ASSESSING THE EFFECT OF OUTPUT-BASED HEALTH BASKET FUND ON THE PERFORMANCE OF HEALTH FACILITIES AND COUNCILS IN MOROGORO AND PWANI REGION 2013-2018

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By

Esther John Lema

A Dissertation Submitted in (Partial) Fulfilment of the Requirements for the Degree of Master of Public Health of

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CERTIFICATION

The undersigned certify that she has read and here by recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation titled *"***Assessing the Effect of Output-Based Health Basket Fund on the Performance of Health Facilities and Councils in Morogoro and Pwani Regions 2013-2018",** *in* partial fulfilment of the requirements for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences.

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Dr. Happiness P. Saronga

(Supervisor)

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Date

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I, **Esther John Lema**, declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature……. Date…….....….....

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DEDICATION

I dedicate this work to my late father John Lema; he has been an inspirational to me, especially for instilling a hard work spirit into me. Besides, I sincerely acknowledge that, I would not be where I am today if not for his love, affection and support he offered me throughout the years. I further dedicate this work to my brother Tumsifu John Lema for sponsoring my studies, encouraging me to pursue this level of education, and motivating me throughout my studying years. May Almighty God bless you all abundantly.

ABSTRACT

Background: The Government of Tanzania (GOT) introduced Health Basket Fund (HBF) in 1999/2000 as part of the health sector reform and sector wide approach (SWAP) for planning. The aim of HBF was to strengthen Tanzania's health systems by providing additional funding to Central Ministries and Local Authorities. Due to lack of demonstrable progress over the past 15 years of the HBF's implementation, the recommendation was made to introduce an output-based approach. The GOT and Development Partners contributing to the HBF designed a new performance based HBF in 2015 to support the fourth health sector strategic plan (HSSP IV) 2015 to 2020. In this approach, the funds are disbursed to the GOT following an attainment of agreed results at National, Regional and Council level. After several meetings the GOT decided to adopt an output-based approach on the health sector performance, specifically in councils and health facilities, because it was not practiced in Tanzania.

Aim: This study assessed the effect of output-based HBF on the performance of the health facilities and councils.

Methodology: The study used descriptive cross-sectional design, and employed mixed methods to enable data collection to attain the research objectives. It utilized an in-depth interview (IDI) to obtain qualitative data, while quantitative data was extracted from DHIS2 database. The study was conducted in Kibaha DC whereby two health facilities namely Ruvu Station and Disunyara dispensary were involved. In Morogoro MC, the study involved Sabasaba and Mafiga health centers. MS Excel was used to perform a trend analysis on the HBF indicators from quantitative data. A thematic approach using NVivo software version 12 was used to conduct data analysis for the qualitative part.

Results: The findings obtained showed that, the use of the HBF funds has led to an improvement of the service delivery outputs and enhanced direct linkage/access for the members of the community, since the services are brought directly to them.

Conclusions: All health facilities visited showed an increase in the star rating assessment from baseline to reassessment. This means that, staff in those health facilities took necessary steps to address the gaps found during the star rating assessments. Besides, the performance of the health facilities on service delivery and health system indicators, as described above, was in turn reflected in the performance of the respective LGA. Nevertheless, increasing availability and improvement of other sources of funding is quite critical in order to ensure that the achievement of HBF performance indicators is maintained. In addition, the introduction of DHFF has led to improvement of the service delivery and enhanced linkage/direct access for the community members. This is because, services are brought directly to the people, while the community members are directly participating in the decision-making process to determine their health-related needs.

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ACRONYMS

ANC	Antenatal Clinic
BRN	Big Results Now
CCHP	Comprehensive Council Health Plans
CHF	Community Health Fund
CHSB	Council Health Service Board
D/CHMTs	District or Council Health Management Teams
DC	District Council
DHFF	Direct Health Facility Financing
DHIS2	District Health Information System version 2
DMO	District Medical Officer
DPs	Development Partners
FY	Fiscal Year
FYDP	Fiscal Year Development Plan
GFF	Global Financing Facility
GOT	Government of Tanzania
HBF	Health Basket Fund
HFGC	Health Facility Governing Committee
HFMT	Health Facility Management Team
HSR	Health sector reforms
HSSP	Health sector strategic plans
ICHF	Community Health Fund
IDA	International Development Association
IRB	Institution Research Board
JAHSR	Joint Annual Health Sector Review
LGAs	Local Government Authorities
MC	Municipal Council
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children

MOHSW	Ministry of Health and Social Welfare
MTR	Mid-term review
MUHAS	Muhimbili University of Health and Allied Sciences
MVC	Measles-Containing Vaccine
NGO	Non - Government Organization
NHIF	National Health Insurance Fund
PHC	Primary health care
PNC	Postnatal Clinic
POA	Plan of Action
PO-RALG	President's Office Regional Administration and Local Government
POW	Program me of Work
RAS	Regional Administrative Secretary
RBF	Results Based Financing
RHMTs	Regional Health Management Teams
SDGs	Sustainable Development Goals
SPHCR	Strengthening Primary Health Care for Results
SWAp	Sector Wide Approach to planning
TDV	Tanzania Development Vision
TT	Tetanus Toxoid immunization
URT	United Republic of Tanzania
USAID	United States Agency for International Development
WHO	World Health Organization

DEFINITION OF TERMS

This section describes the meaning of terms or technical terms used in this study. It provides unambiguous meaning of the terms or technical terms that could otherwise be interpreted in different ways.

Health Basket Fund	Pooling mechanism of development partner's resources to jointly finance Tanzania's health sector with harmonized procedures and processes.
Output based financing	A financing approach that links services' delivery with disbursement of funds
Output based Health Basket Fund	Health basket fund that links achievement of agreed results with disbursement of funds
Performance based financing	A mechanism by which health facilities are, at least partially, funded based on their production of a pre-determined output.
Performance	The degree to which a development intervention or a development partner operates according to specific criteria/standards/ guidelines or achieves results in accordance with stated goals or plans.
Quality health care	Refers to availability of competent and motivated health-care service providers and the availability of essential physical resources, such as clean water, essential medicines, equipment and supplies.
Result	The output, outcome or impact (intended or unintended, positive and/or negative) of a development intervention. Related terms: outcome, effect, impacts.

Results based financing	A cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken.
Service provider	A health worker responsible for giving care to patient and/or client

CHAPTER ONE

1.1 INTRODUCTION

The Government of the United Republic of Tanzania introduced health sector reforms in 1993 that were elaborated in the Health Sector Reform Proposals (URT, 1994). These reforms adopted a Sector-Wide Approach to planning (SWAp), an international development approach that "brings together governments, donors and other stakeholders from any sector". (WHO, World Health Report 2000).

The Government, in collaboration with health Development Partners (DPs) developed the Programme of Work 1999-2003 (POW) and Plan of Action 1999/2000-2000/2001 (POA) to implement the health sector reforms. These were the precursors of the Health Sector Strategic Plans (HSSP) that are now developed every five years. The health sector strategic plans are guided by the Tanzania Development Vision 2025 (TDV2025) (URT 2000) and Sustainable Development Goals (SDGs) (UN 2015).

Consistent with the international agreement on aid effectiveness, (OECD, 2005 & 2008) DPs committed to employ government financial systems to support the health sector. A number of DPs decided to pool un-earmarked resources leading to the creation of the Health Basket Fund (HBF) in 1999/2000. HBF is a financing mechanism whereby DPs pool resources to jointly finance Tanzania's health sector with harmonized procedures and processes. This helps to reduce transaction costs, increase efficiency and productivity. The DPs that contributed to HBF in 1999 included Canada, Denmark, Germany, Netherlands, Norway and Switzerland. Subsequently other DPs joined the HBF while others left from time to time.

The SWAp stakeholders (including DPs supporting the HBF) conduct an annual field visit each year as part of the Joint Annual Health Sector Review (JAHSR) to learn from firsthand about the progress made and challenges faced by implementers of the HSSP at the local level. Over the years, it was noted that though the HBF has been supporting Tanzania's health sector for more than 15 years since its inception, the challenges faced at the local level remain the

same and critical health sector indicators were not improving. As a result, questions began to emerge about the effectiveness of the HBF pooled financing approach in addressing local health priorities.

The World Bank, and several other DPs, decided to change the modality for supporting the health sector and advocated for the adoption of an Output- based approach (World Bank, 2015). This led to the GOT and the DPs to support the HBF's adoption of an output-based HBF (or results based), whereby funds are disbursed following the attainment of an agreed results at National, Regional and Council level. Performance score cards were developed for measuring results (outputs) for each level and for determining the amount of funds to be disbursed at each of these levels. Currently, 2015-2020, the HBF is supported by seven DPs, which include Canada, Denmark, Ireland, Korea, Switzerland, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and the World Bank.

The performance results of all HBF recipients nationally, determine the amount of HBF disbursed by DPs to the GOT. The HBF Memorandum of Understanding (MOU) provides for a base amount of funding that would be provided by DPs upon sustaining achievements (base indicators) made from the implementation of the HSSP III and need to be sustained during HSSP IV (URT, 2015). The indicators used to measure the performance of the councils and health facilities are shown in Table 1.

Table 1: LGAs performance indicators for HBF

LGAs performance indicators for HBF

1. % of pregnant women attending four or more antenatal care visits (ANC4)
2. Proportion of mothers who received 2 doses of intermittent preventive treatment (IPT2) for malaria during last pregnancy
3. % of institutional deliveries
4. % of women of reproductive age (15-49 years) using modern family planning methods
5. % of pregnant women who receive adequate quantity of iron and folate tablets during their current ANC visit (enough supplies for next visit)
6. Proportion of children 12-59 months receiving at least one dose of Vitamin A supplementation during the past year
7. % of PHC facilities with "3 stars" rating or higher
8. Number and percentage of Public Dispensaries with at least one skilled staff
9. % of Public PHC facilities with continuous availability of 10 tracer medicines (medicines, vaccines, medical devices) in the past year
10. % of LGAs with functional Council Health Service Boards (meeting quarterly)
11. % of completeness of quarterly DHIS 2 entry by LGA (MTUHA phase one forms by Day 30 after the end of each quarter)
12. % of LGAs with unqualified opinion in the external audit report

The new HBF prioritizes allocation of funds to the Local Government Authorities (LGAs), which are receiving 90% of all available funds. Other levels are allocated as follows (i) Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) (6%) (ii) President's Office Regional Administration and Local Government (PO-RALG) (1%) and (iii) Regional Health Management Teams (RHMTs) (3%). At the district level, the HBF resources are allocated to the Council Health Management Teams (CHMTs) (15%), Community initiative (5%) and Primary Health Facilities (80%). It is anticipated that, this new approach of the performance-based HBF will contribute to the achievement of the targets identified by HSSP IV.

In addition, the output-based HBF will support effective decentralization of the LGAs and health facilities in order to enhance the delivery of quality primary health care services and strategic prioritization for underserved populations.

In Africa, the government of Kenya has set a good example by establishing The Health Sector Services Fund (HSSF) through its Ministry of Public Health and Sanitation, which disburses funds directly to health centers and dispensaries. This is an innovative scheme that is geared to enable health facilities to improve health services delivery (Waweru, 2013).

Furthermore, the study done in Burundi has shown that, there were impressive achievements with HSSF in terms of ensuring that, the allocated funds reach to the intended facilities, are spent appropriately, are properly managed and used in a way that strengthens community's involvement (Rudasingwa & Uwizeye, 2017).

Therefore, this study aimed to assess the effect of output-based HBF on the performance of the health facilities and councils. The study focused on disbursement and utilization of funds in councils and the health facilities. It also assessed the contribution of output-based HBF on health sector's progress in Kibaha District Council and Morogoro Municipal Council.

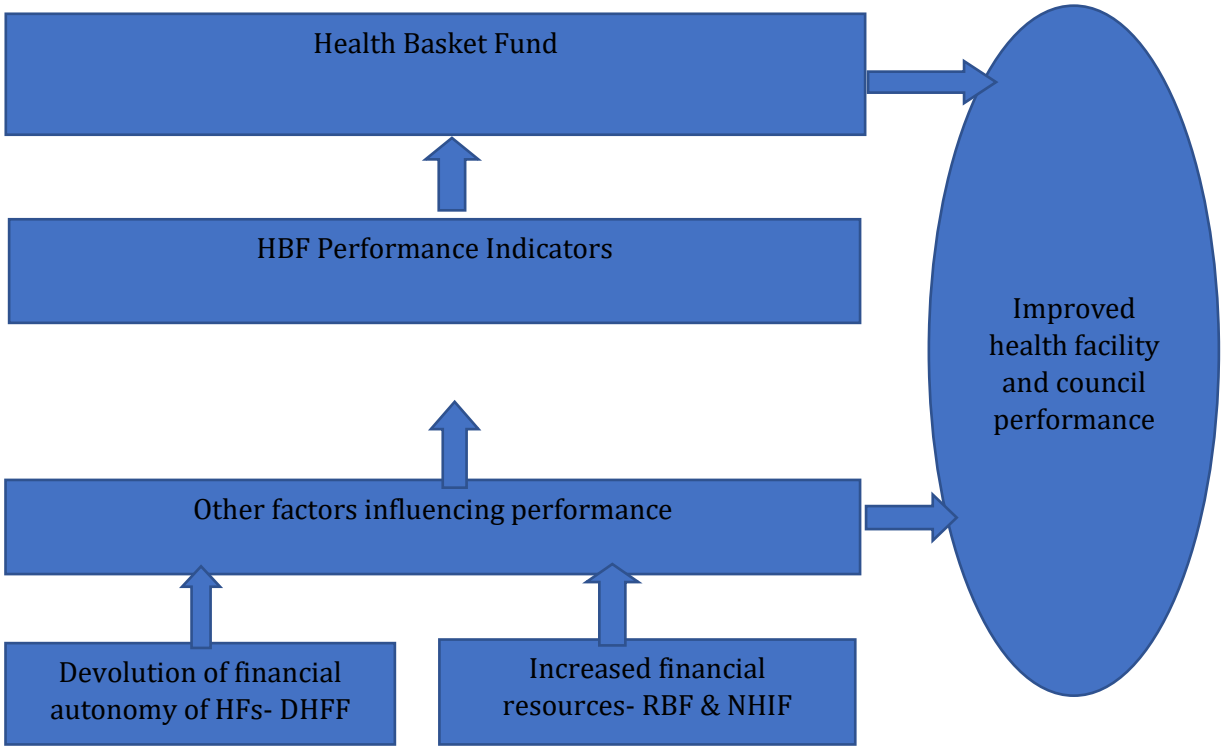
1.2 Statement of the Research Problem

In 2015, the GOT and the DPs who support the HBF changed from an input based to an output- based approach in which the recipients of the funds provided by the HBF including councils and health facilities are allocated funds based on performance achieved in the previous year. This performance is measured by LGAs performance score card with twelve performance indicators developed by HBF that look at health services delivery and health system measures affecting quality of services.

The initial results had shown improvement of the health output based on indicators measured by the HBF in some councils and health facilities, but not in others (URT, 2019). The reasons for this difference in performance required to be scientifically studied. In addition, there is a dearth of information on the link between output-based HBF and improved outputs in the health sector. Hence, there was a need to study the contribution of HBF to improving health outputs and outcomes, as well as other factors that affect the performance of health facilities and councils towards achieving health output targets.

1.3 Conceptual Framework

An article on understanding the implementation of direct health facility financing and its effect on health system performance in Tanzania developed a conceptual framework that centered on the theory of change and the implementation fidelity framework (Kapologwe et al 2019). In respect, the topic studied adopted various health system interventions in order to assess factors that may influence health facilities and councils towards achieving HBF performance indicators. The illustration below shows the relationship between output- based HBF performance indicators that are influencing funds disbursement from HBF, and on the other side factors which are influencing HBF performance indicators towards improved health facilities and council's overall performance. Other sources of funding such as NHIF and RBF improve services delivery at health facilities, which in turn improves HBF performance indicators and ultimately improves overall performance at health facilities and councils' level.



Source: Article on Direct Health Facility Financing, (Kapologwe et al 2019)

Figure 1: Conceptual framework for Health Basket Fund

1.4 Rationale of the Study

Findings from this study will help on expanding knowledge regarding the functionality of the HBF as a mechanism for health sector financing. Also, they will enable stakeholders to gain knowledge concerning how Output Based HBF improves performance of the health facilities and councils on delivering quality health services. Moreover, they will enable health sector's stakeholders to gain deep insight concerning various factors which hinder the adopted HBF model to effectively achieve its intended targets.

The new HBF approach of output-based financing aims to stimulate improved delivery of the quality health care services and utilization at all levels by making health managers and staffs focusing on key service delivery indicators. Therefore, the findings from this study are expected to provide enriched knowledge on how the new HBF approach as a mechanism for health sector financing helps to improve service delivery performance in the health facilities and councils.

1.5 Research Questions

1.5.1 General research question

What is the effect of output-based HBF on the performance of health facilities and councils?

1.5.2 Specific research questions

1. What is the effect of HBF on selected health facilities performance indicators between 2013- 2018?
2. What is the effect of HBF on selected council level health performance indicators between 2013- 2018?
3. What is the effect of other interventions on health performance indicators of the health facilities and councils between 2013- 2018?

1.6 Research Objectives

1.6.1 Broad objective

To assess the effect of output -based HBF on the performance of health facilities and councils between 2013- 2018.

1.6.2 Specific Objectives

1. To assess the effect of HBF on selected health facilities performance indicators between 2013- 2018.
2. To assess the effect of HBF on selected council level health performance indicators between 2013-2018.
3. To determine the effects of other interventions on health performance indicators of health facilities and councils between 2013- 2018.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Health Sector Performance, National and Global Perspectives

The TDV 2025 envisions that Tanzania will have graduated to a middle- income country by 2025. The TDV 2025 aims at achieving a high-quality livelihood for all Tanzanians; attaining good governance and rule of law; and developing a competitive economy. In order to achieve these aims, the TDV 2025 has identified goals and targets that need to be achieved by all sectors including the health sector (URT, 1999).

The health sector target for ensuring the realization of access to quality primary health care for all has guided the development of strategies to achieve MDGs (HSSP III) and now the SDGs (HSSP IV). At the same time, Tanzania has revived the use of five-years development plans to guide and accelerate the progress towards achieving goals set by the TDV 2025. In relation to the health sector, the first of these five-years' Development Plans 2011/12-2015/16 (FYDP I) was aligned to the last 5 years of the MDGs and HSSP III, while the current FYDP II (2015/16-) is aligned to the SDGs and HSSP IV.

The Mid-Term Review of HSSP III (MoHSW, 2013) determined that the reproductive Health Services were not performing well despite investments made in this area. Many areas were not expected to reach the HSSP III targets. This seemed to be a repeat of the situation that has been happening in Tanzania since independence in 1961. The Health policy objective in Tanzania is to improve the health and well-being of all Tanzanians, especially those most at risk, and to be responsive to the needs of the population (URT 2007).

The national Health policy was formally written down in 1990 and revised in 2007. Currently, the third edition is under preparation. However, prior to 1990, the aim of the health policy was to ensure that every citizen resides within 5 km of a health facility. In subsequent years, the heath sector was geared more towards preventive health services, and later towards attaining the universal primary health care (health for all) in line with the World Health Organization (WHO) Alma Ata declaration (WHO, 1978).

In September 2015, the UN adopted the 2030 Agenda for Sustainable Development with its 7 Sustainable Development Goals (SDGs) and 169 targets (UN 2015). The SDGs build upon and aim to address the unfinished work of Millennium Development Goals (MDGs) agreed in 2000. While progress was made in a number of areas, the progress with MDGs was uneven, especially in Africa.

In Tanzania, the MDGs related to child mortality were surpassed as demonstrated by falling infant mortality rates from 99 per 1,000 live births in 1999 to 51 per 1,000 live births in 2000. In the same period under-five mortality declined from 147 to 81 per 1,000 live births. However, there was slow progress in reducing maternal mortality ratio (432 deaths per 1,000 live births in 2012) and neonatal mortality rate (26 per 1,000 live births), hence failing to meet the specified MDG targets (TDHS, 2010).

The lack of progress was partly attributed to low coverage of facility deliveries as a proxy for skilled birth attendance, family planning and the persistent high under nutrition (with stunting in 42% of children under five years of age). The health-related goal 3 of the SDGs aims to ensure healthy lives and promote well- being for all at all ages. SDG 3 has nine targets that include those addressing unmet MDG targets relating to maternal, newborn and child health, as well as ensuring the availability of resources (Financial, Human and Infrastructure) to facilitate and guarantee universal access to safe, effective, quality and affordable essential medicines and vaccines for all.

The targets of SDG 3 among other things, therefore is to ensure that by 2030, (a) global maternal mortality ratio is reduced to less than 70 per 100,000 live births, (b) neonatal mortality is reduced to at least as low as 12 per 1,000 live births and (c) under-5 mortality is reduced to at least as low as 25 per 1,000 live births. In addition, SDG 3 aims to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

2.1.1 HBF in Health facilities and Councils performance

Tanzania is committed towards achieving goal 3 of the sustainable development goals (SDGs). Nevertheless, despite the implementation of the National health policy, and progress made over the years, health outcomes and impact indicators including life expectancy, infant and child health, maternal health and other health indicators have remained poor.

The use of output-based financing is a new strategy which has the potential to reform the health sector with system-wide effects on service delivery, leadership and governance, human resources, health management information systems, medicines and health technology. Strengthening health systems consequently improves accountability, efficiency and equity.

In Tanzania and many low and middle- income countries (LMICs), the government is used to providing funding to health providers by paying for their inputs such as personnel, medicines, supplies and equipment through line-item budgets. The accountability of the service providers is based on how the inputs were used (Kutzin, Yip, & Cashin, 2016).

Thus, with the introduction of output-based financing system's, it is important that more attention is given to understand how these may influence service providers to improve quality and efficiency as well as being accountable for specific outputs or health outcomes.

The government of Kenya through the Ministry of Public Health and Sanitation, has established the Kenya Health Sector Services Fund (HSSF), which disburses funds directly to health centers and dispensaries. This is an innovative scheme aimed to enable health facilities to improve health service delivery (Waweru, 2013).

Moreover, a study in Burundi has shown that, there were impressive achievements with HSSF in terms of ensuring that the allocated funds reach to the targeted facilities, are spent appropriately, properly managed and used in a way that strengthens community involvement (HMFCs), (Rudasingwa & Uwizeye, 2017). Additionally, the study indicated that service delivery and quality of the health care services has been strengthened. Therefore, the introduction of the performance-based HBF's financing in Tanzania raises up a number of questions that need to be answered. One of the intriguing questions include; has the performance based HBF managed to break the long-observed phenomena, whereby increased resources and health sector reforms have failed to show a direct linkage between increased resources and improving health outcomes?

2.1.2 Effects of other innovations on the performance of health facilities and councils on HBF indicators

The Health care Big Results Now 2015-2018 (BRN Health) developed concrete plans in specific health-care areas and in alignment with the health targets of the TDV 2025. Specifically, BRN Health aimed to accelerate the reduction of maternal and neonatal mortality by improving performance, governance, and accountability in primary health care (PHC), specifically in four areas: 1) performance management, 2) human resources for health, 3) health commodities, and 4) mother and child health in priority regions. Thus, the GOT embraced a strong shift towards a performance-based approach in the health sector through the incorporation of the BRN initiatives and Results Based Financing (RBF) as part and parcel of the strategies to achieve goals and objectives of the HSSP IV (URT 2015).

The BRN Initiatives include Star Rating Assessment (SRA), Health Facility Plans (HFP), Direct Health Facility Financing (DHFF), and the Facility Financial and Accounting Reporting System (FFARS). In addition, the GOT developed the Health Financing Strategy (HFS) 2017-2021 to guide the path towards Universal Health Coverage (UHC), which cements the GOT's move towards output-based payment approach for service providers. Other innovations at health facility level included strengthening the availability of other sources of funding such as Result Based Financing (RBF), cost sharing/user fees, National Health Insurance Fund (NHIF) and Community Health Fund (CHF).

The above-mentioned initiatives are some of the factors that may affect performance of the health facilities and councils in achieving the targets of the HBF indicators. However, it is not clear how these factors and the output based HBF enhance each other. Furthermore, there is paucity of empirical literature related to this topic. Following that, this study aimed at answering these questions by assessing the contribution of HBF to improving performance, as well as factors that affect the performance of the health facilities and councils in achieving targets set by

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Design

This study adopted a cross-sectional descriptive study design and employed a mixed method for collecting both quantitative and qualitative data.

3.2 Study area

The study was conducted in Pwani and Mororogoro Regions, respectively. In Pwani Region, it selected Kibaha DC out of nine Districts found in the region, and chose Morogoro Municipality to represent Morogoro Region. Kibaha DC and Morogoro MC were purposefully chosen after being acknowledged to be among the Districts in Tanzania, where the HBF has been well implemented.

In Kibaha DC the study selected two health facilities namely Ruvu Station and Disunyara dispensaries, and chose Sabasaba and Mafiga health centers in Morogoro Municipality. Besides, the researcher justifies the selection of Pwani Region because of its experience with output- based financing scheme, since it was a pilot region for the National Result Based Financing (RBF) scheme.

3.3 Study Population

The study involved health facilities that are owned by the government and are the recipients of the HBF funding. Health management teams, health service providers and health facility governing committees were involved as the key informants for the study.

The two regions were purposively selected for this study. One council was selected from each region based on good performance on selected HBF indicators as reported in the DHIS2 database. From each council involved two health facilities were selected, one based on good performance on selected HBF indicators, and another based on poor performance as reported in the DHIS2 database.

In depth interviews were conducted to CHMT level and the following key informants were interviewed: District Medical Officer (DMO), District Health Secretary (DHS), focal persons for Reproductive and Child Health Services (RCH), District Immunization and Vaccine Development Officer (DIVDO), Health Management Information System Focal Person (HMIS-FP) and a member of the Council Health Service Board (CHSB).

At the health facility level, the following were interviewed: Facility in-charge, focal persons for RCH and one member of the Health Facility Governing Committee (HFGC).

3.4 Sample size

The study used purposive sampling to identify study sites and respondents. Six selected respondents were interviewed from four health facilities and twelve respondents from both councils (CHMT) were also interviewed.

Purposive sampling is commonly used in qualitative research. It involves selecting research participants according to the need of the study (Palys, 2008); that is the researchers choose participants whom owing to their profound experience can provide in-depth information that is suitable for the intended research.

3.5 Data Collection Methods and Tools

Secondary data pertaining to health sector performance was collected mainly by reviewing DHIS2 database at the district level in a respective LGA. Second, key informant interviews were used to elicit information on potential effect of the HBF on healthcare provision, particularly on the quality of care, as well as factors affecting performance of the health facilities and councils. This method was found to be useful because a deeper understanding of the health care providers was extremely required for acquiring accurate and reliable information for the conducted research. Such information could be efficiently obtained through probing questions and dialogue.

3.5.1. In-depth interviews

These were direct, unstructured and formal one-to-one interviews. The interview involved a total of eighteen respondents from both the health facilities and council level. An interview guide was used as a tool to conduct key in depth interviews with the respondents. The research team obtained written consents from all participants before conducting the interview. Besides, while interview guide facilitated and guided the performance of the in-depth interviews, digital recorders were used for recording the conversations. The length of each interview conducted took approximately between 30 to 40 minutes.

3.5.2 Data collection tools

The following data collection tools were used for the study:

i. *A data extraction form*. Data from DHIS2 and Facility HMIS registers/forms was entered in an MS Excel spread sheet to enable trend analysis and comparison for the period before and after the introduction of the performance based HBF.

ii. *Key Informant Interview Guide (KII guide*) was used to gather responses from Health Facility Management Teams and Council Health Management Teams about reasons and factors influencing the trend of the data obtained. The guide was also utilized to collect information from Council Health Service Board and Health Facility Governing Committee on their engagement in planning and overseeing the implementation of facility health plans.

3.5.3 Quality Control

The study tools were pre-tested to confirm their applicability, coherence and comprehensiveness of the questions. During qualitative data collection the audio-recorded interviews were transcribed by the interviewer. The quality of the transcription was assessed by picking the first two transcripts from each transcriber. The supervisor read the Swahili version of the transcripts while listening to the audio-recorded interview to assess the quality. The interviews were translated from Swahili to English. For each translator, the first and seventh translation that was submitted was reviewed, and checked for quality of the translation through reading the Swahili paragraph followed by the English translated paragraph for the full document.

3.6 Variables

Variables explored by the study were based on the twelve performance indictors at council level, which consisted of six variables for service delivery and another six for health system performance. Service delivery was measured using mother and child indicators, which form the bulk of the health care service delivery at PHC level. Health system performance was measured by indicators of the selected pillars of the health system, namely human resources, logistics and health system financing. These indicators were;

- For the mother and child service delivery: Antenatal Clinic consultation (ANC4), Tetanus Toxoid immunization (TT), institutional deliveries, intermittent preventive treatment (IPT2), modern family Planning and vitamin A supplementation in children.
- For health system performance: star rating assessment, human resources (workforce, presence at the service), availability of tracer drugs, council (and facility) governance, HMIS and financial management.

This study investigated the trend of indicators at council and health facility levels before and after the introduction of performance based HBF. Data for the service delivery indicators was extracted from the DHIS2 data and confirmed during KII. Performance of the health system indicators was measured using the star rating assessment results.

Star rating is a Tanzanian certification system that looks at technical aspects of health services quality as well as assessment of organization, management and governance at primary healthcare facilities. The star rating model scores performance in four domains:

(i) Facility management and staff performance;
(ii) Service charters and accountability;
(iii) Safe and conducive facilities;
(iv) Quality of care and services. The star rating is based on the minimum score among these four domains, on the principle that balanced performance in all domains is required for overall quality improvement, client satisfaction, and access to services. Star rating may range from one to five-star rating. The star rating serves as a signal of improvement in the quality of primary health care services.

A baseline assessment is conducted at all facilities in the council jurisdiction: dispensaries, health Centre's and hospitals inclusive of both public and private facilities, and quality improvement plans (QIPs) are developed to address the gaps identified in the star rating assessment report. Periodic re-assessments will provide an objective measure of performance improvement following QIP implementation.

3.7 Data Analysis

Quantitative data was analyzed through MS excel software programme that was utilized to perform a trend analysis on the HBF indicators. The study aimed to compare the performance before the introduction of output-based HBF (2013-2014) and after its introduction (2015-2018).

Qualitative data collected through semi-structured interviews using KII guides was initially transcribed by the interviewers and the data was analyzed using NVIVO software. A thematic approach was used to organize the data, analyze and interpret them. According to Marshall and Rossman (1999) thematic data analysis is the process of bringing order, structure and interpretation to the mass of collected data. The collected qualitative data in the form of notes and rich texts was cleaned, summarized and organized to create established, meaningful patterns with the aim of identifying themes within the data. This process provided an avenue for the researcher to get acquainted with the collected information.

Data analysis for each specific objective was as follows:

1. Health facility performance indicators in 2014 were compared to the performance indicators accomplished between 2015-2018 in order to determine the effect of output-based HBF in the health facilities.
2. Council performance indicators in 2014 were compared to the performance indicators achieved between 2015-2018 in order to determine the effect of output- based HBF in the councils.
3. Health facility and council performance indicators in 2014 and 2015-2018 was dependent on the existence of other factors apart from output-based HBF. Thus, qualitative analysis was designed to explore factors other than the Output-Based HBF, which are affecting performance at the health facilities and councils.

3.8 Ethical considerations

The study was conducted with utmost adherence to ethical procedures governing a scholarly research work. Ethical clearance was sought from MUHAS IRB. Permission to conduct the study was sought from the District Medical Officer (DMO) and Municipal Medical officer (MMO) from Kibaha DC and Morogoro MC, respectively. Written informed consent was obtained from participants prior to their participation in the study. Privacy and confidentiality were seriously observed to protect all participant's information and the records obtained from the health facilities, at all times.

CHAPTER FOUR

4.0 RESULTS

4.1 Socio- demographic Information of the participants

The study involved 18 key informants, aged between 25-55 years old, of which 10 were male and 8 were females. These respondents consisted of 4 participants from Kibaha DC, 3 from Ruvu station dispensary and 2 from Disunyara dispensary. In addition, it involved 4 respondents from Morogoro MC, 2 from Mafiga health center, and the remaining 3 from Sabasaba health center. The in-depth one to one interview was administered to all the respondents involved. Some participants were on travel duty out of their work stations during the time of the researchers visit to their duty stations, which compelled the researcher to make multiple visits to meet them. In some facilities staff targeted as key respondents could not be found. For instance, the positions for 5 staff identified for the interview in the study design were vacant.

4.2 Service delivery and Health System Performance at Health Facility Level

The performance of the health facilities in Pwani and Morogoro Regions on HBF indicators were supported by data obtained from DHIS2 from 2013 to 2018, as well as qualitative information gathered from key informants through interviews.

4.2.1 Distribution of Pregnant Women who Attended ANC4 Plus Visits

Antenatal care visit is one of the indicators used to assess health care service delivery during pregnancy. For the wellbeing of a pregnant woman and that of the infant, a pregnant woman needs to attend at least four or more antenatal care visits. This indicator is measured by the proportion of pregnant women attending ANC4 visits in each health facility. Figure 3 showed that, ANC4 visits at Disunyara dispensary increased rapidly from 35% in 2013 to 100% in 2018, while at Mafiga health center the ANC4 visits were relatively low from 30% in 2013 to 55% in 2016, with a slight drop to 50% in 2017, but risen again to 64% in 2018.

One respondent said that: *"the percentage of ANC4 visits increased over the years due to huge efforts made by the health care workers in educating pregnant women to attend their first clinic and on the importance of completing the planned ANC4 visits for the safety of the unborn child and mother"*. (Respondent, Disunyara dispensary).

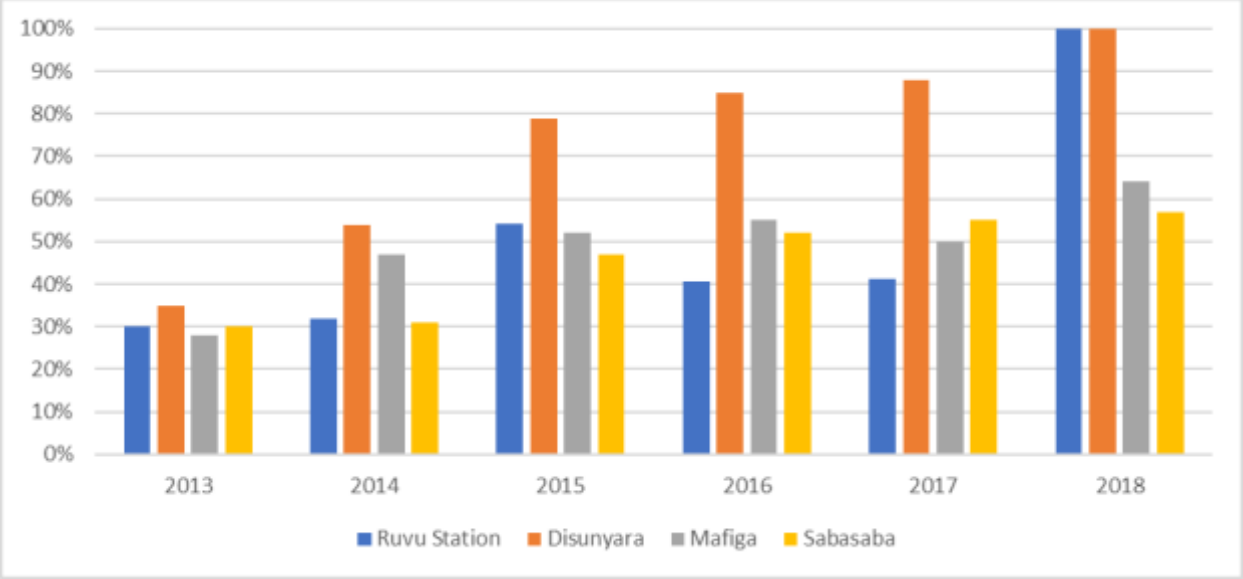


Figure 2: Proportion of clients attending four or more ANC visits in study sites from 2013 to 2018

4.2.2 Coverage of Intermittent Preventive Treatment (IPT2) in ANC Clients

Intermittent preventive treatment is an antimalarial medicine given to pregnant women at routine antenatal care visits, regardless of whether the recipient is infected with malaria or not. This indicator is measured by the proportion of women receiving at least 2 doses of sulfadoxine-pyrimethamine (IPT2) during pregnancy at each health facility. As indicated in Figure 3, the study observed that, there was considerable variation in the trend of IPT2 coverage among the four health facilities during the study period. IPT2 coverage at Mafiga health center was found to be low between 2014 and 2015 with 28% and 32% coverage,

respectively. However, it increased to 68% in 2016, but dropped abruptly in 2017 to 32%, before increasing to 64% in 2018. Ruvu station dispensary achieved more rapid progress with IPT2 coverage having experienced a significant increase in the IPT2 coverage from 30% in 2013 to 78% in 2018.

One respondent said that: "*the increase of the coverage of IPT2 depends on the availability of medical supplies, hence the coverage varied throughout the years"* (Respondent, Sabasaba health center).

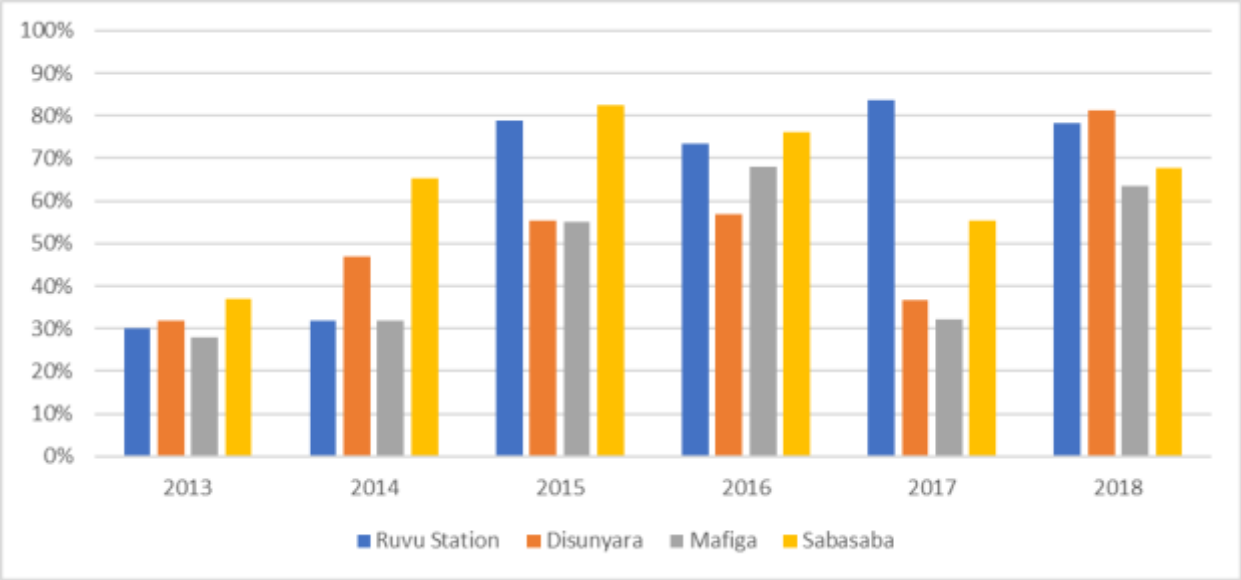


Figure 3: Proportion of ANC clients receiving IPT2 in study sites from 2013 to 2018

4.2.3 Proportion of Institutional Deliveries

This indicator is measured by the proportion of pregnant women giving birth at each health facility. From Figure 5, the study observed a considerable variation in trend for the four health facilities throughout the study years. At Sabasaba health center there was an increase in institutional deliveries from 30% in 2013 to 65% in 2018, while at Disunyara dispensary the trend significantly improved from 28% in 2013 to 76% in 2018.

The findings indicated that, the institutional deliveries had increased in all health facilities over the years covered by this study. One respondent asserted that: *"health workers helped substantially to improve the situation by providing counselling to pregnant women attending ANC4 visits about the importance of institutional deliveries for the safety of the mother and new born".* (Respondent 1, Ruvu station dispensary).

Another respondent said that: *"institutional deliveries have increased over the years as a result of Community Health Workers (CHW) who have been providing door to door counselling to pregnant women on the importance of institutional deliveries".* (Respondent 2, Mafiga health center).

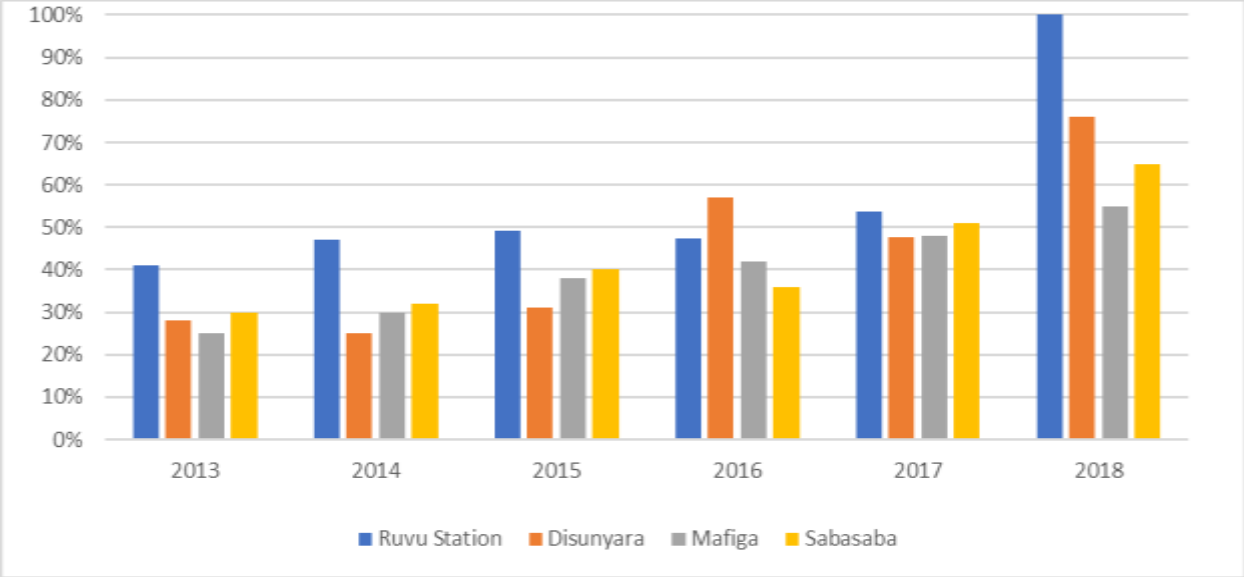


Figure 4: Proportion of institutional deliveries in study sites from 2013 to 2018

4.2.4 Proportion of Women of Reproductive Age (15-49 years) who used Modern FP Methods

This indicator is measured by looking at the number of active contraceptive users (including and excluding condom) as a proportion of the total number of women of child bearing age. As demonstrated in Figure 6, the study observed that, the contraceptive coverage in all four health

facilities increased throughout the years covered by this study. The findings indicated that, in Disunyara dispensary the contraceptive coverage substantially increased from 55% in 2013 to 96% in 2018, which is the highest percentage achieved in 2018 when compared with other health facilities. Nevertheless, the study found that, there was only a modest increase in the utilization of FP methods in all health facilities in Morogoro Region. For instance, in Mafiga health center the FP utilization increased from 45% in 2013 to 60% in 2018, which is an increase of merely 15% in five years.

One respondent said that: *"the FP utilization indicator was used during the piloting of payment for performance (P4P) scheme. This helped us to keep track of this indicator and on increase in its coverage".* (Respondent, Ruvu station dispensary).

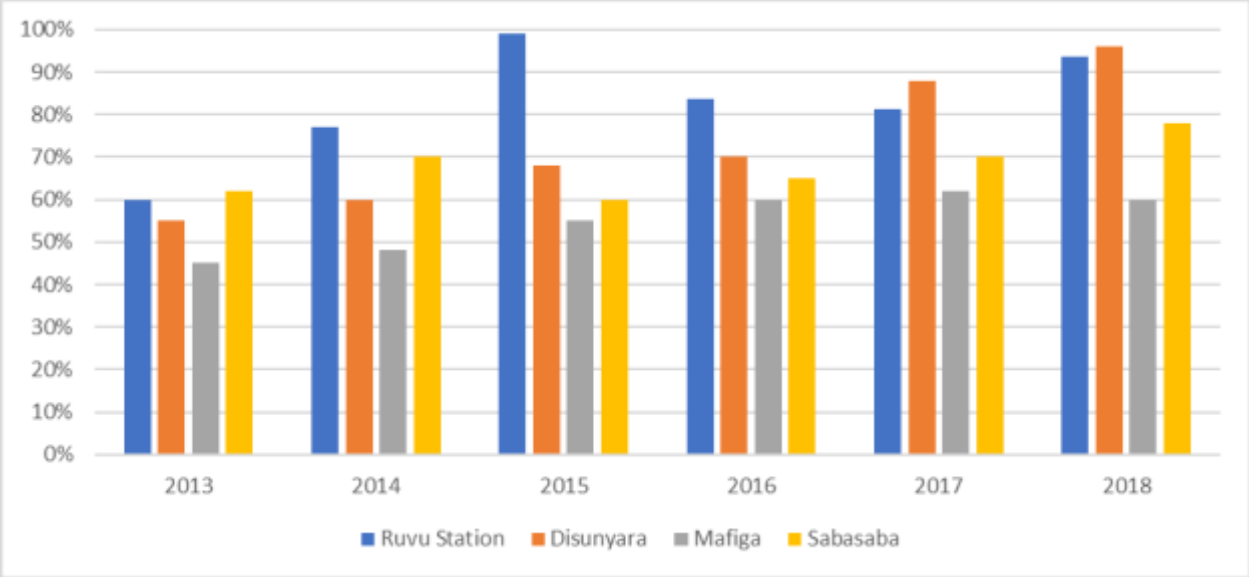


Figure 5: Proportion of contraceptive coverage in study sites from 2013 to 2018

4.2.5 Proportion of Pregnant Women who Received Fefol (Iron Folic) Supplementation

This indicator is measured by the proportion of pregnant women who receive adequate quantity of iron and folate tablets during their current ANC visits. As shown in Figure 7, the study observed that, the proportion of the pregnant women who received FeFol was significantly high substantiated by the fact that, most health facilities managed to distribute Fefol to more than 70% of the pregnant women in all years covered by this study, except in the year 2017.

One of respondents commented during the interview that: *"the achievement of this indicator depends highly on the availability of medical supplies".* (Respondent, Mafiga health center).

Another respondent said that: *"the underperformance observed in the year 2017, was highly contributed by the shortage of medical supplies experienced in that particular year, ultimately led to poor performance in this indicator*". (Respondent, Disunyara dispensary).

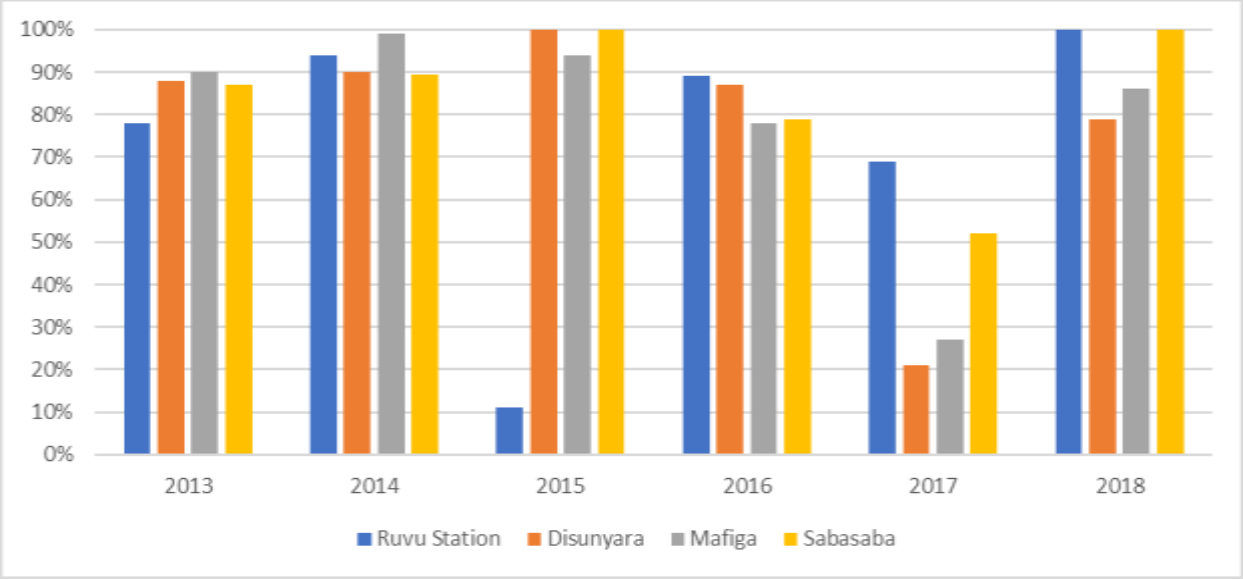


Figure 6: Proportion of Pregnant Women who received Fefol in study sites from 2013 to 2018.

4.2.6 Proportion of Children 12-59 Old Months who Received Vitamin A supplementation

This indicator measures the proportion of children 12-59 months old who received at least one dose of vitamin A supplementation during the past year. From Figure 8, the study observed that, in the years covered by this study, Ruvu Station dispensary and Sabasaba health center achieved the highest proportion of children who received Vitamin A supplement. This is statistically confirmed by the achievement of the Ruvu Station Dispensary from covering 60% of children in 2013 to covering 100% of the children in 2018. Also, Sabasaba Health Center increased its coverage from 88% in 2013 to 100% in the following years of the study. However, Mafiga Health Center experienced a slow increase from 30% in 2013 to 56% in 2018. Disunyara Dispensary achieved 35% coverage in 2013, but made a quite slow increase of merely 37% coverage in 2017. Nevertheless, in 2018 Disunyara Dispensary achieved a very rapid increase of 100% in providing children with Vitamin A supplementation.

One respondent stated that: *"we managed achieve good results for this indicator because Vitamin A supplementation was provided to every child during routine under 5 clinic visits and by conducting campaigns to sensitize community member on the importance of this supplement to children's health".* (Respondent, Sabasaba health center).

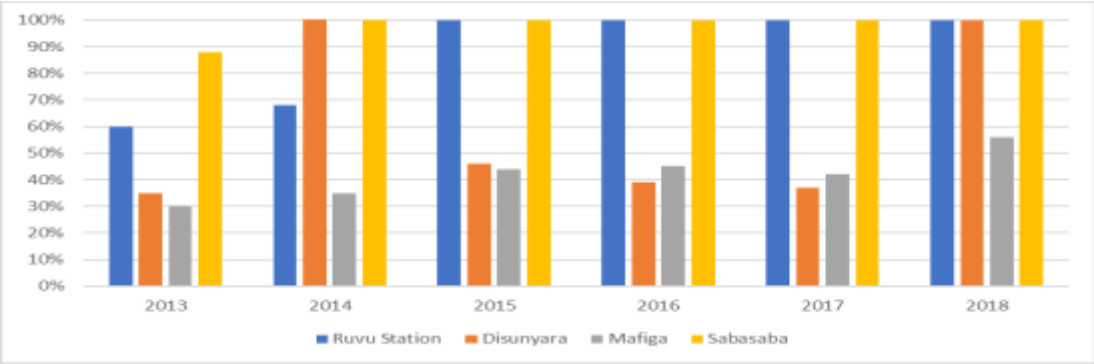


Figure 7: Proportion of Children Who received Vitamin A Supplementation in study sites from 2013 to 2018

4.2.7 Availability of 10 Drugs Tracer Medicine

Based on the results shown in Figure 9, the study observed that, there was adequate tracer medicine at all health facilities achieving more than 70% throughout the years covered by the study. There was a very little variation for the year of 2016 as observed in the stated figure.

Tracer medicines were mentioned as one of the HBF indicators that receive the highest funds compared to others. The four visited health facilities in Kibaha DC and Morogoro MC were found to have a large stock of medicines, vaccines and medical devices. One of the participants commented by saying that: *"HBF funds come with instructions that specify how the funds should be spent, and the priority is attached on the purchase of medicines and medical supplies".* (Respondent, Ruvu station)

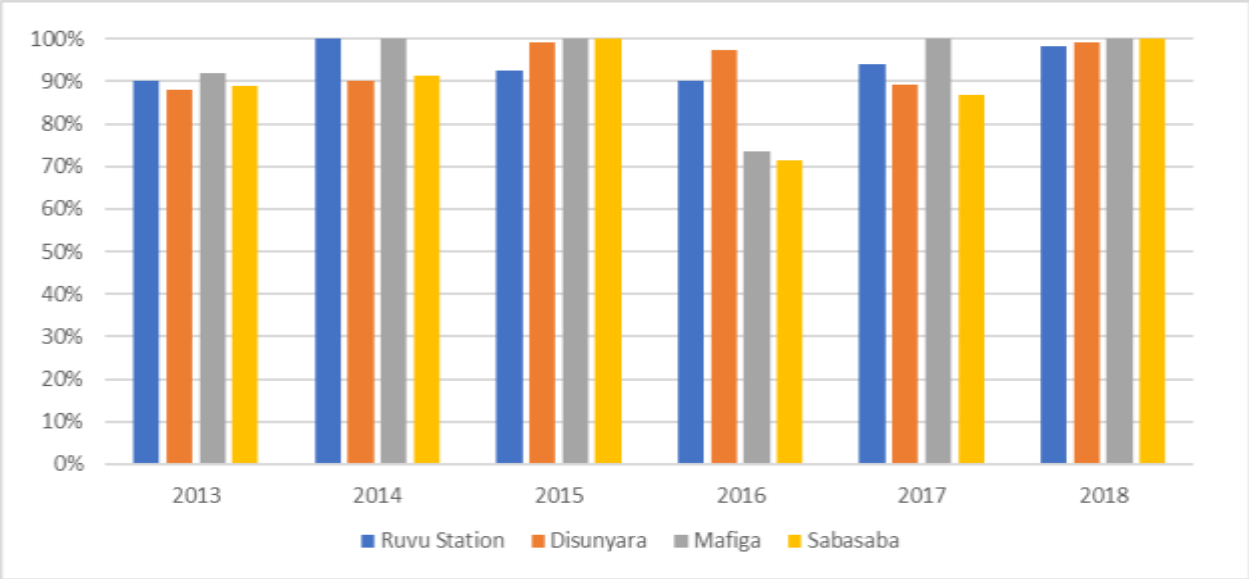


Figure 8: Availability of Tracer Medicine in study sites from 2013 to 2018

4.2.8 Star Rating Assessments to the Health Facilities

The National star rating assessment conducted in 2015/16 (baseline) and 2018 (reassessment) showed that, the percentage of health facilities achieving one star or above increased from a baseline of 66% to 96% during re-assessment. In Pwani region the percentage of health facilities achieving one star or above had rapidly increased from a baseline of 49% to 100%, while Morogoro region had a modest increase from a baseline of 71% to 89% (MOCDGEC 2015/16 & 2018). The performance in star rating assessment at the four health facilities was as follows; Ruvu Station Dispensary and Disunyara Dispensary improved from one star in 2017 to two- star rating in 2018. Mafiga Health Center scored two-star rating in 2016 and three- star in 2018, while Sabasaba Health maintained a three- star rating in both years of 2016 and 2018.

One of the respondents interviewed commented that, *"star rating assessment has helped the health facility to improve in some performance indicators in the health facilities due to routine assessments being conducted" (Respondent, Ruvu station).* Another respondent said: *"star rating assessment provided the CHMT an objective means of measuring and comparing the performance of health facilities in the council and with other councils or regions" (Respondent, Kibaha DC).*

4.2.9 Availability of Skilled Health Care Workers at the Health Facilities

According to the new Staffing levels guideline (2014), the minimum number of health workers required to provide quality health services in all Tanzania's health facilities is 145,454. However, the actual number of health workers available is 63,447, meaning that, currently there is a shortage of 82,007 health personnel, which is equivalent to 56.38% (URT,2014).

Thus, based on the findings of this study, all health facilities in both Morogoro and Pwani regions do not have adequate amount of skilled health personnel to reflect the standard guidelines for staffing requirements in the health facilities.

One of the respondents articulated that: *"80% of the health facilities in this council do not have sufficient human resource. For instance, at the dispensary level there should be 9 staff while at the health center up to 70 staff. However, most dispensaries in the region have 4 to 5 staffs. In fact, we have only 1 dispensary in this council (Magindu), which has 9 staff." (Respondent, Kibaha DC).*

4.2.10 Availability of functional of HFGC at the Facility Level

The study found that, all health facilities in both Pwani and Morogoro Regions have a functional Health Facility Governing Committee (HFGC) that conduct quarterly meetings each year as stipulated by the guidelines.

One respondent said: *"all health facilities in the council have functional HFGC consisted of 8 members, and the frequency of HFGC meetings has increased since 2015. This is essential requirement for approving plans and budget for HBF" (Respondent, Morogoro MC).*

4.3 Performance of HBF indicators at Council Level

Table 2 indicates the trend of the HBF indicators in Kibaha DC and Morogoro MC between 2014 and 2018. While the institutional deliveries and availability of tracer medicines have been high in both regions before and after the introduction of output based HBF, there has been a significant increase in the performance of other HBF indicators in Kibaha DC and Morogoro MC, respectively. For example; in Kibaha DC the proportion of ANC4 visits increased rapidly from 35% in 2014 to 84% in 2018, while in Morogoro MC there was a modest increase from 51% in 2014, to 64% in 2018. Another significant increase was observed in the proportion of ANC IPT2 in Morogoro MC, which increased from 51% in 2014 to 80% in 2018, while in Kibaha DC the IPT2 coverage was 73% in 2014, then dropped to 54% in 2015, before making gradual to 74% in 2018.

Table 2: HBF performance indicators at Council Level from 2014 to 2018

Indicators	2014	2015	2016	2017	2018
Kibaha DC					
% institutional deliveries	100%	100%	98%	100%	100%
ANC4 plus visits coverage	35%	44%	55%	71%	84%
ANC IPT2 coverage	73%	57%	67%	69%	74%
Contraceptive coverage- Modern methods	63%	68%	67%	50%	61%
Proportion of children 12-59 months received Vitamin A supplementation	13%	100%	100%	93%	98%
Proportion of pregnant women receive Fefol (Iron Folic) supplementation	66%	72%	49%	34%	71%
Tracer medicine entire package 10 drugs availability	91%	93%	94%	94%	98%
Morogoro MC					
% institutional deliveries	100%	94%	87%	92%	93%
ANC4 plus visits coverage	51%	50%	44%	48%	64%
ANC IPT2 coverage	51%	80%	56%	48%	80%
Contraceptive coverage- Modern methods	43%	45%	51%	41%	40%
Proportion of children 12-59 months received Vitamin A supplementation	15%	100%	100%	100%	100%
Proportion of pregnant women receive FeFol (Iron Folic) supplementation	68%	80%	77%	35%	77%
Tracer medicine entire package 10 drugs availability	97%	100%	78%	94%	98%

Source: MOHCDGEC, DHIS2 Database and MTUHA Reports

4.4 Effects of other interventions on performance of health facilities and councils on selected HBF indicators

4.4.1 Availability of other Sources of Fund

The other sources of funding such as RBF, cost sharing/user fees, NHIF and CHF have provided direct incentives to staff, which helped to promote better service delivery to clients and ultimately promoting the councils' performance on HBF indicators. Other sources of funding have also helped to support paying Extra Duties' Allowance to health service providers, which cannot be funded by HBF. In addition, they have been supplementing the GOT and HBF funds in supportive supervision activities, footing fuel bills for transportation, purchase of stationeries and conducting outreach activities.

One of the respondents interviewed said *"own source/payment schemes have been of great help in supporting our health facility to improve the performance of HBF indicators by enabling us to continue with service delivery, when we are waiting for the HBF to arrive, since they are always disbursed late." (Respondent, Mafiga Health Centre).*

4.4.2 The Impacts of DHFF to CHMT and Health facilities

The findings have indicated that, the DHFF has improved the utilization of funds provided by HBF for CHMT activities through various ways including the reduction of the long chain of command, by enabling the disbursement of the funds directly to the health facilities. Also, it has helped the health facilities to improve decision making process and prioritization of the needs which have direct impact to the community served. DHFF has led to improvement of the infrastructure, improved community awareness through sensitization during outreach activities, as well as supervision activities, improvement of maternal health care, availability of medicines and medical supplies, and reduction of diseases. At the council level, it has helped to improve service delivery at the health facility through mentorship and supervision, as well as pre- planning budget.

One respondent noted that *"following the adoption of the DHFF scheme the CHMT's have been enabled to focus their efforts on mentorship and supervision in order to improve service delivery at the health facilities"* (Respondent, Kibaha DC).

CHAPTER FIVE

5.0 DISCUSSION

The overall objective of this study was to assess the effect of the health financing model famously known as the output-based HBF on the performance of the health facilities and councils in Pwani and Morogoro Regions between 2015-2018. The achievement made in 2015-2018 was compared with those attained in the period between 2013 and 2014, which was funded using the previous design of the HBF that provided inputs based on approved plans. The GOT and Development Partners decided to transform the HBF to an output-based payment approach after observing that, the key health indicators did not improve significantly for over 15 years of HBF financing modality in Tanzania. Thus, the study analyzed the performance of councils and health facilities in Morogoro and Pwani Regions using twelve HBF performance indicators in the LGAs' performance score card, particularly looking at the service delivery and health system measures that affect quality of the provision of the health care services.

5.1 The effect of HBF on selected health facilities performance indicators

The study found that, there was a significant increase in utilization of the health services in the selected health facilities in Pwani and Morogoro Regions as measured by the proportion of pregnant women attending four or more antenatal care visits (ANC4), proportion of mothers who received 2 doses of intermittent preventive treatment (IPT2) for malaria during pregnancy, percentage of institutional deliveries and percentage of women of reproductive age (15-49 years) using modern family planning methods. Pwani Region made significant and consistent increase in the performance of the mentioned indicators compared to Morogoro Region, which not only had a modest increase in the performance, but also experienced varying performance across the studied period.

A similar study in Kenya that reviewed the Kenya Health Sector Services Fund (HSSF), which also disburses funds directly to health centers and dispensaries (Ramana Gandham & Waalelign, 2013) showed that, this approach “is a successful strategy for ensuring that funds reach the periphery of the health system, with minimal bureaucratic interference”. This led to a positive impact on staff motivation, use of health services, and quality of care at the primary health care facilities. Also, there was a significant increase in the utilization of the health services as measured by the number of people visiting the health centers.

However, the performance of the health facilities with regard to services for prevention of anemia in pregnant women using iron and folate tablets was affected by the shortage of commodities in 2017. The supplies were previously provided by a donor funded program and when the program ended, health facilities were unable to use HBF funds to purchase medical supplies as Medical Stores Department (MSD) did not have FeFol as routine stock items.

The study found that, health facilities used different methods for recording data used for measuring the performance of vitamin A supplementation for children aged between 12-59 months old. Health facilities in Pwani Region recorded both routine and campaign data in DHIS2 while those in Morogoro recorded vitamin A supplementation provided in under five clinics only, so it was difficult to compare performances in the four health facilities and the impact of HBF funds in this indicator.

The improvement in the service delivery indicators as discussed above and the quality of health services provided by health facility is also directly related to the status of the health system indicators including the presence of qualified health workers, availability of medicines and health facility governance. All these are measured by the composite indicator of star rating assessment that has shown significant improved in Ruvu Station, Disunyara and Mafiga health facilities. Sabasaba health center had a very high performance (3 stars) in all assessments.

5.2 Effect of HBF on selected council level health performance indicators

The performance of the councils is better explained by their performance in the star rating assessments, which provide a composite indicator for all service delivery and health system indicators used in the HBF. The star rating for health facilities in all councils in Pwani Region increased from 49% at baseline (2014) to 100% at reassessment (2018). In Morogoro, the increase was from 71% at baseline to 89% on reassessment. Pwani Region had the experience of implementing P4P hence they were able to adapt this new indicator and rapidly improved their performance although they started at a lower baseline. The councils (and therefore, health facilities) in the Pwani Region were therefore able to get more HBF funds allocation due to the improved performance. A similar study conducted in Burundi showed that, there were impressive achievements with HBF in terms of ensuring that, the allocated funds are reaching the health facilities, spent appropriately, as well as managed and utilized in a way that strengthens community engagement in the operations of the facilities (HMFCs), (Rudasingwa & Uwizeye, 2017).

5.3 Effects of other interventions on performance of health facilities and councils on selected HBF indicators

This study revealed that, other factors affecting performance of HBF indicators in health facilities and councils included the availability of alternative sources of funding such as RBF, cost sharing/user fees, NHIF and CHF and the utilization of DHFF.

These factors have increased service delivery in both health facilities and councils in Morogoro and Pwani Regions. The use of other sources of funding have facilitated payment of extra duties to health care workers, supportive supervision activities and improvement of infrastructure. This was particularly useful when there was a delay in the disbursement of the HBF funds.

DHFF have enabled funds reaching directly to the lower health system levels for planning and budgeting according to the health facility's needs. This led to a positive impact on staff motivation, use of health services and quality of care at the primary health care facilities.

These findings concur with the findings of the study conducted in Kenya, which indicated that, Social Health Insurance such as NHIF significantly improved obstetric health services utilization among positive HIV pregnant women (Lawrence POW et al 2020).

Prior to DHFF, health facility funds were managed and controlled by the CHMTs at the council level, therefore health facilities had no direct access/control to financial resources. This resulted in delays in the implementation of various health interventions contributing to the poor quality of health services delivery. Also, there was lack of autonomy at the primary health facility levels and health facility-governing committees did not feel responsible and accountable for funds spent at their health facilities.

5.4 Study Limitations and Mitigations

The Health Basket Fund is one of the sources of funding for the council and health facilities. There are many other sources of funds and factors that influence performance of the health sector. Therefore, the results of this study cannot be entirely attributed to the HBF alone. However, conducting a trend analysis before and after the introduction of performance based HBF may give an indication assuming other factors and sources of funding remain constant.

Moreover, the quality of HMIS data before 2014 when DHIS2 was rolled out nationally may be unreliable. This was because data collection, aggregation and reporting were manual and subject to error. This was alleviated by obtaining data from facility HMIS registers/forms hence reducing or eliminating any errors arising from the use of aggregated data reported to council level before DHIS2 was introduced.

Furthermore, due to resources' limitation (time, financial and human resource) the study was only conducted in four health facilities and two councils.

5.5 Study Strength

The strength of the study was that, respondents for this study were from different health facilities and councils involving high top management personnel constituting key part of the program's implementation. They shared different experiences and practices, which were broadly considered in the analysis. This offered a broad range of experiences regarding the adoption and implementation of the HBF. Moreover, the use of IDI's and DHIS2 contributed to increased reliability of the findings in which the data from DHIS2 were used to verify the information obtained from individual interviews.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

This study has shown that, output based HBF has contributed to improvement of service delivery indicators at the health facility level. It has enhanced and expanded community access to health services especially, ANC4 visits, family planning and institutional delivery. However, the performance of the health facilities varied from one place to another due to local factors including availability of staff, medical supplies and governance. The availability of medicines and supplies is critical for attainment of some service delivery indicators. The performance on Health systems indicators at health facility level was highlighted by the star rating level. All health facilities visited showed an increase in the star rating assessment from baseline to reassessment. This means that, staff at the health facilities took steps to address the gaps found during star rating assessment.

The performance of the health facilities in services' delivery and health system indicators, as described above, was in turn reflected in the performance of the respective LGA. Availability and improvement of other sources of funding is critical in order to ensure effective achievement of the HBF performance indicators. In addition, the introduction of DHFF has led to the improvement of service delivery and has strengthen direct access for community members, since health care services are brought directly to the people. Besides, it engages them directly in the decision-making process concerning the determination and prioritization of their health care related needs.

6.2 Recommendations

Taking into consideration of the study findings, this study recommends the following;

6.2.1 Improving HBF performance indicators at health facility level

The GOT and DPs should sustain the output based HBF and increase its effectiveness by allocating more resources, and periodically reviewing the indicators so that those that have been surpassed by most health facilities are replaced by more challenging ones.

6.2.2 Improving performance at council level

The performance of the CHMT should be measured by different indicators from those used at the health facility level, since the roles of CHMTs differ from those of the health facilities.

6.2.3 Role of other factors in achieving HBF indicators

The GOT should introduce universal social health insurance to enable health facilities getting a reliable source of financing. Also, the processes for disbursing HBF should be streamlined so that health facilities receive the funds on a timely basis for implementation of planned activities.

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APPENDICES

Appendix I: HBF Performance Indicators for the Study Health Facilities in Pwani and Morogoro Regions from 2013 To 2018

ANC 4 plus visits Coverage						
Years	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Ruvu Station	30%	32%	54%	41%	41%	100%
Disunyara	35%	54%	79%	85%	88%	100%
Mafiga	28%	47%	52%	55%	50%	64%
Sabasaba	30%	31%	47%	52%	55%	57%
% institutional deliveries						
Years	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Ruvu Station	41%	47%	49%	48%	54%	100%
Disunyara	28%	25%	31%	57%	48%	76%
Mafiga	25%	30%	38%	42%	48%	55%
Sabasaba	30%	32%	40%	36%	51%	65%
ANC IPT 2 coverage						
Years	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Ruvu Station	30%	32%	79%	73%	84%	78%
Disunyara	32%	47%	55%	57%	37%	81%
Mafiga	28%	32%	55%	68%	32%	64%
Sabasaba	37%	65%	82%	76%	56%	68%

Contraceptive Coverage - Modern Methods						
Years	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Ruvu Station	60%	77%	99%	84%	81%	94%
Disunyara	55%	60%	68%	70%	88%	96%
Mafiga	45%	48%	55%	60%	62%	60%
Sabasaba	62%	70%	60%	65%	70%	78%

Proportion of children 12 - 59 months received Vitamin A supplementation						
Years	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Ruvu Station	60%	68%	100%	100%	100%	100%
Disunyara	35%	42	46%	39%	37%	100%
Mafiga	30%	35%	44%	45%	42%	56%
Sabasaba	88%	100%	100%	100%	100%	100%
Proportion of pregnant women received Fefol (Iron Folic) supplementation						
Years	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Ruvu Station	78%	94%	11%	89%	69%	100%
Disunyara	88%	90%	100%	87%	21%	79%
Mafiga	90%	99%	94%	78%	27%	86%
Sabasaba	87%	89%	100%	79%	52%	100%
Tracer Medicine entire package 10 drugs availability						
Years	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Ruvu Station	90%	100%	92%	90%	94%	98%
Disunyara	88%	90%	99%	97%	89%	99%
Mafiga	92%	100%	100%	73%	100%	100%
Sabasaba	89%	91%	100%	71%	87%	100%

Appendix ii: Indepth Interview Guide for Health Facility Management Team and Health Facility Governing Committee

ENGLISH VERSION

INTRODUCTION

Date of interview: _____

Name of council: _____

Name of health facility: _____

Name of interviewee: _____

Gender: _____

Position: _____

PART 1: HEALTH FACILITY INDICATORS SUPPORTED BY HBF (information not found in DHIS2)

1. How many star rating assessments have been conducted in the health facility? What star rating result was achieved by the health facility in each of the assessments? 2013-2018
2. How many skilled/trained health care workers does the facility have? (Probe: the trend over six years 2013-2018)
3. Does the health facility have functional HFGC? If no, probe why. How many members do they have?

PART 2: EFFECT OF HBF ON HEALTH FACILITY PERFORMANCE

1. How many indicators used by HBF to rate health facility performance? (probe)
2. Which indicators receive the highest funds after performing well?
3. Which indicators does your health facility perform well? (probe; which don't perform well?)
4. Why do health facility not perform well? (the above mentioned)
5. What strategies have been done towards addressing the least performing indicators in this health facility?

6. What other sources of funding apart from HBF do you receive in this health facility? Please mention them (**Probe**: HBF, RBF, NHIF, ICHF, user fees, local partners and Council own source?)
7. Which source of fund did you receive the highest funds? (probe; how much and why?)
8. Since when does this facility receive Health Basket Funds? Has the amount of HBF received each year remained constant or varied from year to year?
9. What service delivery results have been achieved by use of HBF funds? Give examples of key indicators achieved in this facility that would otherwise not been achieved.
10. Are you involved in health facility planning by CHMT?
11. Is the HFGC engaged in the health facility planning process? Specifically, how is the HFGC engaged in the allocation of HBF to specific activities in the health facility plans?

PART 3: FACTORS AFFECTING HEALTH FACILITY PERFORMANCE ON HBF INDICATORS

1. How has the availability and use of many sources of funding affected the facility's performance on indicators supported by HBF? Give examples if any.
2. How has DHFF impacted the amount of funds received through HBF and other sources to the health facility? (Probe:
3. Has DFF improved the way the health facility allocates resources to address priority health issues in the community? Give examples
4. Between funds from donors (RBF, HBF) and own source/ prepayment schemes (NHIF, TIKA/CHF, user fee) which affect the most performance of HBF indicators in this health facility? (probe; why)

Appendix iii: Interview Guide for Council Health Management Team (CHMT) and CHSB

ENGLISH VERSION

INTRODUCTION

Date of interview: _____

Name of Region: _____

Name of Council: _____

Name of interviewee: _____

Gender: _____

Position: _____

PART 1: COUNCIL HEALTH SYSTEM INDICATORS SUPPORTED BY HBF (information not found in DHIS2)

1. How many star rating assessments have been conducted in the council? What percent of health facilities in the councils have achieved a 3-star rating or higher in each of the assessments conducted? 2013-18
2. What factors or issues prevented the health facilities in the council to achieve a higher star rating?
3. How many or what percentage of health facilities in the council do not have skilled HRH? (Probe: the trend over six years 2013-2018)
4. What percentage of health facilities in the council have functional HFGC?
5. Does the Council have a functional CHSB? How many times has the CHSB met each year between 2013-2018?
6. What external audit opinion has the council received each year between 2013/14 and 2017/18?

PART 2: EFFECT OF HBF ON COUNCIL HEALTH PERFORMANCE

1. How many indicators used by HBF to rate health facilities performance in your council? (probe)
2. Which indicators receive the highest funds after performing well?
3. Which indicators does your council perform well? (probe; which don't perform well?)

4. Why do health facilities in your council not perform well? (the above mentioned)
5. What strategies have been done towards addressing the least performing indicators in this council?
6. What are the main sources of funding for the council? Please mention them (**Probe**: HBF, RBF, NHIF, ICHF, user fees, local partners and Council own source?)
7. Since when does the council receive Health Basket Funds? Has the amount of HBF received each year remained constant or varied from year to year?
8. What determines the amount of HBF allocated to your council? Give examples of what results could help the council to get more HBF funds?
9. What service delivery results have been achieved by use of HBF funds? Give examples of key indicators achieved by the council that would otherwise not been achieved. Probe on HBF specific indicators
10. Is there any, changes have been made at your council using HBF funds? Please describe.

PART 3: FACTORS AFFECTING COUNCIL PERFORMANCE ON HBF INDICATORS

1. How has the availability and use of other sources of funding affected the council's performance on indicators supported by HBF? Give examples if any.
2. How has DHFF affected amount of funds provided through HBF for CHMT activities? (Probe: What activities at CHMT are funded by HBF, what was the level of funding before DHFF)
3. Has DFF improved the way the health facilities in your council allocate resources to address priority health issues in the community? Give examples
4. What other factors affect performance of HBF in your council?

Kiambatisho iv: Mwongozo wa mahojiano ya kina na timu ya menejimenti pamoja na kamati ya uongozi ya kituo cha kutolea huduma za afya

JUZUU YA KISWAHILI

UTANGULIZI

Tarehe ya mahojiano: _____

Jina la Halmashauri: _____

Jina la Kituo cha Kutolea Huduma za Afya: _____

Jina la Mhojiwa: _____

Jinsia: _____

Cheo/Nafasi: _____

SEHEMU 1: VIASHIRIA VINAVYOTUMIKA KUPIMA UTENDAJI WA VITUO VYA KUTOLEA HUDUMA ZA AFYA VINAVYOFADHILIWA KUPITIA MFUKO WA AFYA (HBF)

1. Je, ni mara ngapi ukadiriaji wa thamani wa madaraja umefanyika katika kituo hiki cha kutolea huduma za afya? Kituo hiki kilipewa daraja gani katika kila zoezi la ukadiriaji lililofanyika kati ya mwaka 2013-2018?
2. Ni mambo au masuala yapi yalizuia kituo hiki kupata daraja la juu zaidi?
3. Kituo hiki kina wafanyakazi wangapi wenye ujuzi/waliopatiwa mafunzo? (Dadisi: nitajie mwenendo kwa miaka sita iliyopita kati ya mwaka 2013-2018)
4. Je, kituo hiki kinayo kamati hai ya uongozi wa kituo (HFGC)? Kamati hii imewahi kukutana mara ngapi kila mwaka kati ya mwaka 2013-2018?

SEHEMU 2: ATHARI ZA MFUKO WA AFYA KATIKA UTENDAJI WA KITUO CHA KUTOLEA HUDUMA ZA AFYA

1. Vyanzo vikuu vya fedha vya kituo hiki ni vipi? Tafadhali vitaje (**Dadisi**: HBF, RBF, NHIF, ICHF, ada ya huduma, wabia wa ndani ya nchi (local partners) na vyanzo binafsi vya Halmashauri?)

2. Kituo hiki kilianza lini kupata fedha kutoka katika Mfuko wa Afya? Je, kiasi cha fedha kutoka katika Mfuko huo kila mwaka kilikuwa ni kile kile au kilibadilika mwaka hadi mwaka?
3. Ni vigezo gani vinatumika kuamua kiasi cha fedha kinachotengwa kwa ajili ya kituo cha kutolea huduma za afya? Toa mifano ya matokeo ambayo yangeweza kusaidia kituo hiki kitengewe fedha nyingi zaidi kutoka katika Mfuko wa Afya?
4. Ni matokeo yapi ambayo yaligharimiwa na fedha kutoka katika Mfuko wa Afya? Toa mifano ya viashiria vikuu katika kituo hiki ambavyo visingeweza kufanikiwa bila fedha kutoka katika Mfuko wa Afya. Dadisi kuhusu viashiria mahusisi vinavyohusu Mfuko wa Afya.
5. Kuna mabadiliko gani (kama yapo) ambayo yamefanyika katika kituo hiki yaliyogharimiwa na fedha kutoka katika Mfuko wa Afya? Eleza.
6. Je, Kamati ya Uongozi ya Kituo hiki inahusishwa katika mchakato wa kupanga mipango ya kituo? Hususan, Kamati ya Uongozi inahusishwa vipi katika utengaji wa fedha kutoka katika Mfuko wa Afya kwa ajili ya shughuli mahsusi zilizomo katika Mipango ya Kituo?

SEHEMU 3: MAMBO YANAYOATHIRI UTENDAJI WA KITUO CHA KUTOLEA HUDUMA AFYA KATIKA UFANIKISHAJI WA VIASHIRIA VYA MFUKO WA AFYA

1. Je, kuna vyanzo gani vingine vya fedha mbali na fedha kutoka katika Mfuko wa Afya? (**Dadisi**: NHIF, RBF, fedha zinazolipwa moja kwa moja na wadau wa maendeleo kwenye miradi, vyanzo binafsi vya Halmashauri na OC ya Serikali)
2. Je, upatikanaji wa fedha kutoka vyanzo vingine umeathiri vipi utendaji wa kituo katika ufanikishaji wa viashiria vinavyogharimiwa na fedha kutoka katika Mfuko wa Afya? Toa mifano kama ipo.
3. Ni fedha zipi zinazopokelewa na kituo kupitia DHFF? Dadisi (HBF, NHIF, RBF, wadau wengine wa maendeleo, OC, vyanzo binafsi vya Halmashauri)
4. Je, ni kwa namna gani DHFF imeathiri kiasi cha fedha zinazopokelewa kupitia Mfuko wa Afya na vyanzo vingine vinavyopokelewa na kituo?(Dadisi:

5. Je, DFF imesaidia kuboresha namna ambavyo kituo kinatenga rasilimali kwa ajili ya kushughulikia vipaumbele vya afya katika jamii? Toa mifano
6. Je, kituo hiki kinatekeleza mfumo wa utengaji wa fedha kulingana na matokeo (RBF)? Kama jibu ni Ndiyo, mfumo huu ulianza kutumika lini?
7. Ni mabadiliko gani yamepatikana katika kituo hiki kutokana na utekelezaji wa mfumo wa kutenga fedha kulingana na matokeo ya utendaji?
8. Ni kuna uwiano gani wa fedha kwa ajili ya kituo hiki kutoka katika mipango ya malipo kabla ya huduma (prepayment schemes) katika miaka sita iliyopita kati ya 2013-2018 (NHIF, iCHF na Bima binafsi).
9. Kazi za Kamati ya Uongozi zinazohusiana na matumizi ya rasilimali katika kituo hiki ni zipi?
10. Ni kwa namna gani DHFF, mfumo wa kutenga fedha kulingana na matokeo (RBF) na Mfuko wa Taifa wa Bima ya Afya (NHIF) vimeathiri ufanikishaji wa viasharia vya Mfuko wa Afya katika kituo hiki? Dadisi kuhusu viashiria mahsusi
11. Ni mambo gani mengine yanayoathiri ufanikishaji wa viashiria vya Mfuko wa Afya katika kituo hiki?

Kiambatisho v: Mwongozo wa mahojiano na timu ya halmashauri ya kusimamia masuala ya afya (CHMT)

JUZUU YA KISWAHILI

UTANGULIZI

Tarehe ya Mahojiano: _____

Jina la Mkoa: _____

Jina la Halmashauri: _____

Jina la Mhojiwa: _____

Jinsia: _____

Cheo/Nafasi: _____

SEHEMU 1: VIASHIRIA VYA MFUMO WA AFYA WA HALMASHAURI VINAVYOGHARIMIWA NA FEDHA KUTOKA KATIKA MFUKO WA AFYA

1. Je, ni mara ngapi ukadiriaji wa thamani wa madaraja umefanyika katika Halmashauri hii? Ni asilimia ngapi ya vituo vya kutolea huduma za afya vimepata daraja la nyota 3 au zaidi katika kila zoezi la ukadiriaji lililofanyika kati ya mwaka 2013-18?
2. Ni mambo au masuala yapi yalizuia vituo vya kutolea huduma za afya katika halmashauri hii visipate daraja la juu zaidi?
3. Ni idadi gani au asilimia ngapi ya vituo vya kutolea huduma za afya ndani ya Halmashauri hii havina rasilimali-watu ya afya wenye ujuzi? (Dadisi: mwenendo katika miaka sita na zaidi kati ya mwaka 2013-2018) .
4. Ni asilimia ngapi au vituo vingapi vya kutolea huduma za afya ndani ya Halmashauri hii ambavyo vina Kamati za Uongozi wa Vituo vya Kutolea Huduma za Afya zilizo hai?
5. Je, Halmashauri inayo CHSB iliyo hai? CHSB imewahi kukutana mara ngapi kila mwaka kati ya mwaka 2013-2018?
6. Je, Halmashauri imepokea maoni gani kutoka kwa wakaguzi wa mahesabu wa nje kila mwaka kati ya mwaka 2013/14 na 2017/18?

SEHEMU 2: ATHARI YA MFUKO WA AFYA KWENYE UTENDAJI WA SHUGHULI ZA AFYA ZA HALMASHAURI

1. Vyanzo vikuu vya fedha vya Halmashauri hii ni vipi? Tafadhali vitaje (**Dadisi**: HBF, RBF, NHIF, ICHF, ada ya huduma, wabia wa ndani ya nchi (local partners) na vyanzo binafsi vya Halmashauri?)
2. Kituo hiki kilianza lini kupata fedha kutoka katika Mfuko wa Afya? Je, kiasi cha fedha kutoka katika Mfuko huo kila mwaka kilikuwa ni kile kile au kilibadilika mwaka hadi mwaka?
3. Ni vigezo gani vinatumika kuamua kiasi cha fedha kinachotengwa kwa ajili ya Halmashauri? Toa mifano ya matokeo ambayo yangeweza kusaidia kituo hiki kitengewe fedha nyingi zaidi kutoka katika Mfuko wa Afya?
4. Ni matokeo yapi ambayo yaligharimiwa na fedha kutoka katika Mfuko wa Afya? Toa mifano ya viashiria vikuu vilivyofanikiwa katika Halmashauri hii ambavyo visingeweza kufanikiwa bila fedha kutoka katika Mfuko wa Afya. Dadisi kuhusu viashiria mahusisi vinavyohusu Mfuko wa Afya.
5. Ni mabadiliko gani (kama yapo) yaliyofanyika katika Halmashauri kwa kutumia fedha kutoka katika Mfuko wa Afya? Tafadhali eleza.
6. Je, CHSB inahusishwa katika mchakato wa kuandaa mpango kamilifu ya Afya wa Halmashauri (CCHP)? Ni kwa njia gani hasa CHSB inahusishwa katika utengaji wa fedha kwa ajili ya maeneo ya kipaumbele au shughuli mahsusi ndani ya Mpango Kamilifu wa Afya wa Halmashauri?

SEHEMU 3: MAMBO YANAYOATHIRI UTENDAJI WA HALMASHAURI KATIKA UFANIKISHAJI WA VIASHIRIA VYA MFUKO WA AFYA

1. Je, mna vyanzo gani vingine vya fedha mbali na fedha kutoka katika Mfuko wa Afya? (Dadisi: NHIF, RBF, fedha kutoka kwa wadau wengine wa maendeleo zinazotumwa moja kwa moja kwenye mradi, vyanzo binafsi vya Halmashauri na OC ya Serikali).

2. Je, upatikanaji na matumizi ya vyanzo vingine vya fedha vimeathiri vipi utendaji wa Halmashauri katika kufikia viashiria vinavyogharimiwa na Mfuko wa Afya? Toa mifano kama ipo.
3. Je, DHFF imeathiri kiasi cha fedha kinachotolewa kupitia Mfuko wa Afya kwa ajili ya shughuli za Timu ya Halmashauri ya Kusimamia Afya? (Dadisi: Ni shughuli zipi za Timu ya Halmashauri ya Kusimamia Afya zinagharimiwa na Mfuko wa Afya? Upatikanaji wa fedha ulikuwaje kabla ya DHFF)
4. Je, uwepo wa DFF umeboresha namna ambayo vituo vya kutolea huduma za afya katika Halmashauri yako vinatenga rasilimali kwa ajili ya kushughulikia masuala ya afya yenye kipaumbele ndani ya jamii? Toa mifano.
5. Je, Halmashauri inatekeleza mfumo wa kutenga fedha kulingana na matokeo (RBF)? Kama jibu ni ndiyo, tangu lini?
6. Ni mabadiliko gani yametokea katika Halmashauri yako kutokana na utekelezaji wa mfumo wa kutenga fedha kulingana na matokeo (RBF)?
7. Je, DHFF, RBF na NHIF vimeathiri vipi ufikiaji wa viashiria vya utendaji ndani ya Halmashauri yako?
8. Kuna mambo gani mengine yanayoathiri utendaji wa Mfuko wa Afya ndani ya Halmashauri yako?

Appendix vi: Consent Form

ENGLISH VERSION

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS

INFORMED CONSENT FORM

ID-NO ☐☐☐☐

Consent to participate in a study

Greetings!

My name is **Esther John Lema.** I am a student at Muhimbili University of Health and Allied Sciences pursuing Masters of Public Health.

Purpose of the study

Assessing the Effect of Output-Based Health Basket Fund on the Performance of Health Facilities and Councils in Morogoro and Pwani Regions2013-2018

If you agree to join the study, you will be interviewed face to face with me in order to answer a series of questions in the questionnaire prepared for this study, this will take about 15 to 30 minutes for one interview.

Confidentiality

I assure you that all the information collected from you will be kept confidential. Your name will not be written on any questionnaire or in any report/ document that might let someone identify you. Confidentiality will be observed and unauthorized persons will have no access to the data collected. And the information collected during the interview will be analyzed by using identification number. If this study is published or presented at a scientific meeting, names and other information that might identify you will not be used.

Right to withdraw and Alternatives

Taking part in this study is voluntary. You can stop participating in this study at any time, even if you have already given your consent. Refusal to participate or withdraw from the study will not involve any penalty.

Risk

No harm is anticipated to you because of participating this study.

Benefits

You will derive no direct benefit from participating in this study, however the results of this study will provide valuable information regarding health basket fund towards improving service delivery and health systems.

In case of Injury

We do not anticipate that any harm will occur to you.

Whom to contact

Thank you for taking time to read this information letter. Of you have any question regarding this study you may contact **Esther John** mobile number; **0719 414889**. In case you have any questions regarding your rights as a participant you may contact **Dr. Bruno Sunguya**, Director of research at MUHAS P. O Box 65001, Dar es Salaam mobile number **0685 217272** and **Dr. Happiness Saronga**, mobile number **0712 850584** who is supervising this study.

Signature:

Do you agree?

Participant agrees…… Participant does NOT agree…….

I…… have read the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of participant …….

Signature of research assistant……. Date of signed consent …….

Kiambatisho vii: Fomu Ya Ridhaa

JUZUU YA KISWAHILI

IDARA YA UTAFITI NA MACHAPISHO YA CHUO KIKUU SHIRIKISHI CHA AFYA NA SAYANSI CHA MUHIMBILI, MUHAS

NAMBA YA KITAMBULISHO

Ridhaa ya kushiriki katika utafiti

Salaam!

Jina langu ni **Esther John Lema.** Mimi ni mwanafunzi katika Chuo Kikuu Shirikishi cha Afya na Sayansi cha Muhimbili nasoma Shahada ya Pili ya Afya ya Umma.

Lengo la utafiti

Lengo la utafiti huu ni kupima athari za Mfuko wa Afya katika utendaji wa Halmashauri na vituo vya kutolea huduma za afya za mikoa ya Morogoro na Pwani mwaka 2013-2018

Ushiriki unajumuisha nini

Endapo utakubali kushiriki katika utafiti huu, utakuwa na mahojiano ya uso kwa uso na mimi ili kujibu mlolongo wa maswali katika dodoso lililoandaliwa kwa ajili ya utafiti huu. Mahojiano haya yatachukua kati ya dakina 15 hadi 30 kwa kila mshiriki.

Usiri

Napenda kukuhakikishia kwamba taarifa zote zitakazokusanywa zitatunzwa kwa usiri. Jina lako halitaandikwa kwenye dodoso wala katika taarifa/makala yoyote kwa namna ambayo mtu anaweza kukutambua. Usiri utazingatiwa na watu wasiohusika na utafiti huu hawatapata taarifa zilizokusanywa. Aidha, taarifa zilizokusanywa wakati wa mahojiano zitachambuliwa kwa kutumia namba ya utambulisho. Endapo matokeo ya utafiti huu yatachapishwa au kuwasilishwa katika mkutano wa kisayansi, majina na taarifa nyingine ambao zinaweza kukufanya utambulike wewe ni nani havitatumika.

Haki ya kujitoa na ushiriki mbadala

Ushiriki katika utafiti huu ni hiari. Unaweza kusitisha ushiriki wako muda wowote, hata kama umekwishatoa ridhaa. Kukataa kushiriki au kujitoa katika utafiti huu havitakuwa na adhabu yoyote.

Hatari

Hakuna hatari yoyote inayotegemewa kutokea kwasababu ya ushiriki wako katika utafiti huu.

Faida

Hautapata faida yoyote ya moja kwa moja kutokana na ushiriki wako katika utafiti huu. Hata hivyo, matokeo ya utafiti huu yatatoa taarifa muhimu kuhusu Mfuko wa Afya unaolenga kuboresha utoaji wa huduma na mifumo ya afya.

Endapo patatokea madhara

Hatutegemei madhara yoyote kutokea kwako.

Mtu wa kuwasiliana nae

Asante kwa kutumia muda wako kusoma waraka huu wa taarifa. Endapo una swali lolote kuhusu utafiti huu unaweza kuwasiliana na **Esther John** kupitia namba ya simu ya mkononi **0719 414889**. Endapo una maswali yoyote kuhusu haki zako kama mshiriki unaweza kuwasiliana na **Dkt. Bruno Sunguya**, Mkurugenzi wa Utafiti, MUHAS S.L.P 65001, Dar es Salaam; namba ya simu ya mkononi **0685 217272** na **Dkt. Happiness Saronga**, namba ya simu ya mkononi **0712 850584** ambae anasimamia utafiti huu.

Sahihi:

Je, unakubali? NDIYO ☐ HAPANA ☐

Mimi …… nimesoma maelezo yaliyomo katika fomu hii. Maswali yangu yote yamejibiwa. Nakubali kushiriki katika utafiti huu.

Sahihi ya Mshiriki: …….

Sahihi ya Mtafiti Msaidizi ……. Tarehe ridhaa ilipotiwa saini …….

Appendix viii: Approval of Ethical Clearance

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
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Ref. No. DA.287/298/01A/ 13th August, 2019

Ms. Esther John Lema
MPH-Executive Track,
School of Public Health and Social Sciences,
MUHAS.

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED: " ASSESSING THE EFFECT OF OUTPUT-BASED HEALTH BASKET FUND ON THE PERFORMANCE OF HEALTH FACILITIES AND COUNCILS IN MOROGORO AND PWANI REGION 2013-2018"

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has, on behalf of the Senate, approved ethical clearance for the above-mentioned study. Hence you may proceed with the planned study.

The ethical clearance is valid for one year only, from **09th August, 2019 to 08th August, 2020.** In case you do not complete data analysis and dissertation report writing by **08th August, 2020,** you will have to apply for renewal of ethical clearance prior to the expiry date.

Dr. Bruno Sunguya
Ag: DIRECTOR OF POSTGRADUATE STUDIES

cc: Director of Research and Publications
cc: Dean, School of Public Health and Social Sciences, MUHAS