PROCESS EVALUATION OF RESULT BASED FINANCING PROGRAM ON IMPROVING MATERNAL HEALTH IN KISHAPU DISTRICT COUNCIL, SHINYANGA REGION

PROCESS EVALUATION OF RESULT BASED FINANCING PROGRAM ON IMPROVING MATERNAL HEALTH IN KISHAPU DISTRICT COUNCIL, SHINYANGA REGION

By

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A Thesis Submitted in Partial Fulfilment of Requirements for the Award of Masters of Science Degree in Health Monitoring and Evaluation of Mzumbe University.

2019

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **"Process evaluation of result based financing program on improving maternal health in Kishapu District Council, Shinyanga region"** in partial fulfilment of the requirements for award of the degree of Masters of Science Degree in Health Monitoring and Evaluation of the Mzumbe University.

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ACKNOWLEDGEMENT

In a distinguished manner, I thank God, the Almighty for all the gifts of life, love, health, strength, courage, and daily blessings which were extremely vital to complete this work.

My sincere gratitude goes to my major supervisor Dr. Lawrencia Mushi for all her precious time, advices, insight comments, encouragement, kindness and guidance given to me from the beginning to the completion of this dissertation; truly, she is a full-packaged-mentor.

My gratitude is extended to Kishapu District Council, specifically to District Executive Director's office for approving my request for data collection. Nevertheless, I thank all Health Professionals of Kishapu District Council who were selected as respondents of this study for their dedicated time in filling all research evaluation questions, without them nothing would be achieved.

I also express my deepest appreciation to my mother, brothers, Sisters, in-laws and my most beautiful wife for their endless love, prayers and support at all the time of my studies. May God bless them with countless blessings.

Eventually, my gratitude appreciations go to San Francesco University for owing me prestigious scholarship for Master degree in Monitoring and evaluation for health last but not the least, I dedicate this master degree to all my Lecturers and colleagues who devoted their resources to support, encourage and advice me during my studying time at Mzumbe University, and everyone who supported me in one way or another.

Receive my thanks and God bless you lavishly.

DEDICATION

This work is dedicated to my beloved relatives for their outstanding love, support and prayers towards accomplishment of this work, God bless them abundantly

ABREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
BEmONC	Basic Emergency obstetric and Newborn Care
CAG	Control Auditor General
CCHP	Council Comprehensive Health Plan
CDC	Center for Disease Control
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHF	Community Health Fund
CHMT	Council Health Management Team
CHOP	Comprehensive Health Operational Plan
CHWs	Community Health Workers
D by D	Decentralization by Devolution
DC	District Council
DHIS2	District Health Information System
FBPHF	Faith Based Private Health Facility
HC	Health Centers
HF	Health Facility
HIV	Human Immuno Virus
HMIS	Health Management Information System
HSR	Health Sector Reforms
HSSP	Health Sector Strategic Plan
IAG	Internal Auditor General
IMR	Infant Mortality Rate
LGAs	Local Government Authorities
MDGs	Millennium Development Goals
MoF	Ministry of Finance
MoHCDGEC	Ministry of Health Community Development Gender Elderly and Children
MoHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding

MSD	Medical Store Department
NBS	National Bureau of Statistics
NGOs	Non-Governmental Organizations
NHIF	National Health Insurance Fund
NKRA	National Key Result Areas
P4P	Payment for Performance
PO-RALG	President Office-Regional Administration and Local Government
RBF	Result Based Financing
RHMT	Regional Health Management Team
SOPs	Standards Operating Procedures
TB	Tuberculosis
TBA	Traditional Birth Attendants
TDHS	Tanzania Demographic Health Survey
THIMS	Tanzania Health Information Management System

ABSTRACT

Shinyanga region is one among the regions of Tanzania mainland with high maternal mortality rate (MMR). In 2015, it was reported to have 60 MMR and ranked number one due to unsatisfactory health condition and poverty index. Result Based Financing (RBF) was introduced in Tanzania particularly in the regions with high burden of diseases with the aim of achieving Universal Health Coverage goal and to offset the long-term health sector challenges. RBF was implemented in Shinyanga from 2015. It was initially implemented in 157 health facilities where in Kishapu District Council (DC) is implemented to 55. Since the implementation of RBF in Shinyanga, there are limited studies conducted to evaluate its progress. Thus, the study aimed to conduct a process evaluation study on improvement made by RBF program on maternal health services in Kishapu District Council. Specifically, the study ascertain the extent to which maternal health have been improved at health facilities due to RBF implementation; to examine whether maternal health services delivery and support functions consistent with RBF system; also, to examine healthcare provider's perceptions on bonus payment for RBF implementation towards improving maternal health services.

The study employed a descriptive cross- sectional design with a mixed method approach. A semi-structured questionnaire was used to collect data from randomly selected 147 respondents from all 55 health facilities. Quantitative data was analysed by the use of SPSS V. 25.0 and descriptively presented by tables, figures, and measure of central tendency. Qualitative data was analysed with the help of ATLAS ti version 8.2.4 programs for content analysis.

The results reveal that, (82.3%) of the health professionals provided appropriate healthcare to women with delay in labour as per national health guidelines, (80.3%) provided routine postnatal care to mothers and their new-borns, whereas all interviewed health professional (100%) provided care to women and new-borns as per standard precautions for preventing hospital-acquired infections. Nevertheless, (81.65%) of health professionals did not carry out an exit interview with their clients to gather important information about the quality of maternal health services.

Furthermore (41.5%) of health professionals identified dilapidated infrastructures as a major obstacle towards utilization of maternal health services among pregnant women, other factors included traditional beliefs and inadequate maternal health education (25.2%), unethical provision of maternal health services by facility staffs (6.8%), as well as limited participation by male partner of pregnant women (8.8%). Notwithstanding, (17.7%) of respondents considered multiple factors including limited number of medical staffs compared to the number of pregnant women attending ANC, Distance between residence and facility which play as the wall towards accessing maternal health services.

Implementation of RBF need to ensure availability of essential infrastructures, health professionals in some of health facilities, medical tools and medicines for pregnant women, yet availability of all necessary equipments and medicines does not guarantee proper provision of high quality maternal health services for elimination of maternal deaths thus monitoring process for paying RBF incentives need proper adjustments to improve implementation processes for maternal healthcare delivery.

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CHAPTER ONE
INTRODUCTION

1.1 Background of the study

Result Based Financing (RBF) is a healthcare financing approach which was introduced in Tanzania to improve the performance of Primary Health Facilities (PHF) in terms of accessibility to healthcare services and affordability as a strategy to eliminate long term healthcare sector challenges of underfunding which was resulting to poor healthcare quality delivery particularly maternal health services. The Government of Tanzania through Ministry of Health Community Development Gender Elderly and Children (MoHCDGEC) designed (RBF) Program to incentivize health facilities as an alternative intervention to influence healthcare provider's morale towards performing a certain results with the aims of increasing utilization and access to quality health service at Primary Health facilities among healthcare users

RBF is argued to have potential to address a number of health system challenges including underfunding as a major challenge which is leading to poor quality of maternal healthcare service delivery. It is claimed that in Sub Saharan African countries, health sector directed RBF programmes can potentially act as catalyst for reforming the whole public sector into an efficient outcome based institution. It is this vast promise of RBF that makes attractive to Politicians and policy makers in low income countries (Chimhutu, 2016).

Tanzania has adopted RBF intervention to offset health sector challenges of unequal access and low coverage to healthcare services, low quality, inefficient delivery of services and limited financial resources for health system management which undermines the achievements of MDGs goals especially goal number 4 and 5 for reduction of child mortality and maternal mortality.

According to NBS, (2012) Tanzania was reported to have maternal mortality rate 432/1000 per live birth, the Infant Mortality rate (IMR) was 45/1000 per live birth while under five Mortality rate was reported to be 81/1000 per live birth TDHS, (2010).

At the onset of RBF implementation in 2015, seven regions of Tanzania mainland which have high poverty level and poor health outcomes were selected for RBF implementation. Among the selected regions are Shinyanga, Pwani, Mwanza, Geita, Simiyu, Tabora, Kigoma, Mara and Kagera region. Shinyanga region was ranked number one among the rest regions due to the unsatisfactory health condition and poverty index, thus RBF in Shinyanga was initially implemented in 157 health facilities and it firstly piloted in Kishapu District Council (DC) in 52 Health Facilities to test program components targeted to improve selected health indicators one being elimination of maternal death which was resulted to dilapidated infrastructures of health facilities, shortage of medical commodities for pregnant women, shortage of qualified human resources for health and several other factors related to low utilization ANC services among pregnant women. Thus it is believed that RBF can play a potential role to boost health sector systems to an efficient institution in health service delivery.

1.2 Problem statement

Shinyanga Regional Health Report (2019), indicates that maternal mortality rate is still an overwhelming challenge, some RBF indicators remains unachieved especially the indicator for maternal mortality rate reduction, there is an impressive achievements only on infant mortality rate reduction where in 2015 the infant deaths were reported to be 93, moving down to 48 deaths in 2018, despite progressive investment of RBF resources for rehabilitation of health facility infrastructures, training of medical personnel for capacity building in terms of knowledge and skills, acquisition of medicines and medical supplies and disseminations of national standard health guidelines for maternal health services delivery yet the number of maternal death in Kishapu DC increased from 3 to 5 within a period of four years 2015-2018 of RBF implementation ,addition to that, RBF is new approach for healthcare financing in Tanzania and few studies have been conducted on outcome evaluation with special attention only on achievements yet less is known about implementation process-the requirements and how maternal services are being carried out to meet program objectives. Thus this evaluation study evaluated RBF

program to determine the implementation process of maternal health services in Kishapu if were implemented according to the program deign.

1.3 Objective of the Study

1.3.1 General Objective

To assess the implementation process of Result Based Financing on improving maternal health services

1.3.2 Specific Objectives

i. To determine the extent to which maternal health have been improved at health facilities as a result of RBF implementation

ii. To examine whether maternal health services delivery and support functions consistent with RBF system.

iii. To examine healthcare provider's perceptions on bonus payment for RBF implementation towards improving maternal health service

1.4 Evaluation Questions

1.4.1 Principle Evaluation Question

i. What are the implementation processes of RBF program in improving maternal health services?

1.4.2 Specific evaluation questions

i. To what extent maternal health have been improved at health facilities due to RBF programme implementation?

ii. To what extent the maternal health service delivery and support functions are consistent with RBF system?

iii. How does healthcare provider's perception on bonus payment affect the implementation process of RBF towards improving maternal health service?

1.5 Significance of the study

i. The study help to shade the right on the implementation processes of RBF for improving maternal healthcare delivery and whether these processes undertaken by healthcare providers at facilities are consistent and respond to program design in meeting program objectives particularly the improvement of maternal health outcomes. The study also informs the policy actors and RBF implementers on areas which need improvements for strengthening and management of health systems in delivering quality healthcare services particularly maternal health services.

1.6 Result based financing program (RBF) description

RBF intervention targets to measure the performance of selected indicators which were not achieved in HSSP III; it is expected to have significant achievements in healthcare delivery in the selected regions. Verification of RBF indicators is essential for the improvement of healthcare delivery since RBF incentive payment focuses on results which needs quality of data. The data that will be obtained from RBF indicators should be well documented that not only for payment of RBF incentives but verification of results and can also be used to improve facility level information whether they under or over reported, for these reasons it is essential that results be routinely verified before payment is made in view of the fact that verification improves transparency, credibility and good governance of the RBF system.

1.6.1 Expected program objectives/goals

RBF program was introduced in Tanzania to address the bottlenecks of healthcare system with the following six objectives which are;

- To improve the accessibility and utilization of health care services in primary healthcare facilities.
- To improve the quality of health services at all facilities in the Council,
- To improve the productivity and efficiency of service delivery by health care providers,
- To improve the quality and use of data for evidence based decision making,

- To improve accountability and responsiveness of health management teams and facilities governing committees and
- To provide equitable access to cost effective quality health care

1.6.2 Major strategies to implement RBF Program

i. The RBF Indicator's measurements

The RBF program document has outlined the major strategies to undertake for successful implementation of program objectives. The core of any RBF system is the definition and measurements of indicators for improvement. Thus RBF system links the indicator's achievements and financial system that is "Indicators to be purchased". The Indicators of RBF intervention has been delivered from HSSP III and particularly all important areas of the health care delivery have been covered especially MDGs targets. The strategic emphasis has been put on both quantity and quality indicators of health services. These indicators are not static but subject to change whenever need arises. The strategies for implementing RBF indicators have divided into various levels of healthcare systems for effective utilization of healthcare resources in meeting both quality and quantity indicators which are expected to improve the access and quality to healthcare services. The implementation of RBF strategies in regards to both qualitative and quantitative healthcare indicators have considered the key stakeholders in healthcare system thus each indicator have been assigned to the implementing health partner based on the level of technical expertise and ability as pointed out in the stakeholder's analysis.

1.6.3 Program Activities

Through RBF implementing partners various activities have been assigned to stakeholders as core partners of RBF system. The implementations of activities depends on their level of authorities and financial and technical capacities of each RBF implementing partner, the aim is to strength overall health system for healthcare delivery in adherence to standards in terms of quality, quantity and accessibility. Therefore to pursue RBF intervention the following are the main program activities.

i. Financing of healthcare service delivery by facilitating Health facilities to Plan and implement their plans (Business plan)-Council Comprehensive Health Plan (CCHP)

ii. Physical count of medical commodities in comparisons to the ledger books

iii. To design capacity development plans and provide training, mentorship and technical support to Health Centers, Dispensaries, RHMTs and CHMTs under RBF program

iv. Monitoring of health commodities and ensure constant supply of medical commodities such as (a) Life saving commodities for new born health, maternal health and child health (b) program commodities such as HIV/AIDS drugs, Malaria and Family Planning commodities and (c) other commodities of significance public health importance such as Antibiotics and Analgesics, Injections and Infusions and Medical supplies.

v. Regulating of healthcare services delivery in terms of quality and quantity according to the professional health standards as per WHO and MoHCDGEC.

vi. Verification of all RBF indicators in terms of quality and quantity for payment based on the level of performance results achieved.

vii. Financial auditing of RBF financial incentives disbursed to the facility according to the utilization plan that 25% of all incentives should be allocated to Healthcare workers and 75% be allocated to facility for administrative responsibilities including improvement of facility infrastructures.

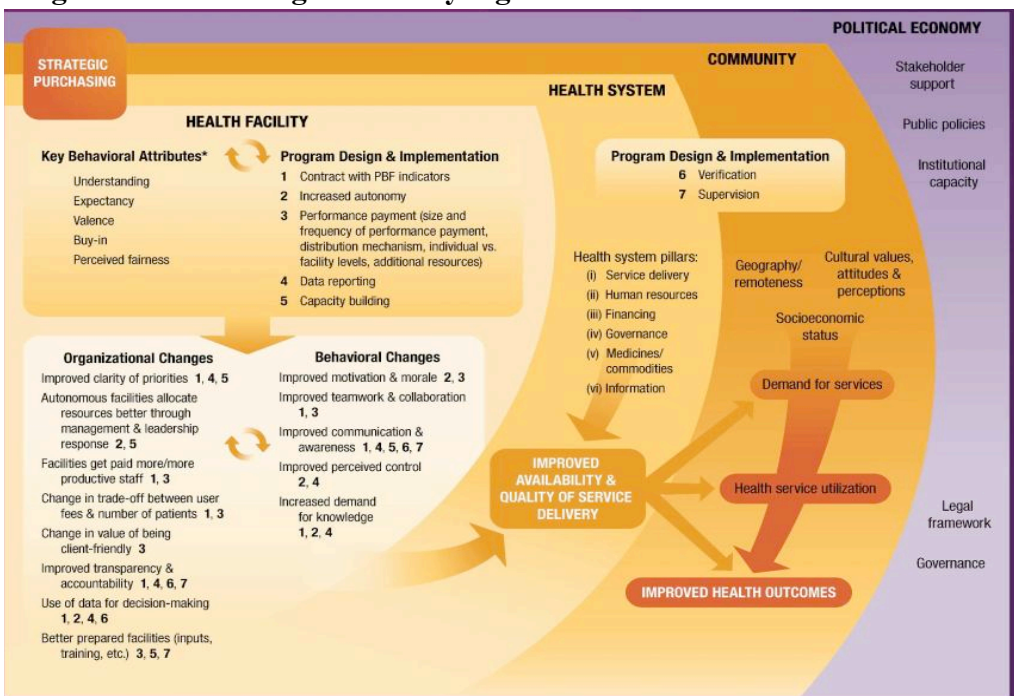
1.6.4 RBF program logic model

The logic model provides the hypothetical descriptions of program activities on how the program intervention will work in the realization of distal results, it theoretically communicates the inputs resources and activities required by the intervention, to meet the intended results, Kellogg, (2004).

Therefore, the RBF framework identifies key determinants of RBF program performance and interlinkages between them for consideration in design,

implementation and evaluation. A traditional linear theory of change is integrated with broader consideration of non-linear multidirectional and indirect relationships between behavioural, organizational and other contextual factors that may influence performance. Since behaviours are influenced by and influence multiple levels of factors, the health facility is imbedded within a multifaceted framework that includes the health system, community and political economy thus the health facility is affected by factors at these other levels in addition implementation of RBF program has consequences at these levels as indicated in part by arrows in a framework. Thus logic framework provides; (i) Understanding, the knowledge of criteria by which incentives are awarded, the amount of money at stake and the additional design features. (ii) Expectancy, health facility staff's belief that they can do things that will achieve the targets. (iii) Valence, the belief that the incentives are sufficiently valuable or substantial to inspire responses predicted by the theory of change. (iv) Buys in, acceptance of the program and its criteria (v) Perceived fairness, staffs believe the program feature and implementation are fair. (Health Results Innovation Trust Fund, 2015)

Figure 1.1: The Program theory/logic model



Source: Health Results Innovation Trust Fund, (2015)

1.6.5 RBF stakeholder's analysis, their roles and responsibilities

Prior to the implementation of RBF program, the analysis of stakeholders to be involved in the plan was very fundamental aspect for the successful implementation of the RBF intervention. Stakeholders are those with vested interest in the program since they affect the program results direct or indirect depending on the types of the resources they can contribute, thus the inclusion of various stakeholders offset the controversial of vested interest on the program and increase the project performance in terms of indicators to be achieved since each stakeholder have the role and responsibility to play. Therefore different stakeholders have been identified with their distinct roles and responsibilities as mentioned below.

For the effective implementation of RBF intervention, the program have identified different health development Actors with different roles and functions. Each of the Actors have the resources to contribute that directly impact the program goals. It is important to recognise the potential contribution and the roles that each Institutions takes towards successful implementation of RBF program. The RBF comprises of Governmental, Non Governmental and Religious stakeholders which all together have distinct activities to perform such as activities are;

1. Community Health Workers (CHWs), the target of RBF is to use CHWs who will be assessed by quantity indicators but could be increased in a subject to initial results of RBF system. Initial the CHWs will start with only five quantity indicators such as
    i. Number of Non- Institutional maternal and perinatal deaths reported within 24 hours to respective health facilities.
    ii. Number of Non- institutional births reported monthly to respective health facilities.
    iii. Number of Non-institutional deaths reported monthly to respective health facilities.
    iv. Number of pregnant Women escorted for delivery at a health facility by known or unknown Traditional Birth Attendants (TBA) or CHW.
    v. Number of Household Visits by CHW

Thus, CHWs act as the link between healthcare providers and population under catchment areas whereas upon the successful implementation of the five indicators, the CHW is rewarded money incentives based on the earned points.

2. Health Centers (HC) and Dispensaries. Have the role to perform Quantity indicators. The RBF intervention has designed an indicator's performance strategies for HC and Dispensaries which have to be measured in terms of quantity at that facility level. Eighteen indicators have been instigated for HC and Dispensaries. These indicators intend to measure the performance of healthcare delivery by assessing the number of population groups of different socio-economic status, sex and characteristics by different health related cases served by the accredited Health Centres and Dispensaries.

3. District Hospitals are responsible to carry out the Quantity indicators; these indicators are measured in terms of management and treatment of disease cases such as Hypertension, Cervical Cancer screening and treatment, AFB+ve pulmonary Tuberculosis (TB) cases detected diabetes mellitus, Medical Male Circumcision and pre-mature neonates.

4. Council Health Management Team (CHMT) mandated to carry out the Management Indicators which includes conducting quarterly supportive supervision of Health Centres and Dispensaries, Health Management Information System (HMIS) report completely entered to District Health Information System (DHIS-2), Monitoring and coordination of CHF enrolment rate and precisely preparation and implementation of Comprehensive Council Health Plan (CCHP).

5. Regional Health Management Team (RHMT) is over all responsible for carrying out the Management indicators, for these indicators are typically based on the role of RHMT technical team responsible for verification process and management of RBF data, Coordination of RBF program at lower facility level, supportive supervision, reports assessments,

Implementation of Comprehensive Health Operational Plan (CHOP) and Management of Human Resources for Health.

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

7. National Health Insurance Fund (NHIF) mandated with the Purchasing role.

   The national Health Insurance Fund under the RBF system act as a purchaser of provider's assigned indicators. The NHIF, MoF, MoHCDGEC and PO-RALG together have signed a master Memorandum of Understanding (MoU) for RBF implementation, thus NHIF as a purchaser have the roles and responsibilities of

   i. Purchasing health services from health facilities according to indicators set by the regulator.

   ii. To purchase supply chain services from MSD strategic business units according to the indicators set by regulator.

   iii. Entering into a contract with each participating health facility and MSD strategic business units

   iv. Participate in the verification process and approve payments after receiving verification reports.

   v. Prepare full list of health facilities with address, bank accounts and verified payments amounts including penalties.

vi. Recommends to MoHCDGEC necessary actions for any irregularities found during verification process as highlighted to NHIF by Internal Auditor General (IAG) of relevant region.

vii. To make follow up with MoF to ensure approved incentive is timely disbursed to the facilities.

8. Provider / Health Facilities

Both public and private health facilities at primary healthcare level are contracted to provide healthcare services to the community. Under RBF system they includes Health centres, Dispensaries and Hospitals at council level, the aim is to improve accessibility and allow competition among providers however for private healthcare providers, only facilities who have agreement with Government are entitled to participate in the RBF program. Specific roles and responsibilities of Health care providers are;

i. Provide quality health care services to clients and communities

ii. Develop clear business plan as part of CCHP

iii. Ensure that all clinical and crosscutting quality standards are observed.

iv. To prepare reports including HMIS reports, financial and technical reports of the business plans

v. Collection analyze report and utilization of data for planning

vi. Collaborate with other key stakeholders and develop strategies for successful implementation of RBF program but also includes leveraging of resources.

vii. Mobilize resources based on available opportunities in the catchments areas

viii. Develop capacity building plan that includes meeting, on job training and mentorship

ix. To improve feedback mechanism to address clients complaints

x. Ensure that all resources are properly and efficiently utilized

xi. Prepare and submit to the respective council the RBF implementation and incentive utilization report.

xii. Ensure availability of reporting tools to facilitate data submission to higher level

xiii. Support community actors to carry out their own strategies under the RBF system.

xiv. Impose sanctions against individuals responsible for professional misconducts.

9. Medical Store Department (MSD) strategic Business Units

Medical Store Department (MSD) through business unit is responsible for

i. Provision of high quality supply chains services to health facilities and MSD clients.

ii. Quarterly reporting logistics performance indicators by the 7th of the following month to the pharmacy council and submit claim invoice at the end of each quarter

10. Ministry of Finance (MoF) responsible for fund holding and disbursement.

The Ministry of finance is mandated to hold RBF funds and is responsible for paying the RBF incentives to the healthcare providers (Heath Facilities, CHMT and MSD). The MoF will be disbursing two types of fund related to RBF system namely Administrative and subsidies/incentive funds. Administrative funds will be channeled to the MoHCDGEC to support programme operations and the incentive funds will be disbursed to the healthcare facilities through the respective councils and to MSD strategic business unit. The MoF will disburse the funds as per indicators of the purchaser.

11. Internal Auditor General and Controller Auditing General Verification of Indicators

Verification is the cornerstone of RBF program because payment of results requires quality data. The internal verifier will be IAG with the involvement of experts from region secretariat including RHMT, NHIF Staff, Regional Hospital and NGOs representatives to undertake the verification. The team of expert under IAG will conduct verifications to health facilities and further the team will conduct patient tracing for 10% of all clients who receive services in the facility to check for patient satisfaction for the selected indicators. The verification is done through the division of team into two parts, that those who will be responsible to verify quality indicators and those who will be responsible to verify quantity indicators which all together will be compiled to mark the performance score by each health facility. Verification of quantitative data involves check of correctness and consistency of data entered into Health Management Information System (HMIS) tools and District Health Information System 2 (DHIS2).

Furthermore the Independent Verifier under RBF is Controller Auditor General (CAG) who is responsible to conduct the ex-post counter verification twice a year by using a sample of 25% of health facilities participating in RBF. The CAG will verify quantity results as verified by the IAG and will conduct quality assessment using the in-force checklist but not merely to that but also will be responsible to audit financial management at each selected facility. Thus both IAG and CAG are responsible to check whether minimum quality standards of service provision in health facilities are met and provide timely feedback to health providers, purchaser and regulator on the quality of health services.

12. President's Office-Regional Administration and Local Government (PO-RALG)

In order to effective implement RBF scheme at Local Government Authorities (LGAs), the major role and responsibility of PO-RALG to have special unit which is responsible to facilitate and ensure that Councils are supported to carry out their roles by providing sound advice to CHMTs and health facilities on how to plan and maximize the future revenue from RBF,

the unit is responsible to support the development of health facility business plans, capacity building of CHMTs and health facilities, Monitoring of RBF activities and health provision through Regional Secretariats represented by RHMT and coordinate the links between regions, LGAs and all other health development partners to ensure health services provision is improved.

13. Non-Governmental Organizations (NGOs) and Private Sector

The NGOs and Private Sector Organizations have been working closely with the Government to support health services in the country, Under RBF program, NGOs and Private Sector are expected to support the program by liaising with the service providers, Purchaser, Fund holder, Verifier and regulator by informing them what is being done at the community and if there is any complaints from them to ensure quality of health services delivery at all levels. They have to participate in design and implementation of RBF health interventions at all levels and provide support to vulnerable groups to access healthcare services but also to inform the community through awareness creation about the health services and the new mode RBF health services delivery.

14. Religious Leaders, Influential people and Representatives of Youth Groups.

These stakeholders are the part of implementation of RBF strategies because of their influence in the community they serve, RBF scheme recognize their potential capabilities and they are responsible for advocating health issues to the community through awareness creation, to provide support to vulnerable groups on the access to health services and to sensitize the community on issues of health promotion and prevention.

15. Village Leaders, extension Workers, health facility committee and Councilors

RBF recognizes the potential consideration of this group as stakeholders with vested power on them, therefore for RBF interventions to be effective, these stakeholders have responsibilities of convening stakeholder's meetings within the village and give feedback to improve health service delivery, income

generated by the facility and fund spent to increase transparency, they are trusted by the people they leads, therefore during the implementation of RBF program they will participate in the selection of CHWs and develop mechanism for monitoring and supervising them through provision of technical support and working tools to meet the desired results.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter cover the key concepts used under the study, theoretical review, conceptual framework and empirical literature reviews of previous studies conducted on the financial incentives for health. The idea of instituting financial incentives in healthcare systems are the results of deteriorated healthcare services at primary facilities resulted into policy option. The concept of RBF in Tanzania is absolutely new, many studies about incentives for healthcare improvement were conducted in western countries and few in Developing Countries due to the fact that the operation of Result Based Financing in developed countries started early at the time when healthcare systems were not performing well. Developing countries adapted RBF from the countries which have enough experience of using this form of payment. Tanzania has officially launched RBF approach in 2015 based on the experience from the pilot study which was conducted in Pwani region however the system is modified from Payment for performance (P4P) to RBF which is common term used by World Bank and other donors.

2.2 Conceptualization of key terms

2.2.1 Incentive

"An incentive is an object, item of value or desired action or event that spurs an employee to do more of whatever was encouraged by employer through the chosen incentive" (Heathfield, 2018).

2.2.2 Financial Incentive

"Any form of monetary benefit offered to consumers, employees and organizations to encourage behaviour or actions which otherwise would have not take place. A financial incentive motivates actions which otherwise might not occur without the monetary benefit" (BD, 2018).

2.2.3 Result based financing

"Result based financing for health refers to any system that transfers financial or non-financial incentives either to healthcare providers (supply side) when they

achieve pre-agreed results or to a patient when they take health related actions (demand side). RBF is an approach to development financing based on payments made after results have been delivered and independently verified. A well designed RBF mechanism motivates staff to deliver quality services and assists them to access the resources needed" (MoHCDGEC, 2015).

2.2.4 Health Service provider

According to (WHO, 2006) report, defines Health Service providers as " all people engeged in actions whose primary intent is to inhance health". This meaning extends from WHO's definition of the health system as comprising activities whose primary goal is to improve health.

2.2.5 Health care utilization

The measure of the population's use of the health care services available to them, this includes the utilization of Hospital resources, Personal Care Home resources and physician resources. Health care utilization and health status are used to examine how efficiently a health care system produces health in a population (MCHP, 2008).

2.2.6 Access to quality health care

Is defined as having timely use of personal health services to achieve the best possible health outcome (IOM, 1993), Access requires gaining into the health-care system, getting access to sites of care where patients can receive needed services and finding providers who meet the needs of patients and with who patients can develop a relationship based on mutual communication and trust (AHRQ, 2009).

2.2.7 Universal Health Coverage

Universal Health Coverage (UHC) means all people and the communities can use the promotive, curative, rehabilitative and palliative health services they need of sufficient quality to be effective while also ensuring that the use these services does not expose the user to financial hardship. The definition of Universal health Coverage is embodies three related objectives (i) Equity in access to health services, that everyone who needs services should get them not only those who can pay for them, (ii) The quality of health services should be good enough to improve the health of those receiving services and (iii) People should be protected against financial risk

ensuring that the cost of using services does not put people at risk of financial harm (WHO, 1948).

2.2.8 Primary Health Care

Primary health care is usually the first point of contact people have with health care system. It provides comprehensive, accessible, community based care that meets the health needs of individuals throughout their life. This includes spectrum of services from prevention i.e. vaccinations and family planning to management of chronic health conditions and palliative care (WHO, 2008).

2.2.9 Maternal Visits/contacts

According to WHO (2016) an antenatal care guideline recommends the word "maternal contacts" instead of "visits" to imply an active connection between pregnant woman and a healthcare provider. The focus of maternal contacts is to have a health pregnancy for mother and baby which including preventing risks, illness and death, thus maternal contacts can be adapted to local contexts though community outreach programs with the involvement of health workers. While Developing countries including Tanzania are struggling to encourage at least four ANC contacts, the World Health organization recommends eight ANC contacts.

2.2.10 Non institutional births

Means giving birth at home in unhygienic environment. There are high risks of getting infected by unhealthy environment in the case of home delivery and sometimes it is difficult to handle birth complications by unqualified care givers as a result of maternal deaths and even risk of getting blood related diseases among the care givers.

2.2.11 Maternal death

The term maternal death means "is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes," (WHO, 2019).

2.2.12 The model of payment for performance

Financial incentives in health sector was introduced through RBF programme as a payment for performance (P4P) for health care providers designed to measure employees performance accurately while aligning pay such that it rises and falls in accordance with variation in performance. The use of P4P comes from simple desire to motivate employees towards more constructive behaviour (Abduljawad & Al-Assaf, 2011). Thus financial incentives may compensate for additional costs of providing a service act as stimulus for behaviour change or motivate practitioners or organizations with economic reward (Glasziou, 2012).

2.3 Theoretical Review: Principal-Agent Theory

Selection of successful model that address complex problem of healthcare systems requires an in-depth understanding of a particular problem to precisely determine an appropriate approach, an institution is responsible to coordinate and manage the manpower's efforts that it work with, this help an organization to focus on achieving program goal and objectives by any possible means. However employee's performance can be affected by the number of factors, this includes but not limited to the nature of work, levels of responsibilities, the nature of leadership, management style of an Institution and satisfaction level to produce optimal results.

The use of supplement payment by government as bonus payment to Public employees and other Faith Based Private Health Facilities (FBPHF) is directed effort to offset the long-term healthcare bottlenecks which is significant for achieving UHC that will not be realized by a single intervention. Incentives produce the results which without them would not be achieved.

The Principal-agent theory is the study of agency relationship and the issues that arises from this, particularly the dilemma that the principal "Employer", the Government" and the agents "healthcare workers" while normally working toward the same goal may not always share the same interests. In order to meet the principal's expectations, therefore principals provide incentives to agents in favour of the agents to act in principal's interests, (Yeungnam University, 2018)

Result Based Financing is typically viewed on this perspective of Principal-Agent theory where the Government as Principal determines an incentive scheme for healthcare providers as Agent to induce positive performance towards an observed action that will lead to the achievement of good quality healthcare provision for maximization of community welfare, The healthcare providers "agent's" trade-off between the action to take and his utility based on the level and amount of incentives provided by the Government "the Principal". In this view the high the utility healthcare workers receives from incentives the high the likelihood of achieving the goal and objectives of the employer resulting into optimal satisfaction by both government and healthcare providers meanwhile it produces an outcome to the target community in terms of accessibility and quality improvement of healthcare delivery which is predetermined target of the Government.

The principal problem is how to design the incentives which feet the requirements of the agent to perform an expected behaviour and determine the optimal action to take, then the agent decides on whether to accept the principal's offer based on the expected payment and in relation to the cost of performing action. Upon accepting an offer, the agent choose an action that maximize his payoff and the principal observes signals associated with action, the principal then pays the agent according to the incentive scheme thereon the agent receives pay off according to the observed performance. Incentive scheme is pre-commitment by the principal even though the agent's action is not since there can be other factors that can influence to induce performance of healthcare workers.

2.4 Empirical Literature Review

2.4.1 Maternal health services improvement at health facilities as a result of RBF implementation

Various studies have indicated that incentive payments play a significant role to improve provision of maternal health services at primary healthcare facilities, pregnant women who attends ANC services received appropriate maternal services including routine postnatal care as it was reported by Mishra et al (2011) that there is impressive improvements in maternal health service delivery from 30% to 53% in India, whereas in East Africa, there is significance improvement of maternal health

services due to the implementation of RBF program in Kenya according to Bellows et al, (2012), This is also witnessed in Uganda that health services deliveries increased from 52% to 61% (Population Council, 2011). The evidence is supported by studies conducted in Rwanda on the great success of payment based performance due to availability of supporting health-infrastructures and commitments of actors that contributes the process implementation of the policy from health facilities to the community through funding and expertise, (University of Rwanda, 2015).

Whilst health indicators in Rwanda improved dramatically in recent years, under five mortality rate (the probability of death per1,000 live births) significantly decreased, infant mortality rate decreased and maternal mortality rate has declined at annual rate of 12.1% in 2008, thus Rwanda was back on track to reach the health MGDs 4 and 5targets, (WB, 2011).

However the studies by Nguyen et al, (2012 in Bangladesh and Lundberg et al, (2013) in Uganda claimed to have seen no improvement on maternal health deliveries before and after RBF implementation. This is also seen in the study by Chimhutu, V. (2016), that health workers use coercive strategies in order to meet RBF performance targets as a results of detrimenting health outcomes which otherwise affect the implementation process of RBF strategies. RBF system is faced by several other challenges such as low community participation and involvement in the RBF program have hampered the implementation of RBF on improving availability of healthcare in vurnerable groups that is why maternal mortality rates are not decreasing (Sithole, 2013).

Performance of health sector is not only determined by providers alone, to achieve the goal depends on clients as patients who use services. If providers want to improve results, they will first have to look at their clients' interests when developing their strategies. Results will only improve if patients are successfully encouraged to use the provider's services. Providers will therefore need to improve the quality of their services, that is, the quality *as perceived by clients*. They will have to identify what prevents clients from using their services, where the bottlenecks are, and then develop strategies to overcome them.. Another way of ensuring that providers will better respond to the wants, needs and demands of the clients is to ensure that

representatives of the community play an important role in managing the facility, including the this development of result plans and contracts. These representatives would then translate demand to the providers, hold them to account when it comes to the results that have been promised, and perhaps act as purchaser of quality care, (Tooren, Lodenstein, & Coolen, 2012).

2.4.2 Maternal health services delivery and support functions consistent with RBF system

According to the study commissioned by (Gorter, Ir, & Meessen, 2013) the evidence from the review of RBF on Maternal and Neonatal Health (MNH) suggest that RBF increases of amount of services utilized by target population for specific priority groups and also for large population. This result is also consistent with the expectations related to output-based payment formula whilst RBF schemes can address different access barriers to healthcare services, thus maternal and Neonatal Health have been a major area of concern in provision and management of antenatal care package, skilled normal delivery, and referral of complicated delivery, neonatal and postnatal care and child care.

However these findings is contrary to the evaluation findings by (Banner, et al., 2016) that RBF performance remain unclear following the evaluation study conducted in Afghanistan and Burundi. It has failed to provide strong evidence on the effects of scheme in health facilities support functions to secure essential drugs and equipments as the same case happen in Tanzania where the scheme has subsequently failed to manage stock outs of essential equipments, medicines and commodities. Maternal services are of poor quality there is serious problem of lack of expertise in a health sector such as midwifery personnel and doctors due to the brain drain posed a serious problem in the implementation of the RBF program since it was one of the conditions by funder to have adequate expertise to start the program. Dilapidated physical infrastructures remain as the major obstacle in delivering maternal health services and shortage of drugs is among other problems highlighted by (Sithole, 2013).

Moreover, financial incentive pays for the results rather than inputs to impress donor countries during a time when aid modalities have increasingly come under scrutiny. RBF for health is therefore seen as one of the new innovative modalities in the development aid scenery considered to help donors in justifying how foreign aid is being used. Many bilateral and multilateral agencies as well as Public Private Partnerships (PPP) have been promoting the use of RBF programmes (Chimhutu, 2016).

2.4.3 health-care provider's perceptions on RBF bonus payment on the improvement of maternal service

Perception of health providers on RBF buns scheme can positively and negatively affect the implementation processes of RBF program towards providing improved maternal health services, understanding such diversities in perceptions about RBF bonus payments leads to an informed decisions towards strengthening the systems for achieving program objectives.

Evaluation study by Gorter, Ir, & Meessen, (2013**)** emphasize that there is no substantial evidence but mainly hypothesis on the negative and unintended side effects of RBF, few studies specifically investigated these effects while more schemes are being implemented

Chimhutu (2016), that RBF can negatively affect social relations among health workers and with their patients. It was revealed that RBF can lead to the use of coercive strategies as a means to reach performance targets in resource constrained settings. RBF has the potential of disrupting social relations, teamwork and intrinsic motivation among health workers. This is explained further by (Harrison, Dusheiko, Sutton, Gravelle, Doran, & Roland, 2014), Pay for performance schemes have not consistently reduced costs and are sometimes associated with unintended consequences and detrimental effects on quality of care for non targeted patients.

In fact provider can easily manipulate the RBF system by concentrating their performance improvement intervention on the specific indicators which will make their focused performance look good but ignoring other indicators or medical conditions included in the program (Abduljawad & Al-Assaf, 2011), there is a

problem of gamimng behaviour whereby the incentive produces improvements in documentation rather than a change in the quality of health care delivered to patients(Laura, Petersen, Woodard, Urech, Daw, & Sookanan, 2006). Health providers attempt to falsify reports to receive more incentives on unfinished jobs, example is drawn in Cameroon where local health officials were reported to be demanding more incentives than what was budgeted for (Sithole, 2013)

There are strong reasons to believe that Performance Based Financing (PBF) schemes will also set perverse incentives and have undesired effects since there is evidence from other results-based approaches as well as from PBF in other settings for existence of perverse incentives (Grittner, 2013).

Due to the shortage of empirical evidence to support or not to support financial incentives for improving quality of primary health care, implementation should proceed with caution and incentive schemes should be more carefully designed before implementation (Scott, et al, 2011). Observation and surveys suggest that non-monetary incentives such as more empowerment and involvement of staff, more flexibility or fear of reputation loss may have played an important role concerning improvements in healthcare delivery.

2.5 Existing evaluation gap

RBF is relatively new approach in healthcare financing with vast promise that is capable to offset challenges of health system and boost health system functioning the move towards health coverage. The quality of healthcare provision direct linked to the availability of healthcare commodities, accessibility to health services at the right time and affordability, It is this promise that with RBF system the maternal health will be improved, however other researchers indicators that RBF has improved maternal health with the focus only on impacts of RBF, but little is known on the processes behind the implementation of RBF which is very crucial as this help explain why the program may succeed or fail thus this research is a cornerstone for understanding the processes for undertaking RBF activities for alleviation of maternal death.

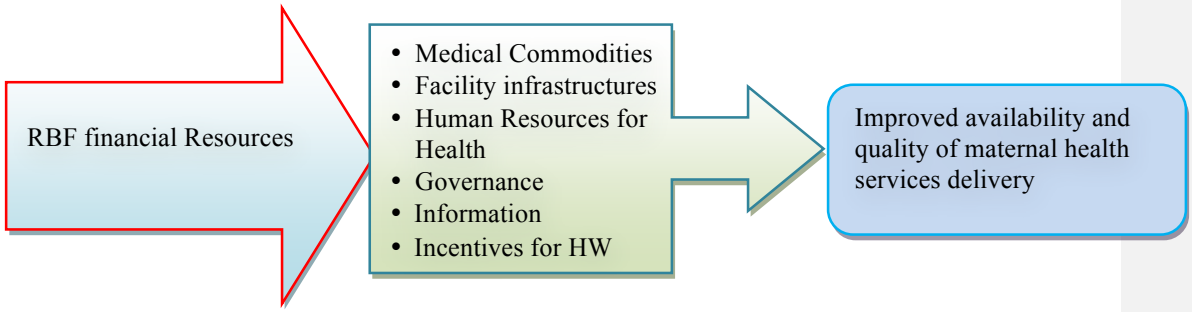
2.6 The conceptual framework

The conceptual framework analyses the RBF processes and how they link to each other for administering healthcare services. It depict the principal "the government-Ministry of Health desires of improving maternal services utilization among pregnant women by providing incentive scheme which target the health care facilities where Health Providers as "agents" are expected to act according to the incentive packages towards achieving the goal of principal in terms of improved availability and quality of services delivery, to improve UHC particularly elimination of maternal death. If these results are to be achieved the target is the final consumer who demands for healthcare services where it is expected that utilization of maternal health services will increase due to promotive measures of RBF program which is resulting into improved maternal health outcomes being a target to eliminate maternal death in a long run. The conceptualized relationship is like a supply chain of service where the RBF incentives will predominantly finance the healthcare infrastructures such buildings; ensure availability of healthcare commodities such as medical equipments and drugs, ensure adequate human resources for health with skills set, eliminates household income through designing of incentive packages to motivate pregnant mothers attend ANC for at least four visits and addressing harmful socio-cultural norms such the use of local herbs to support quick births and attending maternity services to traditional birth attendants which all together if addressed well, it is expected that utilization of modernized maternal services will increase which reduces maternal death.

Therefore the government is responsible to mobilize, allocate and monitor resources for implementation of RBF program, and is accountable for developing capacity building plans, implement and evaluate so that all implementers (agent) have adequate capacity for effectively implementation of RBF to deliver services (MoHCDGEC, 2015). Health Service providers as agents contracted by the Ministry of Health through National Health Insurance Fund (NHIF) for provision of healthcare services to the community particularly the elimination of maternal death. They are responsible for providing quality health services to clients and communities and develop innovative strategies including community sensitization, outreach

services to increase service utilization (MoHCDGEC, 2015). Under theoretical point of view, bonus payments will be provided upon the verification of indicators as per agreements.

Figure 2.1: Conceptual framework



CHAPTER THREE
EVALUATION METHODOLOGY

3.1 Introduction

This chapter presents how the evaluation research was carried out; study area, evaluation period, evaluation approach, evaluation design, the focus of evaluation and dimensions, indicators/variables to be evaluated, population and sampling, target population, source population, population under study, study unit and sampling units, sample size, sampling procedures and techniques, inclusion and exclusion criteria, data collection, development of data collection tools, data collection field work, data management and analysis, data entry, data cleaning, data analysis, evaluation ethical considerations, evaluation dissemination plan and the limitations of evaluation.

3.2 Study area

This study was conducted at Kishapu District council in Shinyanga despite the fact that before the scale up to other Councils in Shinyanga the Pilot study was firstly conducted in Kishapu from April 2015 because during the star rating assessments Kishapu District council was behind in meeting Health objectives of HSSP III, with an estimates of 3 maternal death being the results of dilapidated health infrastructures, unreliable medical commodities, and shortage of qualified health staffs which all these lead to poor maternal health service delivery

3.3 Evaluation period

Evaluation was carried out from mid-November 2018 whereas the first step was the development of evaluation proposal that was submitted to Major supervisor by May 2019 for assessments and further to approval for data collection process and come up with evaluation report that was submitted at the onset of August 2019 for further assessment.

3.4 Evaluation approach

Because the evaluation seeks to evaluate the implementation process of RBF programme on improving maternal health since it was initiated in 2015, this evaluation approach is formative evaluation

3.5 Evaluation design

The evaluation study design is descriptive cross sectional study that allows the collection of multiple data from sub set groups at one point in time to support the research evaluation questions. The evaluator used concurrent explanatory design where both quantitative and qualitative data were collected through semi structured questionnaire administered to healthcare providers, the purpose for employing mixed method approach was to explore more information and shed the light on why maternal death increases despite having RBF program.

3.6 The focus of evaluation and dimensions

The main purpose of this study was determines the processes for the implementation of RBF program towards elimination of maternal death in Kishapu District Council, thus this evaluation provides evidence based information that furnish the RBF implementers with the knowledge to improve program performance towards healthcare delivery in achieving UHC.

3.7 Indicators/variables evaluated,

The indicator which was evaluated is maternal health which is direct linked to RBF financial resources disbursed to the health facilities with the target to incentivize healthcare workers and improve working environment of health facilities by ensuring friendly infrastructures which are consistent and respond to standard delivery of maternal health services as per recommended standards but in line with the program design. thus with all inputs required for maternal health service delivery such as (a) facility infrastructure rehabilitation to increase availability of maternal services (b) Human resources capacity building for quality improvements (c) adequate supply of medical commodities (d) good governance for adherence to standards operational procedures and (e) information sharing mechanism to cascade knowledge for attending clients concerns which all synchronized together and facilitate the implementation process of RBF for maternal health service delivery

3.8 Population and sampling

3.8.1 Target population

The target population of this study is the healthcare providers of Kishapu district council particularly health facilities which enrolled to RBF program.

3.8.2 Source population

The source of population for this evaluation study is all health facilities which implements RBF program within Kishapu District Council.

3.8.3 Study population

The population under the study is health facilities which implements RBF intervention specifically the facilities with maternal health services of Basic Emergency obstetric Newborn Care (BEmONC) and Comprehensive Emergency obstetric and Newborn Care (CEmONC) where the facility in charges, District Medical Officer and other health professional who performs BEmONC and CEmONC will participate in this study**.** The selection of study population is based upon the person's experience regarding to maternal health services.

3.8.4 Study unit and sampling units

The study unit is Kishapu DC with facilities of different levels which provide maternal health services (BEmONC and CEmONC) principally the facilities under RBF system that furnishes the information on prevailing of maternal death despite having implemented RBF intervention.

3.8.5 Sample size

Sample size for this study was determined by using Yamane (1973) formula where the level of precision is 8%. The study area has 55 health facilities with a total of 2479 employees including both who performs BEmONC and CEmONC services while the health professional for maternal services are 151 at all 55 facilities therefore the estimates for sample is provided by the formula below

$$n = N/1+N\,(e)^2$$

Where, **n**= sample size, **N**= number of members and **e**= level of precision.

Given that, $2479 / (1+2479(0.08)^2 = 147$, participants with experience in maternal services from all 55 facilities participated in this study.

3.8.6 Sampling procedures and techniques

The sampling procedure is purposive sampling technique for qualitative and quantitative data collection; the purpose is to target only health professionals who had experience in Comprehensive Emergency Obstetric and Newborn Care services (CEmONC) and Basic Emergency Obstetric and Newborn Care services (BEmONC).

3.8.7 Inclusion and exclusion criteria,

The study unit that was recruited to participate in the study were health facilities with CEmONC and BEmONC services enrolled to RBF scheme for the past five years since the RBF intervention and the participants were healthcare workers who work in labour wards. The purpose was to include in the study the right candidates with the rich information to respond to the research questions.

3.9 Data collection

Data used were collected through semi structured questionnaires. The target was to obtain more information about the processes for the implementation of RBF for maternal health improvement.

3.9.1 Development of data collection tools

Semi-structured questionnaire that was administered to the labour ward healthcare providers was developed based on the evaluation objectives The reason for administering the questionnaire to labour ward healthcare providers was to collect the right data to generate the information which relies on their experience rather than any other health professional of different field of expertise.

3.9.2 Data collection field work

The principle researchers with data collection assistants oriented themselves on the principle procedures for data collection processes including assessment of the quality of tools used in the research to increase consistency and accuracy of data needed. Because of geographical locations and cost consciousness, motorcycles were used to reach the study subjects however mainly close communication through

mobile phones was used to monitor the subjects and data collectors for quick response to any challenge and errors that may occur during the period of data collection.

3.10 Data management and analysis

3.10.1 Data entry

Before any other procedures, both quantitative and qualitative data was managed separately. Quantitative data was managed in paper form and Microsoft excel 2010 this is before processing to SPSS version 25.0, the same for qualitative data which was managed in paper form and Microsoft word, 2010 as part of preparation for analysis by using ATLAS ti version 8.2.4 for content analysis.

3.10.2 Data cleaning

Data cleaning process was conducted through SPSS version 25.0 to detect and fix errors which includes examining the number of questionnaires, missing of respondent's characteristics, unfilled questions and any inconsistency.

3.10.3 Data analysis

3.10.3.1 Quantitative data analysis

Quantitative method of data analysis; specifically a descriptive statistical analysis aided by Statistical Packages for Social Sciences (SPSS) version 25.0 and excels spreadsheet programs. The analysis produced measure of central tendency, yet employed tabulation techniques and graphical representation.

3.10.3.2 Quantitative data analysis

Qualitative data was analysed with the aid of ATLAS ti Version 8.2.4 for content analysis which involved analysis and organization of data for importing to ATLAS software, establishment of networks for the imported materials, coding of key words and categorization of words based on the research questions and objectives.

3.11 Ethical issues

Ethical procedures was taken into consideration according to formal guidelines thus; the researcher obtained an introductory letter for data collection from Mzumbe University, whereas other organized bodies concerned in this research were further informed for other necessary procedures that allow a researcher to collect data from

health facilities. As Kishapu is an area of concern, the researcher consulted the government officials from Regional Commissioner's office and District Executive Director of Kishapu to release the data collection permit. The information which was obtained from respondents was sorely kept confidential and no participant's names were disclosed except only the use of respondent's position tittles or otherwise anonymous.

3.12 Evaluation dissemination

Since the dissertation is for fulfilment of Master in Science Monitoring and evaluation for Health was conducted on government program these findings are important to the public agencies and will be disseminated to RBF stakeholders so as to inform them on what is happening on the ground for the informed decision in strengthening the implementation of RBF systems in Tanzania.

3.13 Limitations of evaluation

Authenticity of data quality required by the researcher, this largely depended on the respondents perceptions on the research questions that may drive a respondents into the answers that did not respond to the evaluation questions and redness of service providers to support the researcher on answering the research question was a source of limitations for the study hence filling in questionnaire requires voluntary actions.

Despite having the aforesaid anticipated limitations, the study conducted still. The researcher tried to buy in the senior managements on the importance of this study for program improvement thus the researcher believed that the body with authorities provided invaluable support to make sure that this research is accomplished.

CHAPTER FOUR
PRESENTATION OF FINDINGS

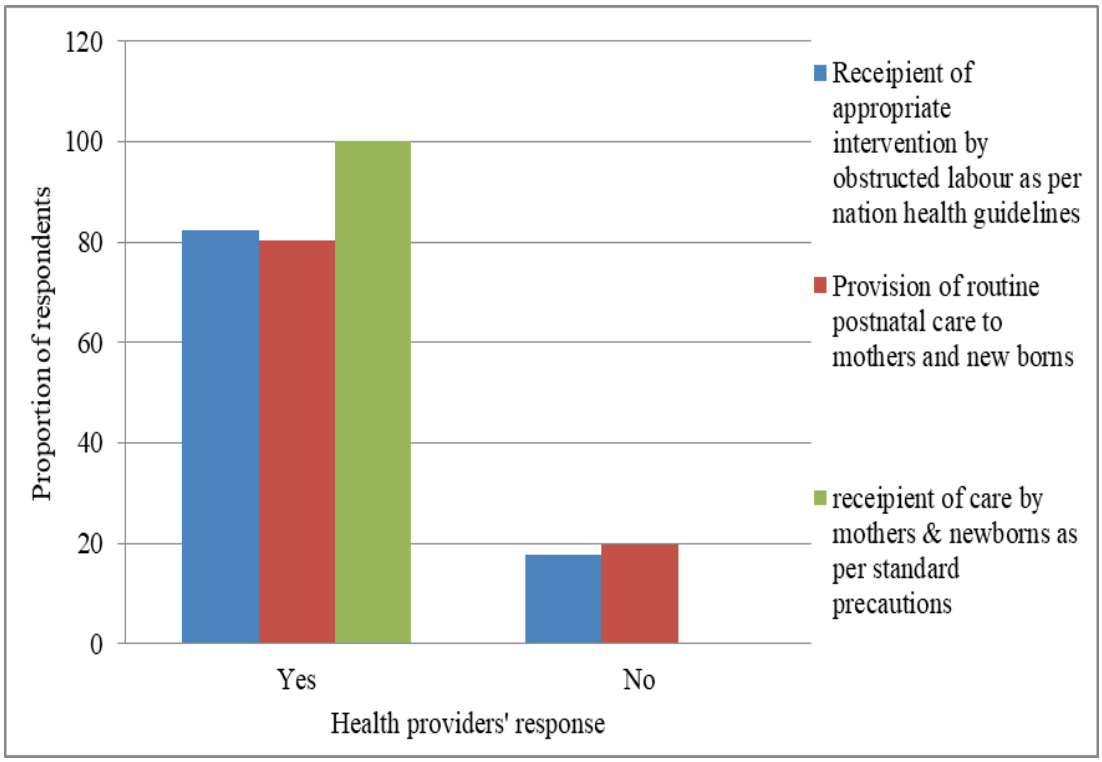
4.1 Introduction

The study aimed to evaluate the process of RBF program on improving maternal health services by studying 147 respondents in which at least 2 to 3 participants from all 55 health facilities in Kishapu district were involved in information gathering. Therefore, this chapter presents the findings of the study regarding the extent to which maternal health services improved among health facilities following RBF implementation. Also, consistency of maternal health services and RBF system; and finally, the perception of healthcare providers on RBF payment system towards maternal health service improvement.

4.2 The extent to which maternal health services have been improved at health facilities following RBF implementation

To examine the extent in which maternal health services were improved following RBF implementation, the study assessed if women whose labour is obstructed received appropriate interventions as per national health standard guidelines; if mothers and new-borns received routine postnatal care; and yet if they received care as per standard precautions for preventing hospital acquired infections. Figure 4.1 reveals that 82.3% of the interviewed maternal health care providers agreed that women with delay in labour received appropriate intervention as per national health guidelines, while 17.7% disagreed. Nevertheless, 80.3% of heath care providers have provided a routine postnatal care to mothers and their new-borns, while 19.7% did not; whereas, all health providers (100%) provided care to mothers and new-borns according to standard precautions for preventing hospital acquired infections.

Figure 4.1: Maternal health services improvement due to RBF implementation



Source: Research data, (2019)

Notwithstanding, the study assessed whether or not health care providers conducted exit interview with clients to explore their satisfaction on improved ANC services. Table 4.1 exhibits that only 18.4% of health care providers conducted an exit interview with their clients while the majority 81.6% did not carried an interview with health clients. Hitherto, 4.8% of the health care providers who conducted an exit interview reported clients view the health facility to have provided quality maternal health facilities, while 12.2% and 1.4% view the respective health facility to have provided satisfactory, and poor maternal health services respectively.

Table 4.1: Exit interview and health clients' response

		Conduct of exit interview with clients		
		Yes (%)	No (%)	Total (%)
Feedback report regarding maternal health services provision	Quality Service provision	7 (4.8)	0	7 (4.8)
	Satisfactory service provision	18 (12.2)	0	18 (12.2)
	Poor service provision	2 (1.4)	0	2 (1.4)
	No exit interview conducted	0	120 (81.6)	120 (81.6)
Total **(%)**		27 (18.4)	120 (81.6)	147 (100)

Source: Research data (2019)

Furthermore, (15.6%). of the respondents noted unethical provision of maternal health services by health care providers as among the factors hindering improvement of maternal health services, yet, unethical provision of health services takes into account of harsh language used by health specialists, and lack of work dedication in attending pregnant women. Notwithstanding, 17.7% of respondents considered multiple factors including limited number of medical staffs compared to the number of pregnant women attending ANC, Distance between residence and facility which play as the wall towards accessing maternal health servicesas the wall towards implementation of RBF for improving maternal health services; according to one of the interviewed respondents said that;

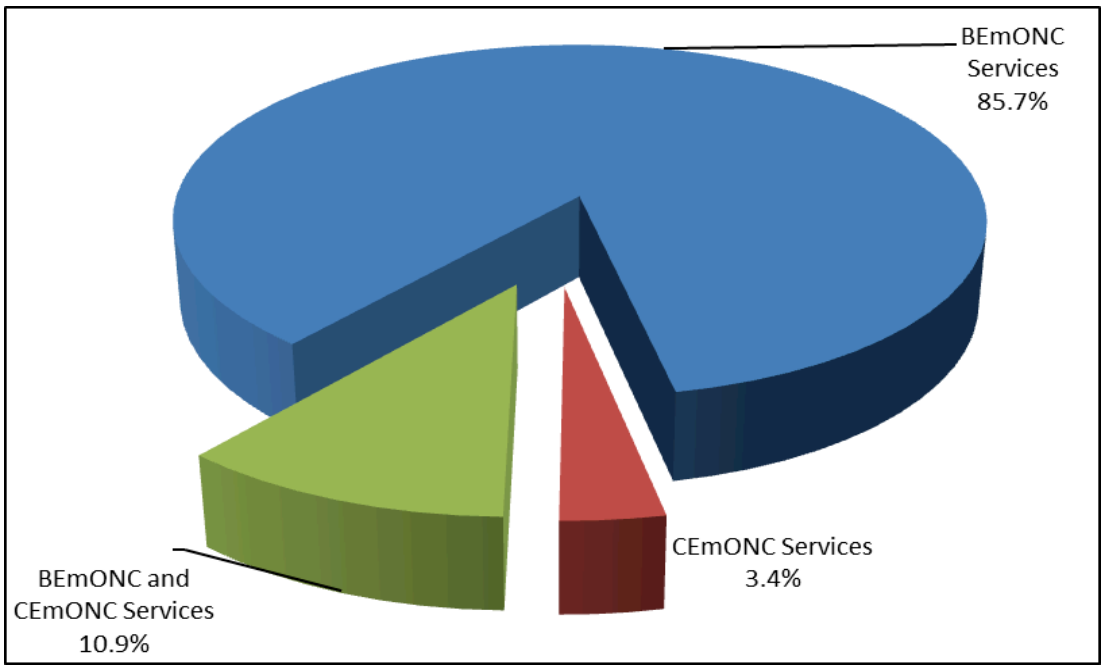
> *"Despite the ongoing implementation of RBF in our health facility, inadequate number of medical staffs compared to pregnant women attendance, distance between some residence and our facility, yet common tendency of pregnant women not attend health facility for maternal health, stands as setback wall towards effective utilization of maternal health services"*(Assistant Medical Officer, 2019).

On the other hand, 66.7. % of the respondents considered infrastructure constraints among the impeding factors, and this takes into accounts of inadequate tools and medicine for pregnant women, limited number of medical attendants, scant health facilities.

4.3 Consistence of maternal health services delivery and support functions and RBF system

Regarding maternal health services provided, Figure 4.2 reveals that 85.7% of the respondents indicated BEmONC services as among the maternal health services offered by their health facility; 3.4% indicated CEmONC services; while only 10.9% indicated that their health facility offers both BEmONC and CEmONC.

Figure 4.2: Maternal health services by health facilities



Source: Research data, (2019)

However, Table 4.3 exhibits that only 13.6% of the respondents (health providers) said that their facilities have sufficient and competent staffing level with adequate knowledge, skills, and experience to provide maternal health services. Also, 72.1% of the respondents argued to have insufficient staffing level but also acknowledged that the available staffs have adequate knowledge, skills, and experience in maternal

health services. Hitherto, 14.3% of the respondents claimed that their health facilities have insufficient competent staffs for maternal services, and yet the available staffs have inadequate knowledge, skills, and experience to provide maternal health services to clients.

Table 4.2: Staffing level in providing maternal health services

		Available staffs have adequate knowledge, skills, and experience in maternal health services		Total
		Yes	No	
Health facility with sufficient and competent staffing level	Yes	13.6	0.0	13.6
	No	72.1	14.3	86.4
Total		85.7	14.3	100.0

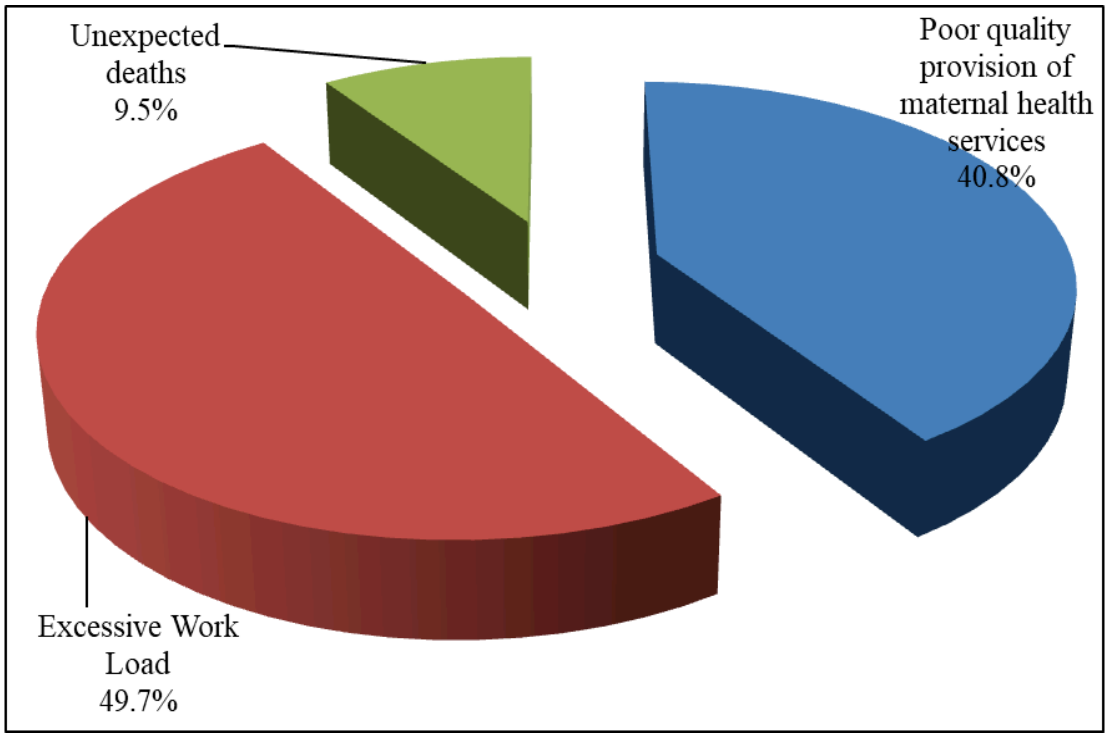
Source: Research data, (2019)

The study also assessed the ways in which shortage of staffing level affect maternal health services delivery. According to one of the respondents pointed out that;

> *"Our health facility has limited number of staffing level compared to attending clients for maternal health services; which has resulted to work overload especially when our colleague take vacation, ultimately poor provision of quality maternal health service that may results to unexpected deaths of pregnant women, their child, or both*"(Clinical Officer, 2019)

Generally, Figure 4.3 exhibits that shortage of staffing level have led to excessive work load among staffs, poor provision of quality maternal health services, and ultimately unexpected deaths; as indicated by 49.7%, 40.8% and 9.5% of the respondents respectively.

Figure 4.3: Effect of shortage staffs level on maternal health service delivery

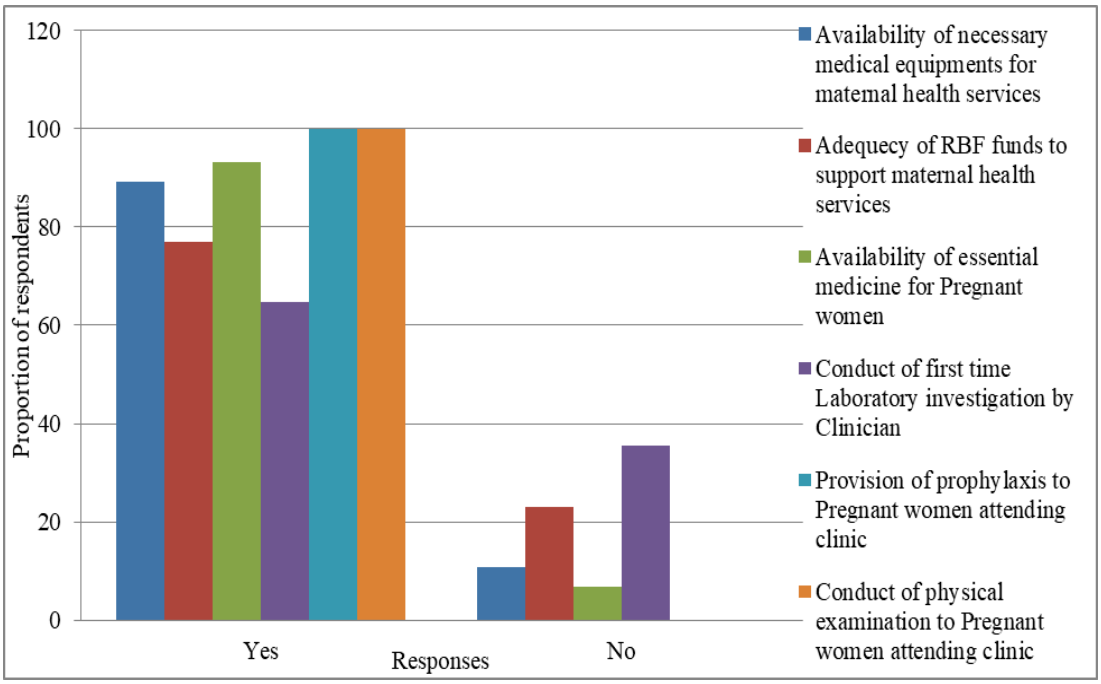


Source: Research data, (2019)

However, Figure 4.4 reveals that 89.1% of the respondents claimed that their health facilities have all necessary medical equipment for maternal health services, while 10.9% claimed otherwise. Also, 76.9% were satisfied by the available RBF fund to support maternal health services in their facilities while 23.1% of the respondents claim that RBF funding is inadequate to support maternal health functions,. Majority of the respondents (93.2%) agreed that their facilities have all essential medicine for pregnant women attending the clinic, while 6.8% disagreed; yet, 64.6% of the respondents (clinician and/ or physician) conducted all laboratory investigation (HIV check, Haemoglobin, VDLR/RPR and MRDT) for the first time pregnant women attend clinic, whereas 35.4% did not conduct any of the named investigation for the

first appearance of pregnant women in their health facilities. Finally, all respondents agreed to normally provide all prophylaxis (SP, F/folic acid) and conduct all physical examinations (Blood Pressure, fetal heart rate, lie, presentation) to pregnant women attending ANC visits.

Figure 4.4: Maternal health services delivery consistency with RBF system



Source: Research data, (2019)

4.3 Healthcare provider's perceptions on RBF bonus payment on the improvement of maternal service

Regarding the impact of RBF supplement payments on individual performance, Table 4.4 exhibits that 66% of the health professionals agreed that RBF supplement payments has impact on individual performance, while 34% disagreed. One of the respondents, who agreed, claimed that;

> *"Yes, RBF payments have impact on individual performance as most of health professionals tend to focus on the bonuses yet to be paid instead of ethically and professionally dedicating their services to health clients; which ultimately lead to poor performance and more chances of unexpected death"* (Clinical Officer, 2019)

Other health professionals considered RBF payments to have impact on individual performance in a positive manner. One of the respondents said that;

> *"Yes, RBF supplement payments impact my performance individually as the dedicated work effort diminish in absence of RBF bonuses; these extra payments draws in a motivation to perform my duties competently with extra dedicated efforts"(*Enrolled Nurse, 2019).

Hitherto, among the proportion of health professionals who considered RBF supplement payment to have no impact on their individual performance, argued that providing health services to their client is a call of duty and part of their responsibility which cannot be affected by bonus payments.

Table 4.3: Impact of RBF supplement payments on individual performance

		Impact of RBF supplement payment on individual performance		Total
		Yes	No	
Ways in which RBF affect individual performance	Motivate staffs to fully dedicate their efforts in provision of maternal health services	91 (61.9)	0	91 (61.9)
	Inflict hatred and envious feeling among staffs	6 (4.1)	0	6 (4.1)
	Does not affect; It is our call of duty, and responsibility	0	50 (34.0)	50 (34.0)
Total		97 (66.0)	50 (34.0)	147 (100)

Source: Research data (2019)

Generally, table 4. Further exhibit that 61.9% of respondents claimed that RBF supplement payments motivate staffs to fully dedicate their effort in providing quality maternal health services while 4.1% perceived it negatively as it inflict hatred and envious feeling among staffs. 34% of respondents agreed that RBF incentives do not affect individual performance.

Apart from the impact of RBF supplement payment on individual performance, Table 4.5. Shows that 40.8% of the interviewed health professionals perceived such

payments have no effect on employees' relationship in any way; while 59.2% perceived otherwise, 32.7% of respondents agreed that payment differentials inflicts hatred and ill feelings among staffs, 40.8% of respondents agreed that it does not inflict hatred and ill feelings while 26.5 of respondents said that it discourages working efforts One of the respondents claimed that;

"RBF incentives affect employee's relationship as significant packages are allotted to high ranking staffs, while their subordinates who performed loads of work are paid low; this inflict hatred and ill-feeling among staffs which eventually discourage dedicated working effort"(Registered Nurse, 2019)

Table 4.4: RBF incentives on employees' relationship

		RBF incentive payment affect employees' relationship		Total
		Yes	No	
Ways in which RBF incentives payment affect employees' relationship	Inflict hatred and ill-feelings among staffs due to payment differentials regardless of work performance	48 (32.7)	0	48 (32.7)
	No, does not affect in any way	0	60 (40.8)	60 (40.8)
	Discourage working effort	39 (26.5)	0	39 (26.5)
Total		87 (59.2)	60 (40.8)	147 (100)

Source: Research data (2019)

Notwithstanding, the study went further to assess the weather respondents agree or disagree on prior studies regarding the mismatch between change in quality of provided health services, and the documented statistics performance to draw in RBF incentives. As Table 4.6 exhibits, 8.2% of the respondents were unsure of the conclusive argument of prior studies; while 6.8% claimed it to be a false conclusion, stressing that they document statistics that matches their actual improvement in health services especially maternal health. However, majority—85% of respondents

support the conclusion reached by prior studies that RBF incentives produces improvement in documentation rather than an actual change in quality of health services particularly maternal health. One of the respondents said that;

> *"It is TRUE, RBF incentives produces improvement in documentation rather than actual quality of health services… respective staffs prepare sound statistics narrating improvement in health services after being informed of the next monitoring official visit… because most of the monitoring agency or officials recommend incentives payment relying on documented statistics rather than actual improvement in health services"* (Assistant Medical Officer, 2019).

Table 4.5: Health professional's perceptions on conclusion of prior studies that RBF incentives produce improvement in documentation rather than a change in quality of maternal health services

		Frequency	Percent
Perceptions in line with prior study's findings regarding actual improvement in health services and documented performance statistic s	**TRUE**, as the monitoring agency depends on documented statistics to awards RBF incentive	125	85.0
	FALSE, documented statistics must match the actual improvement in health services	10	6.8
	I Don't Know	12	8.2
Total		147	100.0

Source: Research data (2019)

Therefore, majority 53.1% of interviewed health professionals end up recommending that, RBF implementation is crucial for the improvement of health services especially maternal health; however, improvement in monitoring methodology of the program is in desperate need of revision. They suggested that monitoring schedules should be unknown to health facilities to avoid fabrication of documented performance statistics of a respective health facility. Other proportion of respondents 29.3% suggested that RBF incentives should be awarded based on individual performance by setting Key Performance Indicators (KPI) to avoid unfair distribution between high ranking staffs and their subordinates. Finally, 17.6% stressed for a timely payment of RBF incentives as it motivate individuals to devote their efforts in quality provision of health services.

CHAPTER FIVE
DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter take into consideration of the most crucial part of the results presented in the preceding chapter. It provides the implication of the findings on improving maternal health outcome, and the RBF program progress status. The discussion of the finding for this study are centred on the extent of maternal health improvement with regards to RBF implementation; consistency of maternal health services delivery and RBF system; and finally, healthcare provider's perceptions on RBF bonus payment on the improvement of maternal service

5.2 The extent to which maternal health services have been improved at health facilities following RBF implementation

The program aimed at quality health provision, and to improve the accessibility and utilization of health care services at all facilities; and the findings of this study justify the achievement of these objectives to a greater extent. The majority of the interviewed health professionals reveal the improvement of services following the implementation of RBF program. For instance, greater number of women whose labour is obstructed has received appropriate intervention as per settled national health guidelines; new-borns and their mothers have received routine postnatal care in line with standard precautions for preventing facility-acquired infections.

Previous similar studies have reported improvement in maternal health following RBF implementation. For instance, Mishra et al (2011) revealed a positive change in health service deliveries to 53% from 30% in India. Also, Ir et al (2010) revealed improvement in the health service deliveries to 64% from 27% in Bangladesh; whereas, in East Africa, the improvement in maternal health due to the implementation of RBF program were reported by Bellows et al (2012) in Kenya, and an increment of health service deliveries from 52% to 61% in Uganda (Population Council, 2011). However, the finding of the current study are inconsistence with previous studies by Nguyen et al (2012) in Bangladesh, and

Lundberg et al (2013) in Uganda who claimed to have seen no improvement in maternal health deliveries prior and post RBF implementation.

However, the improvement was not fully achieved as some of the health professionals interviewed claimed that some women with delay in labour do not receive appropriate intervention, and a routine postnatal care. This is considered to be the case as health professionals in their respective facilities attended greater number of clients which exerted work load that diminished the efficiency of service provided. Other reasons were inadequate medicine and tools for pregnant women; and ill- attitude of some health professionals towards their clients.

Also, the programmed aimed at improving the quality and utilization of data to identify challenges or problems facing health facilities for further evidence based decision making. Being the case, the findings evidenced that majority of health professionals interviewed (81.6%) did not carry an exit interview with their health clients to identify their level of service satisfaction. This imply that most of the facilities failed to conduct an exit interview with their client, which is a paramount effort in identifying problems facing a particular health facility; limiting the successful achievement of the program objective(s). On the other hand, the minority group that conducted an exit interview were fed back to be providing a satisfactory health services (12.2%), quality services (4.8%), and poor services (1.4%). It should be noted that, only the high ranked health professionals were responsible for carrying out the interview. These findings imply that, the feedback obtained was not significant enough to justify the performance of a particular health facility in term of quality service provision. Yet, mandate to carry out exit interview should not be vested in high ranked staffs only to allow gathering information for a successful improvement of health facilities.

In line with Universal Health Coverage goal (WHO, 2010) RBF was introduced in the country to strengthen health system through quality health care provision which is directly linked to the availability of health care commodities at the health facilities at the right time, quantities, conditions, and for the right procurement and delivery cost. The goal was to allow all people to access health services without suffering

financial hardship; however, the finding report that majority of the respondents indicated infrastructure constraints by **66.7. %**, thus inadequate tools and medicine for pregnant women, inadequate number of medical attendants, scant health facilities, and a long distance between residences and specific facilities, as a major factor limiting the improvements of maternal health services among pregnant women. This implies that, some health facilities still have limited staffs compared to number of clients they attend, yet, to some extent clients have to purchase medicine and tools off the facilities expensively, and spend long distance to access health services that jeopardize their health status, the current study evidence is supported by the previous study conducted in Zimbabwe by (Sithole, 2013) that inaccessibility of maternal services in rural areas led patients to walk long distance to access antenatal care, moreover previous study conducted in Mvomero Tanzania correspond to the current findings that patients have to walk 15 km from residence to the nearest functional health facilities for medical services, (Chimhutu, 2016) However, these findings contradict those of Basinga, (2010), and Hatt, (2010) who claimed that RBF implementation improved facility infrastructure, facility supplies, as well as medical equipment at every stage, being prenatal, maternity, and postnatal services.

Furthermore, (15.6%). of the respondents noted unethical provision of maternal health services by health care providers as among the factors hindering improvement of maternal health services, yet, unethical provision of health services takes into account of harsh language used by health specialists, and lack of work dedication in attending pregnant women as it was evidenced by Chimhutu, (2016) that negative attitude from health workers affects availability of the quality of healthcare. Notwithstanding, 17.7% of respondents considered multiple factors such as limited number of medical staffs compared to the number of pregnant women attending ANC, Distance between residence and facility which play as the wall towards implementation of RBF for improving maternal health services.

5.3 Consistence of maternal health services delivery and support to RBF system

The implementation of the RBF program stresses on providing quality improvement incentives to health facilities in term of health services, health specialists, facility improvement, and availability of necessary medicine for health clients. Regarding

maternal services offered, majority (85.7%) of the health facilities provides basic emergency obstetric and New-born care, implying that clients had to seek other services like comprehensive emergency obstetric provided from few facilities (3.4%) away from their nearest facilities. This increases the cost of accessing health services by health client which defy the primary goal of the program. Hitherto, few facilities (10.9%) have managed to be in line with RBF program as they provide both maternal health services to their clients. Concerning staffing level; most of the facilities still have inadequate number of staffs with adequate knowledge, skills, and experience in maternal health services; implying that these facilities lag behind the objective of the RBF program as majority (86.4%) of the health facilities have no sufficient and competent staffing level for maternal health services. As consequences of the named setbacks, health professionals in these facilities have been overloaded with work leading to poor provision of quality maternal health services, and in some cases unexpected deaths of mothers or new-borns or both.

Notwithstanding, majority of health professionals in the studied health facilities agreed that their facilities have necessary medical equipment (89.1%), receive adequate RBF funding for maternal (76.1%), have essential medicine for pregnant women (93.2%), and conduct all first time laboratory investigations (64.6%). These finding implies that, to a larger extent RBF implementation have played crucial role in improving maternal health service delivery. These findings discard the conclusion of previous studies by USAID (2016) which reported inconsistence between maternal health service deliveries to RBF implementation. In their study conducted in Democratic Republic of Congo, they concluded that procurement of necessary health commodities as RBF implementation did not significantly change maternal health services for both control and intervention groups.

5.4 Healthcare provider's perceptions on RBF bonus payment on the improvement of maternal service

The focus of the current study was to ascertain the impact of RBF payments on individual performance and employees' relationship; and the relevance of prior studies concerns regarding documented statistics for performance, and actual delivery of maternal health services. Being the case, the results postulate that RBF

supplement payments have impact to the majority of the respondents (health providers) interviewed in both positive and negative manner. Similarly to the findings of previous studies (See, IHI, 2015; WB, 2013) the majority of impacted group however, stressed RBF payments to have positive impact as it draw in the motivation among health professionals to fully dedicate their efforts in performing their responsibility. The minority group of respondents also perceive the payment to have negative impact, stressing that it inflicts hatred, envious, and ill-feelings among staffs; consistent to previous studies by Chimhutu, (2016) and Harrison et al,(2014). Nevertheless, other health professionals appeal to recognize their call of duty to serve their clients regardless to whether the supplements RBF payments are made or not; this was from feedback dominated the high ranked health professionals. These findings imply that majority of the health professionals have neglected their primary role of providing quality health services to client and communities as expected by the program. This is necessarily the case as the RBF supplement payments are more likely to influence health professionals to focus on material benefits rather than the health quality of their clients. These findings are consistent with previous studies (See, Abduljawad & Al-Assaf, 2011; Grittner, 2013; Laura et al., 2006).

These findings also have implication in the preparation of performance reports. Majority of the respondents supported the argument of the previous studies, thus RBF incentives exert improvement in documentation rather than actual quality of health services delivered. This finding imply that most health facilities have had fabricated their reports regarding the role in improving health service delivery to attract more RBF incentives; consistent with previous studies by Laura et al (2006), Chimhutu (2016), Anna et al (2014), and Sophie et al (2013). This finding calls for change in monitoring methodologies by monitoring authorities towards successful implementation of the program as suggested previously by Scott et al (2011). The finding further implies that the program should employ individual key performance indicators to conveniently award the incentives based on individual performance rather than paying much too high ranked officials compared to their subordinates, regardless of work performance which ultimately inflict hatred, envious, and ill-feeling among staffs.

CHAPTER SIX
SUMMARY, CONCLUSSIONS, AND POLICY IMPLICATIONS

6.1 Summary

The RBF program was adopted to achieve Universal Health Coverage (WHO, 2010) by strengthening health systems to allow all people to access the needed health services with less financial difficulties. Following the implementation of RBF program in various health facilities in Tanzania, this study aimed to conduct a process evaluation study on improvement made by the program so far on maternal health services in Kishapu District Council. The study specifically focused to ascertain the extent in which maternal health has improved as a result of program implementation, determination of whether the maternal health service delivery and function are consistent with the program; and finally examine the perception of health care providers on RBF bonus payment on the improvement of maternal health services.

To address the objective of the current study semi-structured questionnaires were distributed to collect data from randomly selected 147 respondents specialized in maternal health services from all 55 health facilities. The results obtained after data analysis reveals that, majority of health professionals (82.3%) provided appropriate intervention to women with delay in labour as per national health guidelines; provided routine postnatal care to mothers and their new-borns (80.3%); while all interviewed health professional provided care to women and new-borns as per standard precautions. Nevertheless, majority of health professionals (81.6%) did not carry out an exit interview with their clients to gather important information to address the identified health problems at the facilities. The results of the current study further revealed that infrastructure constraints was identified as the majority of health professionals (41.5%) to be the major obstacle towards utilization of maternal health services; while among other factors includes 15.6 % of respondents identified unethical provision of maternal health services by facility staffs who deviates from standards operational procedures (SOPs) on provision of maternal health services whereas 17.7 % of respondents identifies multiple factors such as limited number of medical staffs compared to the number of pregnant women attending ANC, Distance

between residence and facility which play as the wall towards accessing maternal health services.

The findings further evidence that, the delivery and support of maternal health services among health facilities are to a greater extent consistent with RBF program. Eventually, majority of health professionals (61.9%) perceived the program incentives to positively motivate their effort to provide health services; yet majority (85%) acknowledge the finding of prior studies, such that RBF incentives produces improvement in documentation rather than an actual improvement in the quality of health services, thus maternal health services in particular.

6.2 Conclusion

The implementation of the RBF program need to ensure the availability of necessary and essential infrastructures including expansion of maternal health services to increase coverage of CEmONC services to respond to current needs in addition to that, there should be constant distribution of health professionals in some of the health facilities based on the skill set and facilities requirements but with constant supply of essential medical tools and medicine for pregnant women; improving health facilities. Also, monitoring process of paying RBF incentives needs proper adjustments; such that the payment of quality improvement incentives should not be justified by documented statistics to avoid falsified results rather payment of incentives to health professionals should base on individual performance to avoid hatred, envious, and ill- feeling among health professionals. However un-informed semi-quarterly and quarterly facility visit by verifiers is recommended to observe how maternal services are being delivered for the purpose of exerting accountability and responsiveness of health professionals on patients needs.

6.3 Policy Implications

The findings of the process evaluation enlighten policy makers on the effectiveness of RBF program on improving health services delivery, and maternal health services utilizations in particular. However, the following recommendation should be taken into consideration towards successful achievement of program objective in the study area; and prior to extension of the program all over the country.

i. Infrastructural constraints remain a major factor for making the successful utilization of maternal health services by pregnant women to become obstacle-ridden. Basing on this finding, it is recommended that RBF quality improvement incentives should be dominated with necessary and essential tools and medicine for pregnant women; as well as increasing the number of health attendants in relation to attending clients to reduce work load which diminishes the provision of quality of maternal health services.

ii. Unethical attitude of health professionals towards clients, and traditional practice, belief, and lack of awareness on maternal health was also found to be the limiting factors in utilization of maternal health services. Being the case, having periodical trainings to health professionals, and campaigns to create awareness in the community regarding formal maternal health services stall as a future policy option towards improving the quality of health services.

iii. The upgrading of some health facility also underline the future policy option as minority of the facilities provided both services (BEmONC and CEmONC). This has forced clients to seek maternal health services away from nearest facilities which are likely to be associated with financial difficulties limiting the smooth attainment of program's goal.

iv. The RBF program employed point-based calculation of the staffs' incentives which was found to favour the high ranked staffs irrespective of loads of duties compared to their subordinates. It is recommended for the program to adopt an individual Key Performance Indicators (KPI) in which the payment of incentives should base on to discourage hatred, envious, and ill-feeling developed among employees in health facilities.

v. The monitoring of the performance of health facilities is based on documentation developed by respective health official rather than actual improvement in health services. Therefore, this study considers the adaptation of uninformed snap checks regarding the performance of health facilities to underline the future policy option for the success of the program. Yet, the

performance monitoring officials should not base on documented performance statistics in judging the quality improvement of a particular health facility.

vi. To achieve the program objective of collecting and utilizing data for planning purpose, it is important to consider health clients as among the program crucial stakeholder. Thus, each facility implementing RBF program should have a quality performance questionnaire to be filled up by clients to document the quality and satisfaction of health services provided by the facility; and they should be submitted and reviewed by program monitoring officials during their visit.

6.4 Limitation of the study

Improvement in health services with regards to the implementation of RBF program is a desired objective to health professionals and their respective facilities. Being the case, information collected from health professionals might have been subjected to biases; ultimately, the respondents might have overestimated the level of improvement in maternal health service provision. To the best of researcher knowledge, no process evaluation have been carried out in the study area since the implementation of RBF program; and this study being dominated by cross-sectional data exert limitation in establishing a causal relationship between program implementation and improvement in maternal health services.

6.5 Area for future evaluation

Reference made to the mentioned limitations of the study, future studies should be extended to both parties—health professionals and clients. Such studies will anticipate the problem of overestimation of maternal health services improvement as the result of RBF program implementation. They will also allow justification of prior studies regarding the consistent between documented performance of health facilities and actual performance narrated by clients regarding the health improvement. Yet, future studies accommodating longitudinal data will be suitable to clearly establish the causal relationship between improvement in health services and RBF program implementation.

REFERENCES

Abduljawad, A., & Al-Assaf, A. F. (2011). Incentives for Better Performance Healthcare . *SQU Medical Journal, May 2011, Volume 11, Issue 2* .

AHRQ. (2009). *National Health Disparities report.* Rockville, MD 20850: U.S. Department of Health and Human Services.

BD. (2018). *Business Dictionary*. Retrieved January 18, 2018, from www.businessdictionary.com: http://www.businessdictionary.com/definition/financial-incentive.html

Benjamin Olken, B. A., Onishi, J., Wong, S., Gulo, G., Wilson, J., Guggenheim, S., Surya, S. (2014). Should Aid Reward Performance? Evidence from a Field Experiment on Health and Education in Indonesia. *American Economic Journal: Applied Economics*, 6(4), 1–34. https://doi.org/10.1257/app.6.4.1

Chand, S. (n.d.). *your article library.com*. Retrieved May 23, 2018, from www.yourarticlelibrary.com:http://www.yourarticlelibrary.com/hrm/incentives/incentives-types-financial-and-non-financial-incentives-explained/35360

Chimhutu, V. (2016). Result Based Financing in the health sector of a low-income country.

Glasziou, P. (2012). When financial incentives do more good than harm: aa checklist.

Grittner, A. M. (2013). Result Based Financing: Evidence from performance-based financing in the health sector. 7.

Harrison, M. J., Dusheiko, M., Sutton, M., Gravelle, H., Doran, T., & Roland, M. (2014). Effect of a national primary care pay for performance scheme on emergency hospital admissions forambulatory care sensitive conditions: controlled longitudinal study.

Health Results Innovation Trust Fund. (2015, February). *RBF HEALTH*. Retrieved April 21, 2019, from https://www.rbfhealth.org/resource/performance-based-financing-conceptual-framework: https://www.rbfhealth.orgat-work-1917994

Heathfield, S. M. (2018, January 31). *the balance careers*. Retrieved may 23, 2018, from www.thebalancecareers.com: https://www.thebalancecareers.com/what-are-incentives

IHI. (2015). Taking Result Based Financing from Scheme to System.

Implementation Research to Improve Quality of Maternal and Newborn healthcare, Malawi2016*Bulletin of the World Health Organization*

IOM. (1993). *Access to Health Care in America.* Washington D.C: National Academy Press.

Laura, Petersen, Woodard, L., Urech, T., Daw, C., & Sookanan, S. (2006). Does Pay-for-Performance Improve the Quality of Health Care? *Effectiveness of Pay-for-Performance* .

Lemiere, C. (2013). Evaluating the Impact of Result based financing on health workers performance. New Review of Information Networking, (2), 133–146. https://doi.org/10.1080/13614570802105992

MCHP. (2008, 02 14). *University of Monitoba*. Retrieved 05 24, 2018, from http://umanitoba.ca/:http://mchpappserv.cpe.umanitoba.ca/viewDefinition.php?definitionID=102752

Ministry of Health. (2011). Health Sector Strategic Plan 2011-16, 2020(July). Retrieved from,http://www.gov.scot/Topics/International/int-dev/mdp/healthsectorstrategicplan

MIT*http//:web.mit.edu*

MoHCDGEC. (2015, 10). Result Based Financing (Rbf). *Operational Manual* . Ministry of Health Community Development Elderly Gender and Children.

MoHCDGEC. (2015, 10). Results Based Financing (RBF). Tanzania: Ministry of Health Community Development Elderly Gender and Children.

MoHCDGEC. (2016). United Republic of Tanzania the National Road Map Strategic Plan To Improve Health in Tanzania (2016 - 2020), (June).

MoHCGED. (2016). the United Republic of Tanzania, (february), 1–32.

MoHSW. (2009). Health Sector Strategic Plan III July 2009 – June 2015: "Partnership for Delivering the MDGs." Ministry of Health and Social Welfare, (July 2009).

MoHSW. (2013). Health Sector Strategic Plan III. *"Partnership for Delivering the MDGs"* . Dar es Salaam: MoHSW.

MoHSW. (2015b). Tanzania Health Sector Strategic Plan 2015 -2020 (HSSP IV), 2020(July), 53.

Mujinja, P., & Kida, T. (2014). Tanzania: Policies, Indicators and Accessibility to Health Services.

NKRA. (2014, 09 22). *Development Partners Group Tanzania.* Retrieved 01 26, 2018, from www.tzdpg.or.tz:https://www.tzdpg.or.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/health/Key_Sector_Documents/Induction_Pack/Final_HSSP_IV_Vs1.0_260815.pdf

Result Based Financing in Zimbabwe: Any Changes in Health Delivery System2013*Journal of Social Welfare and Human Rights*

Result Based Financing of Maternal and Newborn Healthcare in Low and Middle Income Countries2013

RHMT. (2019). Mwenendo wa vifo vitokanavyo na uzazi na Vifo vya Watoto Wachanga Katika Mkoa wa Shinyanga: Mwaka 2015 - 2018. *Uzinduzi wa Kampeni ya Jiongeze Tuwavushe Salama* (p. Slide 4). Shinyanga: Shinyanga Regional Commissioner's Office.

Scott, A., Sivey, P., Ouakrim, D. A., Willenberg, L., Naccarella, L., Furler, J., et al. (2011). The effect of financial incentives on the quality of health care provided by primary care physicians.

Toonen, J., Lodenstein, E., & Coolen, A. (2012). Results-Based Financing in healthcare. *Developing an RBF approach for healthcare in different contexts: the cases of Mali and Ghana* .

UN. (2015). *Financing for Development.* New York: United Nations.

UN. (2015). *Transforming Our World: The 2030 Agenda for Sustainable Development.* New York: sustainabledevelopment.un.org.

University of Rwanda*who.int › entity › alliance-hpsr › projects › alliancehspr_rwanda_report*

WB. (2013). *Africa Health Forum.* World Bank.

WB2011Yes Africa Can*Success Stories from a Dynamic Continent*

WHO. (1948). *World Health Organization*. Retrieved 05 24, 2018, from www.who.int: http://www.who.int/health_financing/universal_coverage_definition/en/

WHO. (2008). *Primary Health Care-Putting People Front.* Geneva: WHO.

World Health Organization (WHO). (2016). *WHO recommendations on antenatal care for a positive pregnancy experience WHO Library Cataloguing-in-Publication Data WHO recommendations on antenatal care for a positive pregnancy experience*. World Health Organization, 10(January), 176.

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APPENDICES

Appendix I: Questionnaire

This semi structured questionnaire is prepared for Healthcare Providers who works in maternal health services to serve the purpose of ***"process evaluation of result based financing program on improving maternal health in Kishapu district council in Shinyanga region***" which is conducted by **Tedson Ngwale**, a master student in Monitoring and Evaluation for Health (MSc.HM&E) at Mzumbe University. Kindly you are requested to tick the appropriate answers based on your experience and understanding in implementing RBF program. The researcher believes your precisely information will help him fulfil the award of Master degree in Monitoring and evaluation for Health and the researcher by any means guaranteeing you the confidentiality of the information provided upon the completion of this questionnaire.

SECTION A

To determine whether the maternal health services delivery and support functions consistent with RBF system

1) Which one of the following of maternal services does the facility provides?
   a) BEmONC services
   b) CEmONC services
   c) Both of A and B

2) Does the facility have sufficient and competent stuffing level and to perform maternal services?
   a) Yes, b) No.

3) If No does the health provider who attends clients have adequate knowledge, skills and experience in maternal services?
   a) Yes, b) No

4) What are the staffing level professional requirements of the facility for maternal services?

..... And how many professional does the facility currently have?.....
.....

5) How does this problem of shortage of staffing level affect maternal services delivery?.....

6) Does the facility have all necessary medical equipments for maternal services?

a) Yes b) No.

7) Is the RBF funding adequate to support maternal functions?

a) Yes b) No

8) Does the facility have all essential medicines pregnant women when attending ANC?

a) Yes b) No

9) Does the Clinician/Physician conduct all laboratory investigation (HIV check, Haemoglobin, VDLR/RPR and MRDT) for first time pregnant women attending clinics?

a) Yes b) No

10) Do you normally provide all prophylaxis (SP, F/folic acid,) to pregnant women attending ANC visits?

a) Yes b) No

11) Do you normally conduct all physical examinations (BP, Fetal heart rate, lie, presentation) to pregnant Women in every clinic visit?

a) Yes b) No.

SECTION B

Assessment of maternal health services whether have been improved at health facilities due to the RBF programme implementation.

12) Do the Women with delay in labour or whose labour is obstructed receive appropriate interventions according to the National Health guidelines?

a) Yes b) No

13) Do the Mothers and newborns receive routine postnatal care?

a) Yes b) No

14) Do all women and newborns receive care according to standard precautions for preventing hospital-acquired infections?

a) Yes b) No

15) Do you normally conduct exit interview to clients and or relatives of clients to assess satisfaction on whether the ANC services have improved?

a) Yes b) No

16) If yes, what are the relative/client's feedbacks?

.....

.....

.....

.....

.....

.....

SECTION C

Perception of health professionals on RBF bonus payment

17) Does RBF supplement payment have impact on individual performance?

a) Yes b) No

18) How does RBF program have affected your performance?

.....

.....

.....

20. Previous studies indicates that RBF incentives produces improvement in documentation rather than a change in quality of health services particularly maternal health (what can you say about this?)

.....

.....

.....

21. Does RBF incentive payment affect the employee's relationships?

a. Yes

b) No

22. Ways in which RBF incentives payment affect employees relationships

.....

.....

.....

.....

23. Any policy recommendation to improve RBF performance?

THE END