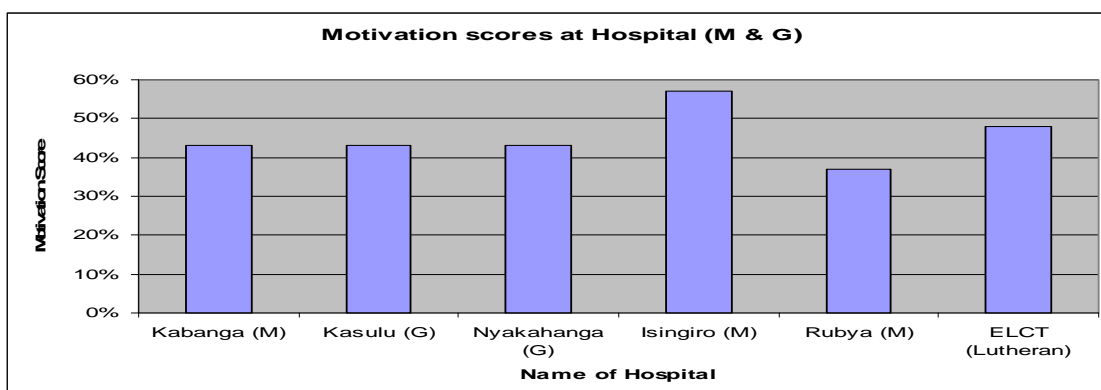
A short motivation survey questionnaire was administered in every health facility visited by the evaluation team to a selection of available health workers. A total of seven factors were included (see Figure 3 below) which staff were asked to rate on a scale of 0-3. Results were then tabulated by health facility and analysed for each facility and an aggregate "motivation score" for each level of health facility was also obtained. Here we present the results by level of health facility in order to compare the hospitals, health centres and dispensaries across the various districts.

Figure 3 Motivation factors for rating by staff

Questionnaire motivation factors study - Percent Satisfaction of the facility providers to scores [0-3] 0 (not satisfied at all), 1 (not very satisfied), 2 (sufficiently satisfied) and 3 (very satisfied).

1. Sufficient numbers of skilled health workers in the facility
2. The working hours
3. Working conditions
4. Team work
5. Salary
6. The P4P-bonuses received
7. The tasks and responsibilities

Table 28 Motivation scores for P4P and non-P4P hospital staff



Health provider motivation survey for Hospital staff;

Most striking is the similarity across all hospital staff ratings with the average score for all the motivational factors below 50% with Isingiro mission hospital at 55%. Providers in both P4P and non-P4P were least satisfied with number of skilled workers at the facility, salary, working hours and work conditions. This response is supported by observation and geographical remoteness of the providers as transport; travel and cost of living are much higher than other parts of the country with limited housing available to hospital staff. Staff were more satisfied with team work, task and responsibilities entrusted to them. In fact, non-P4P hospital staff rated higher on team work (average 70%) if compared to P4P facilities (average 55%), this was confirmed in interviews with staff who explained that the level of autonomy is high in government facilities and may be more hierarchical in diocesan health structures. P4P bonus scored low among hospital staff

Table 29 Motivation scores for P4P and non-P4P (HC staff)

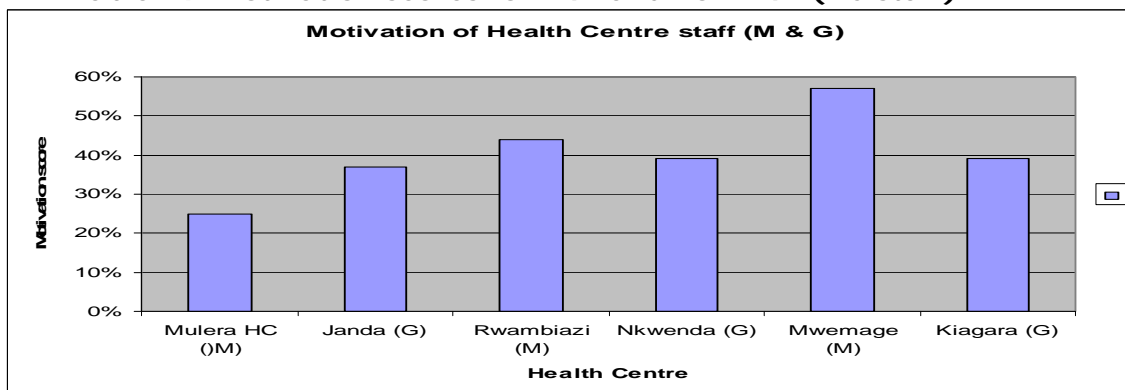
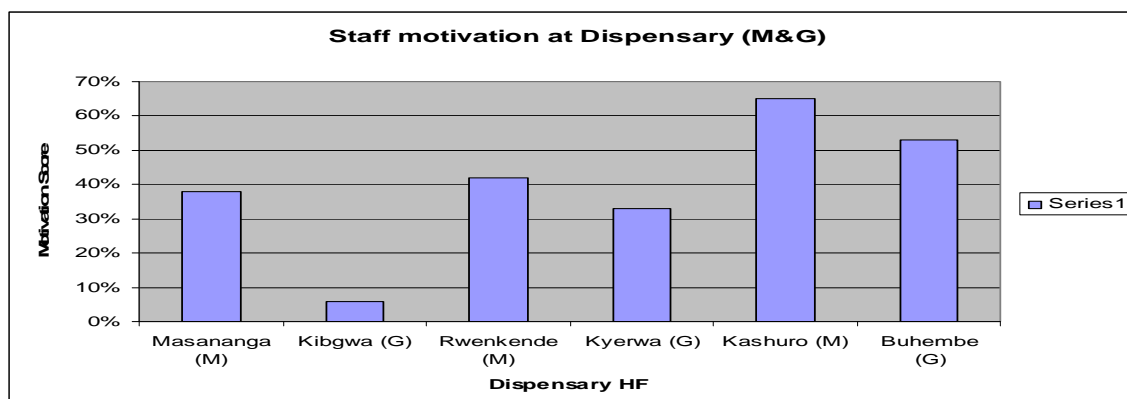


Table 29 shows aggregate motivation scores for all health centre staff. Two of the P4P health centres score highest with government HCs also demonstrating average of 40% total motivational score. Mweru diocesan HC scored the highest total, but also scored highest on team work and empowerment of staff, this was notable in terms of the management style and communications between the staff members. They also felt satisfied with the P4P bonus scoring 91% which is consistently higher for primary level staff compared to hospital staff.

Table 30 Motivation scores for P4P and non-P4P (Dispensary)



For dispensary level staff, they demonstrate wide variation across dispensaries but regardless of P4P effect, one government dispensary shows a high total score where management was instrumental in motivating staff and mobilizing resources.

To summarize the findings of the motivation study it is evident that overall work environment provided is not meeting staff expectations with work conditions (building, equipment), salary and sufficient levels of skilled workers rating the lowest scores for both groups. However, what is most notable, are the higher scores awarded consistently to intrinsic factors, including (i) team work and (ii) tasks and responsibilities entrusted to the individual health workers and of particular note here is that government health workers rated team work and empowerment higher than diocesan staff in many cases. Given the current approach to P4P, it is unlikely to produce positive effects on staff motivation, it has however contributed small scale innovations that reward health workers, this is where potential lies in future to build on these opportunities.

3.3 Probable outcomes

3.3.1 Accessibility of services

“Even if substantial improvements in performance can be achieved through performance based incentives, the approach is still limited in terms of improving access for the poor. People who are not able to pay the user fees will get no benefits from better quality of care or improved drugs supply; (*Client satisfaction survey, TANESA (2008)*).

In order to address the issue of promoting equity of access to healthcare, Cordaid advocated for introduction of a flat rate user fee at hospital level in 2007. Based on other country experiences including Uganda, such a fee system has potential to improve (1) access for the poor (2) efficient use of resources and (3) sustainability of the health provider. Moreover, it should be easy to understand by the population and reduce the administrative burden of the provider compared to current fee systems.

A rather surprising finding from this client study conducted in Bukoba diocese was revealed in relation to satisfaction with user fees with a majority (89%) reporting to be satisfied with the level of user fees adopted across all health facilities²⁹. However, 45% of users were not aware of the amount of fee been

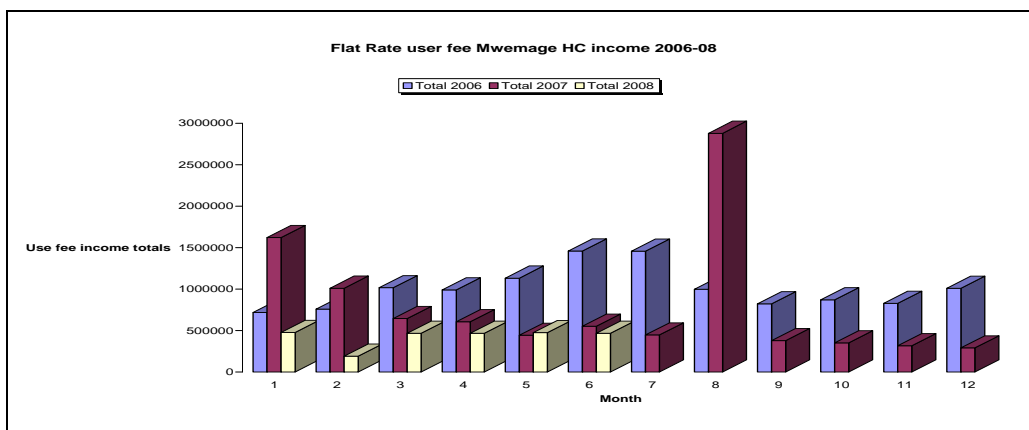
²⁹ The study did not elicit ability to pay by monetising how much the user can afford to pay for service.

charged at HFs, which indicates a low level of community sensitization for cost sharing and agreement on user fee payments. In this case, there was no difference between Cordaid and non-Cordaid HFs.

In November 2006, Cordaid appointed an independent consultant to advise on the adoption of flat rates and allocation of risk funds to all pilot health facilities. Based on the assessment, a tentative fee schedule was calculated based on the current average fee income per case per category and subsequently reduced by 20-25%. This calculation was used as a basis for fee income projections under different scenarios³⁰. The reason for the conservative reduction of the fees was to minimize the financial risk involved. Further fee reductions may well be possible but are not considered at this stage. Subsequently, the loss of income was calculated at 20% while compensation was set at 33% of base funding³¹.

A total of six hospitals and one health centre commenced the use of flat rate fees in February 2007. There is no exemption system but if the patient cannot afford the cost, they are still treated and expected to pay later. We undertook a small case study in one health centre where the flat rate fee was introduced in February 2007 to assess the income trends since adoption of flat rate fees. Cordaid plan to conduct a full scale review of the user fee flat rate pilot in late-2008.

Table 31 Results of Income at Memwage Hospital (Flat rate user fee review)



Results as show in Table 31 above concur with the anecdotal evidence presented by the Memwage Health Centre management team; the HC has experienced a notable reduction in income since the introduction of the flat rate in February 2007. Contrary to the anticipated increase in utilization due to access by the poor, a minor decrease is reported from 0.47 visits per capita per year (2006) to 0.43 (2007). Comparing the income levels by month from 2006 through the successive months since the start of the flat rate fee, there has been a reduction by month with Month 8 (August) presenting an anomaly due to a visiting ophthalmologist which accounts for a marked increase in income.

Options to increase facility revenue from cost recovery may include a re-introduction of selective charges (laboratory, minor surgery, drugs) which would enhance the revenue of the facilities that opted for the flat rate charges.

³⁰ -Introduction of Flat rates under Pay for Performance; *Pilot Phase in the Catholic Dioceses of Arusha, Bukoba and Rulenge. Mission of Mr. David van de Velde (Senior Advisor, PUM), 5-25 November 2006. The actual fee schedule commenced from February 2007.*

³¹ Due to flat rate user fees, loss of income was calculated at 20%. Therefore compensation was set to 33% of base funding. For hospitals this means, 6 million per year in the old setup and 7 million after the review meeting in 2007.

Overall summary of P4P outcomes

Discussion of outcomes on P4P cannot be determined as previously stated, given that the essential pre-conditions were not met and therefore the contracting of health facilities was not fulfilled. It is well advised that the project adopts these aspects for inclusion in the next phase to ensure that the project can benefit from the expected outcomes of results based financing.

With respect to health service organization including management and planning of health system delivery, the P4P has not been instrumental in improving the systems development, due in part to the relatively low level of resources and absence of technical assistance at diocese and facility level. Again, this is an area that requires additional resources in the next phase of the program. Management teams talked of the need for review of policies (HR, administration, organograms) while staff also requested training on HMIS, M&E and quality of care tools. All of these are essential components of a performance based financing system, which require additional resources.

Finally, in terms of community health structures and health outcomes, this project is curative focused with no resources allocated to establishing the community participation structure or direct investment in community health interventions. It is therefore not appropriate at this point to attribute any community demand for services or health seeking behaviour directly to the P4P project.

4 Sustainability

4.1 Institutional Sustainability.

The institutional sustainability can only be guaranteed if there are clear divisions between the various entities involved in the P4P. Roles and responsibilities of the regulator, fund holder and provider should be discussed with all stakeholders and written into contracts, thereby fostering complementary relationships and improved partnerships. Omission of P4P in the respective CCHPs has far reaching implications on its potential for acceptance, scaling up and sustainability within the district.

The Council Health Service Board (CHSB) is the legal instrument of the local government that is responsible and accountable for district health care following decentralisation of the role of services delivery from the central level. The Comprehensive Council Health workplan (CCHP) ensures that the community and all health facilities regardless of ownership are involved in the management and planning of healthcare services of the district. NGO/FBOs health facilities under the Dioceses are required to participate in CHSB and also in the planning and implementations of the CCHP. Members of CHSB, District Medical Officers members of Council Health management teams (CHMTs) and non project church facilities had very limited information on P4P³². The P4P project will have to be included CCHP in order to be embedded into the district and national health system.

It is also nascent within the social services structure of the CSSC system that includes lead agents, zonal coordinators and the central level. There is great potential for CSSC at central level to support policy and advocacy activities that will engender improved collaborative efforts in support to P4P and advocacy for inclusion in national policy.

4.2 Financial sustainability

Concerns are expressed by the diocesan management that if P4P is donor supported, what happens when the funds are terminated? This concern was also raised by several health workers interviewed. If the funding and thus the incentives cease, the situation may actually be worse than it was prior to P4P. Reassurance is provided by other country experiences, that if P4P can stimulate enhanced performance and if the government can see such tangible results there is a much higher chance of adopting it as national policy with government resources as in the Rwanda case.

Given the current institutional developments with the advent of the formal service agreements with official service contracts to be drawn up between the district council the diocese, this will enable faith based health organizations to access more funds from government resources (from MOH regular fund and the basket fund by donor partners) based on the provision of a package of health services. It is also anticipated that with an increase in basket fund allocations to 0.90 per capita which is expected to include the 0.2 allocation for performance financing, there will be more funds available for health service delivery. Cordaid as a donor to the Catholic diocese can complement the government funds in this transition phase of performance financing.

³² DMOs reported that they only became aware of the Cordaid P4P operational modality with the advent of the MOH request for inclusion of the performance financing budget in the 2008-09 workplans. This led them to an enquiry about the P4P and how it works.

4.3 Technical sustainability

The current design of the P4P project does not include extensive technical assistance budgets with the major focus on operational costs for HFs coupled with the performance related bonus payments. Cordaid provide program support from its head office, with one program officer and a financial manager (multi-country), who is dedicated to the financial, administrative and technical support functions. The team visit the project once per year (last visited Tanzania in October 2007) to conduct review meetings.

In-country, elements of TA include, occasional trainings for staff on P4P (provided by the DHO) and on the job mentoring on HMIS during the verification visits (this is an extended role of the Cordaid consultant), and planning workshops for the DHO managers³³. Virtually all health managers and staff interviewed recognised the need for increased technical capacity building. Some of the areas mentioned included; (a) HMIS and M&E, (b) management of P4P including reporting and financial management (c) Health system planning and management. It is evident that this is a major gap within the existing health system functioning; where senior management are overwhelmed with the scale of tasks and have limited time to support and supervise their teams. Extension of this role to include on site technical advisory services is vital to support the capacities of the diocesan offices, health providers and facilitate links with the district health councils.

Capacity building for supervision and line management currently consists of DHO level quarterly visits to HFs. No training has been provided to these managers as yet on how appropriate planning and management as related to P4P, with the exception of discussions held at review meetings. As most of the health coordinators are senior people with experience within the regional and/or district health systems, they usually improvise and endeavour to do their best with limited support. The financial and administrative oversight is provided by a the diocesan treasurer who is tasked with the management, fund raising and representative functions on behalf of the Diocesan Health Board.

To ensure strong organizational accountability and transparency, the current contracts (service agreements) need to be expanded to include roles and responsibilities of the various stakeholders. The issue of verification needs further consideration as currently the verification is limited to audit of the HMIS to determine the veracity of reporting against the five performance target indicators. There is no community verification which fosters communication between health facilities and the health providers. This should be an integral activity within the monitoring framework. As part of the transition to district council ownership, elements of monitoring, verification and evaluative processes supported by Cordaid can be adopted by the district health system within the newly introduced "bonus for results" framework. In the medium to longer term, this will enable district health teams to conduct the monitoring (supervision and QA) of all health facilities under their jurisdiction.

Based on the above scenarios and need for increase technical support, it is evident that as yet there is no model for technical sustainability within the project. Further attention needs to be given to conducting organization capacity assessment, specific training needs assessments and determining the priorities for resource allocation to respond to the needs identified.

³³ A total of two workshops were supported by Cordaid; (Mwanza, Nov 2005 and Dar Es Salaam, October 2007) to plan and subsequently review the P4P implementation.

5 Discussion and conclusions

5.1 Discussion

5.1.1 Conceptualisation

The basic principle of P4P is “the money follows the patient”, if health facilities attract more patients and provide quality services they will receive more subsidies and incentive payments on a scheduled basis (quarterly or bi-annual). This in turn has potential to transform health workers productivity towards improved quality of care and thus improved health outcomes for the population. The current P4P project was informed by the previous Cordaid supported performance based projects in the Great Lakes region which demonstrated success in terms of increased utilization and quality of care for the populations served. This evidence was a catalyst to the introduction of a similar approach in Tanzania in 2006. The conceptualisation of P4P was undertaken through a series of meetings and a formulation workshop (Mwanza, November 2005). Given the previous input based approach which was characterised by limited transparency and accountability, the shift to an output based approach required a full situational analysis in collaboration with all local stakeholders. More time was required to deliver such a contextualised model for performance based financing.

The opportunity of introducing a comprehensive P4P approach was compromised with little of the design architecture seen in Cordaid's projects in Rwanda and DRC, in operation here. The question also arises, if the baseline assessment took account of the unique contextual factors that would inform the application of the design and implementation. As the essential principles of a contracting approach are not in place, its not appropriate to delineate expected outcomes based on the current application.

In order to address the conceptual aspects (management and operational) of the project, the evaluators attended to the supply and demand side services to explore the current status and how P4P was envisaged to contribute in the medium to longer term to improved health outcomes. We commence with the community, followed by analysis of the health service issues and draw conclusions on links to the organizational framework (financing, sustainability, accountability) within which P4P is currently implemented:

Is P4P serving the community interests?

The major gaps in the current project include, lack of community participation with limited community representation on the health management committees for decision making and feedback from the community. Also, there are no tools used to elicit community voices on their perceptions of health services (patient exit interviews, client satisfaction studies³⁴). Indeed, it is noted in health financing studies, that there is a threat of supply induced demand (promoting treatment as opposed to prevention) as the need to meet utilization targets exist. As malaria is one of the main diseases within the target communities, there are no current efforts to reduce this disease burden through malaria prevention and control activities, but the measure of utilization of HFs is largely accounted for by malaria (estimated at 40% of the total disease burden but with seasonal variations). It's very likely that local stakeholders would have selected this as a priority in view of its significance to their community.

³⁴ One study has now been undertaken on client satisfaction in three dioceses (TANESA, 2008). The report is still in draft and not for circulation.

Is P4P impacting on utilization of HFs?

The assumption that P4P will increase utilization patterns is in question. In this context, fluctuations in utilization patterns were caused by division of catchment populations by the district council (causing an increase or decrease in users), impact of malaria vector control (residual spraying) in Muleba district caused a notable decrease in malaria incidence (thus a reduction in overall utilization rates), staff attrition and in particular the lack of doctors and nurses in certain health facilities created gaps in quality consultation (thus a drop off in HF utilization), changes in user fees and introduction of the flat rate would increase access especially by the poor. Adoption of the flat rate user fee does not seem to have contributed to increase in utilization based on the participating facilities reviewed. Further analysis is required to determine what if any changes have occurred when compared to prior access and utilization patterns within the pilot health facilities.

Is there a link between performance and the bonus?

A common assumption made is that the performance bonus will enhance health worker motivation and thus improve the health service outputs for the users; based on interviews with health workers, the majority have a basic understanding of the concept of P4P and how it works within their health unit. However, there is a gap in the conceptual link between performance and the applied bonus. Most of the staff at health centres and dispensaries see it as a "top up to their salaries" when they get it and additional money to spend on inkind activities. The gap in bonus payments whereby staff has not received a bonus for one year has not helped with their recall of the benefits and the advantages of P4P.

Is there a Business Plan developed?

The business plan or service contract is usually based on the terms agreed by the fund holder with the regulator and provider. In this case, a comprehensive business planning process to include the district councils, representation of providers and management teams was not done. The main tenets of the service agreement therefore include the inputs and outputs agreed at the Mwanza (2005) meeting. The service contracts were subsequently developed by Cordaid and the intermediary fund holder (Diocesan office) received the "agreement" from Cordaid in 2006 at the commencement of the project with a revised agreement developed following the review meeting of October 2007. The specification of targets and outputs were not agreed independently with each health provider, this means that they are obliged to accept the conditions rather than be instrumental in determining their own priorities, yet expected to perform to meet the prescribed targets. Ownership is therefore excluded by virtue of limited engagement.

What is the role of CSSC?

Currently, CSSC engagement with P4P is limited, with no clear role specified in the contracts. Participation has therefore been limited to attending the review workshop with more recent (June 2008) appointment of a Cordaid consultant to support training and mentoring for verification of P4P. In line with the forthcoming service agreements, and ongoing support to the five dioceses in the next phase of the project, CSSC has potentially additional roles such as policy and advocacy for development of the P4P approach with government.

What is the funding status of P4P?

Currently Cordaid is providing Euro 0.5 per capita which includes 50% as base funding for health facilities (recurrent costs) and 50% for performance bonus. The funding for the P4P is sourced from a mixed donor pooled fund managed

by Head Office in The Hague. They envisage that the next phase will have additional resources in order to pilot innovations in one of the five dioceses (Subawanga)³⁵ as part of the PPP service agreement plan. This will provide an opportunity to build in a pilot for handover to the district health council, which can in turn be scaled up to other districts over a 3-5 year strategy. Additionally, the diocesan health boards are interested to mobilize increased resources to support the delivery of the health services while some hospitals also expressed the need for increased private fund raising efforts.

5.1.2 Results

In this section, we explore the results and associated conclusions based on this evaluation study while taking stock of confounding factors associated with implementation of P4P. Again, we use a framework informed by the methodology starting with the health provider (who is the primary beneficiary of the P4P) with a focus on their motivation level, and effect on productivity and quality of care as indicators of improved access and delivery of healthcare. We also conclude on some findings based on both secondary data (research studies) and primary data from the evaluation of how the community perceives the services.

Essential Health Package;

The EHP is the basic package of health services developed by the MOH, although not uniquely linked to P4P, it forms the core of what health facilities should provide to their patients. The Diocesan health services under the auspices of the DHO and the Diocesan authorities, are implemented broadly in line with the national health strategy and essential health package. Due to resource constraints, faith based ethics and parallel management processes, the health services do not meet all of the essential elements outlined in the EHP (2000). For example, the reproductive health package does not include artificial methods of contraception (OCP, injectables and condoms) as they advocate for natural family planning methods. Other elements are compromised by resource constraints whereby outreach services are limited within immediate service coverage area for EPI and ANC. Preventive health care is limited as current HF budgets do not cover malaria control (ITNs), school health education and water and sanitation promotion. Any community health interventions (eg, Rubya Hospital) are funded under the CCHP as based on requests to the district council, however these are also limited in scope due to limited budgets.

Health service utilization and P4P; Based on this study which draws comparisons between diocesan supported HFs (P4P) and government services (non-P4P) over the three years (2005-2007), there are no remarkable improvements in the delivery of health services since the inception of P4P. A conclusion that was voiced at the review meeting in October 2007 stated that "with the exception of a few H/Fs, P4P has not yet generated the boost, the challenge for innovative strategies to increase output and improve performance". The evaluators concur that given the current design of P4P as implemented, it is not possible to expect health outputs and outcomes that can be directly attributable to P4P. While the principles of P4P are sound, the practice requires more thorough attention in line with the pre-conditions to operationalise it and ensure its success.

Performance targets; the current five indicators that are used to measure performance are uniquely service supply focused (IPD, OPD, institutional

³⁵ Cordaid submitted a proposal to the EC (June 2008) for scale up of support to Subawange Diocese for promotion of sustainable financing and organizational mechanisms.

deliveries, drug stock outs and VCT). Most staff advocated for consideration of use of other indicators (eg malaria control, ANC, outreach activity). The use of supply side only indicators potentially creates a perverse effect whereby they encourage increase in patient utilization rather than considering reduction in burden of disease. Perverse incentive effects are difficult to measure and cannot be verified fully in this case.

The major problems encountered with the use of the indicators include (a) Use of VCT as an indicator is not useful given the current impetus to support VCT service and its use, while also consideration of the quality of counselling and testing conditions should be included; frequently the HIV test is conducted with inadequate patient information and consent. It was witnessed in one government health facility where all pregnant women attending ANC were tested for HIV while sitting in one room with a nurse. (b) the use of drug stock outs has led to some health facilities using separate drug cupboards for the “ P4P drugs” ; this leads to fragmenting the drug management system The choice of this indicator does not support a systems approach of improved drug supply management.

Perverse or neutral incentives; A concern noted by other researchers in the context of individual performance incentives for health workers, is the possibility of undermining the natural values and motivation with provision of extrinsic incentives; if workers expect to be paid (or praised) for good performance then they may or may not be motivated in its absence. Additionally there is a risk that the health workers perceive it to be yet another entitlement or top up with a neutralising effect once the incentive becomes established as part of their income. Under 50% of staff reported satisfaction with P4P bonus and qualified this in focus group discussions stating that the performance bonus in most cases is insufficient and received very late or with large intervals (last received in July 2007) so they don't feel that it sustains their motivation directly. Indirect benefits are of an intrinsic nature whereby it has stimulated improved staff-management communication and empowered staff in decision making regarding the bonus allocation criteria.

Intrinsic benefits to the health staff: The shift in organizational culture to a more results oriented way of working has demonstrated increased levels of staff motivation (self reported and via direct observation) and has in many instances promoted empowerment of staff and management where staff felt they were more actively involved in decision making. This concurs with the findings from the motivation study which shows higher ratings for team work and tasks entrusted to staff in select health facilities.

Technical Assistance; A major vacuum exists in the senior to middle level management and skilled health workers (doctors, midwives) across all dioceses. As a consequence, the administrative, financial and procurement capacities are overwhelmed within the diocesan offices and within the target health facilities. P4P assumes certain pre-conditions including; (HR capacity and skills, financial/administration skills), a baseline needs assessment would have supported identification of gaps in skills levels which would require capacity building. Resources to support building of capacities were not identified thus leaving a gap in comprehensive technical assistance in P4P.

Quality assurance systems? There is no standardised quality assurance system in place at mission or government health facilities. The MOH have developed supervision checklists but they are not routinely used by district supervision teams and if used they are not followed up. Diocesan health coordinators do fulfil the quarterly visits to supported HFs but do not always

use the MOH standard supervisions checklists and do not always follow up on the problems identified in previous visits.

Changing role of Diocesan Health Office; The role of the DHO staff has changed with the advent of P4P. Historically, an input based funding modality was used by Cordaid; this resulted in limitations in reporting and monitoring; with annual reports serving as the main method of reporting. The volume of monitoring and reporting has increased (six monthly narrative and financial reports, verification reports, mini-proposals for top ups), this has increased the burden of administration on the DHO offices. In some cases the staffing levels reduced with the advent of P4P (2006) while the health coordinators assumed dual role of P4P coordinator and zonal coordinator (33% LOE) for CSSC. This in turn has increased the administrative and liaison roles of the diocesan offices while they have witnessed major cut backs in their income, this is not a viable scenario in future.

Cost Effectiveness of P4P; The debate on the cost effectiveness of introducing and scaling up performance based financing approaches points to the costs of implementing such system. It also raises the question of shifting the priority to productivity rates which may compromise improving quality of healthcare delivery.

The key objective is to provide sustainable and equitable healthcare that is cost effective and efficient through adopting appropriate health financing mechanisms that are tailored to Tanzania context. In the context of P4P in Tanzania, it is not possible to determine the actual transaction costs of the project due to gaps in vital financial information and inconsistency in budget tracking across diocesan and Cordaid offices respectively. In order to verify if the project is indeed cost effective, more financial information is required and the evaluation would recommend a review by the end of the project period.

5.2 Recommendations

5.2.1 On the P4P approach.

1. Conduct a reappraisal of the current P4P with a view to redesign of the organizational and operational approaches for the next phase, involve health providers with other significant actors including; (district health council members, MOH, WHO Health economist) who can advise, support and actively participate in the planning process. Review the relative allocation of base and bonus funding, in line with the categories of hospital, health centre and dispensary funding.
2. With the advent of district wide ' bonus for results approach' as regulated and monitored by the district councils, Cordaid should discuss the plan with the respective district health councils on their current level of interest and engagement with P4P. In the longer term, consideration for transfer of ownership to district councils needs to be initiated with potential for development of a solid partnership for co-financing of P4P.
3. Review the role of the Diocesan Health Offices in line with No 1 and 2 above, and allocation of resources to augment the low level of current income.
4. Cordaid in collaboration with the DHOs need to consider the future role of the fund holder and how to transfer the authority to a national/local institution; with a view to moving toward national ownership.

5. P4P has shown potential to act as leverage for initiating innovative and proactive management actions that will motivate the staff. Health facilities should be given autonomy to decide on how the base and bonus funds are spent so they can use them in line with the priorities identified at facility level.
6. Adaption and improvement of existing systems are required for monitoring and verification of outputs, development of contracts with the health providers, data collection and periodic audits. The verification system is well organized but needs to be less labour intensive and linked to built in technical assistance for HMIS/QA.
7. Extend the verification system to the community to include; client satisfaction interviews, focus groups discussion with target groups, (eg women users) and annual reviews with community groups.
8. Build in an operational research component to determine the contribution to health outcomes and impact over time, to a sustainable strategy through documenting lessons learned and disseminate to all parties interested in P4P incountry; including district authorities, MOH, CSSC and private health providers.
9. Develop a tool kit (expanded implementation manual) on the organizational an operational steps to effective performance financing. Include guidelines on suggested modalities for bonus allocation, based on experiences from P4P committees,
10. Review the role of CSSC and determine the potential for assuming the role on tasks such as advocacy and monitoring of the P4P linked to documenting of the practices on improving access to healthcare for the poor and hard to reach communities.
11. The current project is running at 0.5 per capita for the full package including contribution to operational costs. Further analysis is required of the transaction costs to determine the range of P4P overhead costs thus make an analysis of economy of scale and total transaction cost for the project.
12. It is timely to consider the development of a transition plan to cultivate ownership of P4P by the district health councils. The introduction of a 'bonus for results" approach nationally is also an opportunity to link in with the mainstream development of performance based financing. Cordaid in support to its local diocesan partners are positioned to assume leadership at district level in provision of technical support to the district councils for P4P implementation and monitoring.

5.2.2 For the program

1. Provide technical assistance to ensure an appropriate design of the P4P program: to introduce an appropriate institutional architecture, responding on the one hand to the national and contextual factors and on the other hand to the basics in the P4P or contracting approach (separation of responsibilities). Ensure that all actors are on board, that there is informed consent. Introduce appropriate instruments needed for P4P. Agree on an appropriate distribution of roles and tasks between different stakeholders. Ensure participation of national/ policy making level from the start on the approach and process of P4P.
2. Rethink resource allocation to essential preventive interventions that will attend to priority morbidities, (e.g., Malaria, diarrhoeal disease, TB); this will be inclusive of demand side incentives which will encourage women and children to access services appropriate to their

needs. This can be achieved via input or output funds but linked to the district comprehensive council workplan priorities.

3. Strengthen the quality of care at health facilities, through introduction of standardised approach to quality assurance (tools such as LQAS, Client oriented provider efficient), these will aim to focus on key quality of care indices across all health facilities.
4. Strengthen HMIS through a full scale needs assessment of current capacities (TNA), prioritise training of essential staff followed by all other users. Use HMIS quality as an indicator for performance bonus thereby linking strengthening of HMIS approach to performance targets.
5. Strengthen participation of state and non-state actors at the level of (i) local government, (ii) P4P steering committee; ensure regular meetings and document action plans and outcomes.
6. Promote greater accountability to the community by the health providers, through use of feedback mechanisms and regular meetings and annual reviews with the community.
7. Develop a capacity building plan; the health providers and managers are in need of urgent TA, to include planning and management skills, HMIS and M&E, financial management training.
8. Advocate and act to ensure improved access to services by the poor, through review of the flat rate user fee, promotion of alternative health financing mechanisms and advocacy to the MOH and donors. Explore with CSSC in terms of their role in advocacy and policy development for pro-poor strategy implementation.

Annex 1 Terms of Reference

Formative Evaluation; Performance Based Financing in Cordaid (supported) projects in Tanzania

A. Introduction

In many low income countries with high disease burden, health systems are not responsive to the health needs of the population, due to low human resource capacity, poor infrastructure and technology resulting in poor coverage and access to quality health services by the catchment population.

Cordaid aims at improving the access and quality of health services for people in low income countries, with emphasis on the poor and vulnerable. Reducing poverty also means changing power relations. Empowerment of the users of health services and enhancing the performance of the health work force are seen as important prerequisites for sustainable improvement in accessibility and quality of care.

Cordaid's main strategy is supporting partner organisations through capacity building. Where local partners are not available, as for example in some (post-) conflict countries, Cordaid implements programs by itself. The organisation adopted a programmatic approach, intervening at three levels: direct poverty reduction, civil society building and policy influencing. Cordaid assists in developing new innovative, approaches in order to achieve its aim.

One of these new approaches used in supporting health developments is Performance Based Financing (PBF). PBF means financing of health care based on results that are measurable and agreed upon in contracts. This is in contrast with many still existing systems within de-concentrated health services, being based on input planning and financing. So far PBF seems theoretically having many advantages compared to the classic input based planning and financing model. This however is based on assumptions, often context specific and depending on the way PBF is operationalised. On the other hand PBF is questioned internationally for bearing a number of important risks.

In Tanzania, Cordaid started introducing Performance Based Financing in 2006 through the P4P –project (Pay for Performance). In this project, the focus shifted from merely input based support in five dioceses, towards a results based scheme with five indicators (IPD, OPD, institutional deliveries, VCT and stock outs of essential drugs). The total target population is estimated at 2 million and the average per capita investment is \$0,5. The scheme covers hospitals, as well as health centres and dispensaries. In a few cases, extra incentives were given for the introduction of a flat-rate for admissions and consultations.

In the context of “linking and learning” within Cordaid’s program Access to Health and on the basis of its PBF position paper 2007, Cordaid initiates a process of formative evaluation and linking and learning with and among partners. Cordaid is implementing the PBF approach in a number of Sub-Saharan countries and has expressed interest to evaluate systematically its PBF projects with the aim to analyse findings to date, document lessons learned and share lessons with all stakeholders involved. It has invited the Royal Tropical Institute to coordinate and supervise this review. The World Health Organisation has shown keen interest to accompany Cordaid and KIT in this exercise.

Key assumption in this systematic formative evaluation is:

Provision of incentives to health service provider for meeting agreed health service delivery targets will result in increased access to quality health services for the catchment population, enhances participation and influence in health care provision by the users of the services (and consequently suiting the needs and priorities of the poor). For this reason PBF is a suitable approach for Cordaid to support and lobby for.

This assumption can be split into the following assumptions:

On Direct Poverty Alleviation:

- *Health service providers will increase productivity by actively contacting clients through out reach services*
- *Health service providers will improve quality of services (through buying knowledge and skills) to increase utilisation of services and hence incentives*
- *The provider/purchaser partition increases the efficiency of the health care system*
- *Fees will decrease by using PBF*

On Civil Society building

- *Communities involvement in monitoring outputs and quality of services will have direct influence on quality of services and users choice on provider (if choice is available)*
- *Capacity building needs reveal from the quality assistance monitoring and community feedback and form a comprehensive output monitoring status*

Testing these assumptions requires studying grey literature and defining conditions and potential risks of PBF. Some of these are listed in Annex 1. Annex II provides a short overview of Cordaid's present PBF supported project activities in DRC (Katana and Kananga), Tanzania, Zambia and Burundi. Rwanda concerns a desk study only. Annex III provides background on terminology used.

B. Overarching objective of the multi country review

The multi country evaluation will consist of 3 components. It starts with a desk study involving grey literature, relevant project documents and reports, followed by country specific evaluations. These countries differ in that some are so called fragile states and others are more 'stable'. In these countries different approaches were used. Therefore the evaluations are conducted on basis of country specific terms of references and bear elements of accountability studies (what has been the effect of the PBF approach towards achieving the overall aim). For comparison all individual country studies will fit in one overall framework, which is this terms of reference.

Findings of these country evaluations are fed back to the respective partner organizations and Cordaid liaison- and project offices.

The third component in this evaluation process is an analysis and comparison of the separate country evaluation documents, using the overall framework to answer the question: what can we learn from applying PBF in different contexts? Is PBF in general a suitable approach for Cordaid to use, considering Cordaid's vision? Which conditions are more favorable to PBF?. Findings of this third component will be shared with all stakeholders within Cordaid and in various countries.

Overall aim:

What can we learn so far from the results of Performance Based Financing support on the improvement of quality and accessibility of healthcare for the poor and vulnerable.

Specific objectives for the Tanzania P4P evaluation

- To which extent have determinants be taken into account in the situation analysis at time of defining the program (perspective health consumers, providers, policy makers, national policies /guidelines, gender issues, HIV/AIDS, are priority problems addressed)? Which determinants have been identified and integrated in the project and project indicators? Have these determinants consistently been taken into account during the implementation of the program? In relation to this, what has been the relevance and appropriateness of the interventions chosen from the perspectives of government, donor, implementers and beneficiaries?
- What has been the aim of the project in terms of efficiency and efficacy?

Based on this what can be said about the actual:

- Input: -resources used, incl. government (transaction costs versus providers payments)
 -level of TA required (short term/long term)
- Output: -performance of health services in terms of productivity
 -performance of health services in terms of quality of care
 -geographical/financial/socio-cultural accessibility and utilization of services
 -accessibility of services (geographical/financial/socio-cultural)
 -extent of sustained involvement of the users
 -organizational management of health services, taking in account gender aspects
 -human resource development (capacity building, staff retention, skills-mix)
- Outcome: -appreciation of indicators (trends towards expected impact)
 -analysis of household studies (trends towards expected impact)
 -accountability to the user, including the level of involvement of the users
 -effect on health system organization

- Can conclusions be drawn with regards to probability on basis of results of household surveys and project outcome? Can conclusions be drawn with regards to the impact of flat rates, which were introduced in five hospitals?
- To which extent did substitution of utilization take place? In other words, if utilization in the participating facilities increased, did the utilization in non-participating facilities decrease?
- What is the likely sustainability of the results achieved? Sustainability can be measured in terms of financial dependency and level of support from others. But also the level of embedding in the national system: does the project cohere with policies of the Ministry of Health or has separate vertical systems been realized?
- Is P4P institutionalized properly?
- Can conclusions be drawn regarding the purchaser-provider split?
- How is the scheme appreciated in terms of complexity? Is clear how P4P works and how incentives can be obtained? Is the number of indicators optimal? Is it clear how targets are calculated?

- Which conclusions can be drawn concerning the usage of catchment population as an important denominator?
- To which extent has the capacity of the organization be improved with regard to technical and managerial capacity?
- What has been the quality of M&E of the partner organizations? This concerns adequacy of indicators, and quality of collection, analysis and use of data.
- How can PBF be summarized in terms of Strength, Weaknesses Opportunities and Threats in the project? What can be concluded considering the applicability in the various contexts/countries?

In terms of Linking, learning and lobbying:

- What have organizations been doing to enhance linking and learning in order to enhance their operations?
- Have organizations targeted policy influencing in the field of PBF and what has been the result?

C. Methodology

The review will consist of 3 components being a desk study, followed by country specific reviews. The specific country study for Tanzania will be done by: 1 local consultant, 1 international consultant (KIT; Royal tropical institute) and 1 participant from another program to be evaluated and will be coordinated by KIT.

Tasks of the local consultants include:

- Preparatory work (collection of data & documents) – 1 week
- Visit stakeholders at 'central level' (MOH, MOF, EFA's), discuss national policy issues, together with international consultant (2 days)
- Visit diocesan health offices & local stakeholders, analysis doc's and HIS, together with international consultant (2 days)
- Visit selected clinics/ HC/ Hospitals: staff and local stakeholders: data collection, interviews, analysis operationalization PBF, together with international consultant: 4 days
- Development aide memoire (collecting of results and findings)- to support analysis in each review during the last week, together with international consultant(s): 3 days
- Feed back workshops immediately after the reviews (country specific) for last input by respective country assigned consultants : 1 days
- Assistance in drafting the country report: 2 days

Annex II Questionnaires

Semi-structured Interviews (FGD) with regulatory body, local community representatives, CSO,

Q 1.: In general:

(Please introduce your self, explain the aim of the discussion, explain what you understand by the PBF-approach).

- a. Why did you introduce PBF? What were the drivers for change? What were the challenges of introducing it?
- b. What are the most important changes in management and implementation of health services that are evident since the introduction of the PBF approach?
- c. Give specific examples of some key positive and negative changes that have occurred since PBF was introduced?
- d. What were the challenges (obstacles and/ or enabling factors) when introducing PBF? What were the drivers for change?

Q2: Are organizational systems in place to manage the PBF approach (fraud control/ verification, M&E, Q/A, criteria for incentives/ disbursements)?

- a. Do they function well? If not why not?
- b. What are opportunities to improve them?

Q3: Did the introduction of PBF change the **motivation** of the health staff here?

- a. Is an increased motivation because of the financial incentive
- b. Have the conditions for staff changed eg; support, capacity building with PBF
- c. Are there other human resource needs to ensure improved healthcare for your population?

Q: About changes after introducing PBF

- a. Do more patients use the Health Facility after introducing PBF – how can you tell?
- b. What types of services are offered– are there other health services needed that are not offered?
- c. Did quality of care in the Health Facility improve after introducing PBF – how can you tell? Did conditions to deliver quality of care, continuity of care, diagnostics, or the results of treatment improve?
- d. Did the level of user fees change – if so, did they increase or decrease?
- e. Is PBF approach feasible if user fees are abolished?

Q4: About your role in managing PBF

- a. Did you participate in developing the business plan – what was your role, were your needs and priorities taken into account?
- b. What is your role in managing the facility? In day to day management; can you influence decisions, bring changes – or even take decisions? Which type of decisions?
- c. Are you involved in planning, implementing and monitoring the health activities? Do you contribute financially, from your own resources (besides fee for services)?
- d. What is the system of recording and reporting in the health facility? Is the information reliable?
- e. Is a system in place to ensure that the poor members of the community use the facility? How are they treated?

Q5 About your preparation for your role in PBF

- a. How was the institutional framework for PBF developed – who is participating, what is the distribution of roles and responsibilities? (triangulate with Q4a)
- b. Did you receive any capacity building (training, technical support) to prepare for implementing of PBF? What type of support did you receive?
- c. What are the gaps in your skills and knowledge for use of PBF? What actions are taken to address the capacity gaps?

Semi-structured Interviews (FGD) with health staff in selected health facilities

Q1: In general:

(Please introduce your self, explain the aim of the discussion, explain what you understand by the PBF-approach).

- a. Why did you introduce PBF? What were the drivers for change? What were the challenges of introducing it?
- b. What are the most important changes that are evident since the introduction of the PBF approach?
- c. Give example of some key positive and negative changes that have occurred since PBF was introduced?

Factors (De-) motivating the health staff

Q2: Of the following list of factors of (de-)motivation, a score is requested from health workers

- i. Sufficient numbers of skilled health workers in the facility?
- ii. The received support from the direct superior level
- iii. The feedback received on his/her work, the assessment,
- iv. The number of patients that presents themselves to the HS
- v. The working hours
- vi. The received continued education
- vii. Working conditions (building, infrastructure, equipment)
- viii. Job security
- ix. Team work
- x. Salary
- xi. The PBF-bonuses received
- xii. The tasks and responsibilities entrusted to him/her

For each of the criteria, a score of 0 (not satisfied at all), 1 (not very satisfied), 2 (sufficiently satisfied) and 3 (very satisfied). Based on this, the accumulated total arrives at:

- The health workers are not at all motivated (<10 points)
- The health workers are little motivated (10 - 19 points)
- The health workers are sufficiently motivated (20 - 30 points)
- The health workers are very motivated (31-40 points)

Ask an explanation of the answer ("but why")

Q3: Did the introduction of PBF change your **motivation** for working here?

In what way?

- a. How long have you worked here? How long do you plan to continue to work here?
- b. Is an increased motivation because of the financial incentive, the increased autonomy, or was there another reason?

Q4: Are systems in place and function well to manage the PBF approach?

- a. fraud control/ verification,
- b. M&E, Q/A, criteria for incentives/ disbursements
- c. Is a system in place to ensure that the poor have access to services – in your perception, does it work?
- d. What are opportunities to improve the systems and procedures?

Q5: Did you receive any capacity building (training, technical support) to adapt yourself to PBF?

- a. What type of support did you receive?
- b. What are the gaps in your skills and knowledge for use of PBF? What actions are taken to address the capacity gaps?

Q6: About changes after introducing PBF

- a. Do more patients use the Health Facility after introducing PBF – how can you tell?
- b. What types of services are offered– are there other health services needed that are not currently offered?
- c. Did quality of care improve after introducing PBF – how can you tell? What did improve? Did conditions to deliver quality of care, continuity of care, diagnostics, or the results of treatment improve?
- d. Did the level of user fees change – if so, did they increase or decrease? Is PBF approach feasible if user fees are abolished?

e. Additional questions for the Health Management Team:

Q1: About the institutional framework for PBF

- a. What is your role? Can you influence decisions, bring changes?
- b. What was your role in developing the business plan – what could be improved?
- c. How is your relationship with the MOH organised – at central level/ at district level?
- d. How is your relationship with the CSO and with the community organised?
- e. How is your relationship with the private sector organised – be it for profit or not?

Q: About the support provided (by Cordaid et al) for PBF:

- a. Is funding predictable and timely, the amount related to agreed criteria? Clear exit strategy?
- b. How is technical assistance organised – needs based? Planned? Efficient and effective?

Q: About human resources for PBF-health facilities:

- a. Does the facility count with enough personnel to meet the demand for services?
- b. Does the facility count with personnel having the right skills to meet the demand for services?
- c. Is there a training plan?
- d. What kind of incentives are in place to motivate the HRH – besides the financial ones?

Q: About efficient use of resources in PBF-health facilities:

- a. What could you do to reduce the waste in the system?
- b. What is your opinion on the efficiency and effectiveness of checks and balances (fraud control, verification,) – what could be improved?

Client Satisfaction (FGD in health centre)³⁶

General Satisfaction

Q1 Are you satisfied with the content of the services that your health facility offers?

Q2 Are you satisfied with the package of services offered by your nearest hospital facility?

Q3 The last time when you needed health services, did you visit the HC close to you or did you go elsewhere? Where did you attend if you do not use your local health facility?

Q4 Are you in general satisfied with the quality of care in the HC?

Other aspects of satisfaction, related to the quality of care

Q6 : are the costs in the center reasonable and affordable for you?

Q7 : are the costs, way of tarification transparent (eg; . payment is announced and a bill is provided?)

Q8 : is the state of the hardware of the HS in order (cleanliness, electricity, provision of water, etc) ?

Q9 : were the drugs that you needed the last time that you were sick available (in the HS)

³⁶ Not necessary in DRC, Burundi (HHD surveys). In Zambia, Tanzania: please invite representatives from (village) health committees to come to the health centre/ hospital

Additional questions for FGD with CSO-representatives

Q1 : How long have you been a community representative? Why did you decide to volunteer for this role?

Q2. Are you involved in the management of the health facilities?

- I. Priority setting, establishing the expected results
- II. Planning of the health activities
- III. Planning of the expenditure on capital costs
- IV. Planning of the expenditure on recurrent costs
- V. Implementation of health activities
- VI. Monitoring & evaluation of the (health) results
- VII. Monitoring & evaluation of the (financial) results
- VIII. Feedback to your community and advocating for service improvement?

Q2 : Are you satisfied with your involvement in the management of the health facilities?

Q3 : Can you influence decision-making?

Q4 : How would you describe your relation with the health staff?

Q5. What would you change or improve in terms of health facility management and services if given the resources?