

Results-Based Bonus
Design, Implementation & Budget

**“Malipo kwa Ufanisi Bora katika Huduma za Afya”
(MUBHA)**

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ANNEXES PRESENTED SEPARATELY

**Report of the design team describing detailed model, implementation
strategy and funding requirements**

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The views expressed in this report are those of the authors and do not necessarily represent the official position of the Governments of Norway or Tanzania.

Acronyms

ANC	Antenatal Care
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CMO	Chief Medical Officer
D-by-D	Decentralisation by Devolution
DCCO	District Cold Chain Coordinator
DDH	District Designated Hospital
DED	District Executive Officer
DMCHCo	District MCH Coordinator
DMO	District Medical Officer
DPP	Director Policy & Planning
FBO	Faith-Based Organisation
FY	Financial Year
HMIS	Health Management Information System
IPT	Intermittent Preventive Treatment (for malaria in pregnancy)
ITN	Insecticide-Treated (mosquito) Net
MCH	Maternal and Child Health
MEDA	Mennonite Educational Development Agency
(I)MMR	(Institutional) Maternal Mortality Ratio
MO I/C	Medical Officer In-Charge
MOHSW	Ministry of Health and Social Welfare
OPV 0	Oral Polio Vaccine (Zero)
OR	Operations Research
P4P	Payment for Performance
RAS	Regional Administrative Secretary / Secretariat
RBB	Results-Based Bonus
RCCO	Regional Cold Chain Coordinator
RMCHCo	Regional MCH Coordinator
RHMT	Regional Medical Officer
TA	Technical Assistance

Executive Summary

This report sets out the proposed design, budget and implementation arrangements for a “results-based bonus” scheme to commence in July 2008. The proposed design is the first step in an approach that will evolve based on experience. This point is critical - as stakeholders in the Tanzanian health system must be prepared to view this as a “living” and changing process.

The scheme is conceived as a strategy that will be mainstreamed within the work of the health facilities, CHMTs and RHMTs. It will focus on maternal and neonatal health. It is expected to complement – and magnify the impact of – the technical strategies set out in the government’s Roadmap. In addition to leading to better results in the near term, it is expected to catalyze changes that will lead to a stronger and more results-oriented health system.

National coordination of RBB will be managed in the Policy and Planning Department of MOHSW with external technical support. This unit will facilitate implementation, track progress, share/disseminate best practices, undertake annual assessments and revise the model for subsequent years. This unit will compile baseline performance, targets and actual results to enable assessment of impact at a national level and to undertake comparative performance assessment across regions and councils.

RBB will ultimately cover all government and FBO facilities at the district level. This will include Regional Hospitals that serve a District Hospital function for the host council. CHMTs and RHMTs will also be eligible for performance bonuses to enhance results-oriented planning, resource allocation, support and supervision. At each level of the system, the staff eligible for performance bonus will be clearly specified. This will include all staff at dispensaries, health centres, CHMTs and RHMTs. Within hospitals, only staff contributing directly towards maternal health will be included.

A fixed maximum bonus amount per year has been determined for each type of facility. The levels are as follows:

- Dispensary T.Shs 1 million
- Health Centres, CHMTs, RHMTs: T.Shs 3 million
- Hospitals T.Shs 9 million

These bonus levels add up to approximately \$7 million per annum (as a maximum if all targets are achieved), equivalent to Norway’s contribution to the basket.

The facility bonus will in turn be shared among relevant staff. Facilities with below-average staff strength will therefore obtain higher individual bonuses than those with above-average staff strength.

Allocation of bonuses to individuals will vary according to grade, following the system currently used for per diems. Senior staff with greater responsibility stand to

earn a higher bonus than junior staff. For a typical facility, achievement of all targets will result in bonus payment per individual of about T.Shs 200,000/= per year. The award of maximum bonus requires a facility/team to have met its targets on each of the relevant indicators.

The indicators for each level are as follows:

Dispensary, HC	5 indicators	IPT, Deliveries, OPV-0, Infant ITN vouchers, HMIS returns
Hospitals	6 indicators	As above, plus partographs properly completed
CHMTs	6 indicators	Aggregate performance of their council on the 5 indicators above plus complete HMIS quarterly reports for all facilities
RHMTs	6 indicators	Aggregate performance of all facilities in a region; plus complete HMIS quarterly reports for all councils

For every facility / team, targets will be set for all of the indicators. The targets are set according to a rule that requires improvement over previous performance – with a larger improved needed where performance is presently low. Targets cannot be amended within the year.

Written performance agreements will be made at each level specifying roles, responsibilities and targets. A new performance agreement will be made for each financial year. Principle signatories of the agreements will be the facility/team and their respective line management and counter-signed by other relevant parties.

Reporting on performance against target will initially be on a quarterly basis. In the second year (assuming changes to the HMIS have been implemented), reporting will switch to a monthly basis. Bonuses will be calculated and paid six-monthly. An internal data audit system will verify data reported. An external data audit system will be introduced in the second year to complement the internal data audit system.

Implementation preparations need to begin without delay if the system is to be operational in July 2008. Most urgently, councils must be informed in time⁷ to allocate a part of their basket funds for FY2008/9 for performance bonuses. Tools, guidelines, templates, training materials need to be developed and training itself needs to be planned and organized. Training will then be undertaken using the “cascade” approach. Regions will be trained in (zonal) groups. Regions will train CHMTs, who will in turn train facilities. Contracted support will be needed for 3 years to support the MOHSW to coordinate the scheme.

At the national level, the RBB Unit in the MOHSW (DPP) will comprise 3 MOHSW counterpart staff and 3 temporary project staff. At Regional, Council and Facility levels, the system will be operated by existing staff (principally those responsible for HMIS).

⁷ Guidance must be issued before finalization of council plans and budgets

Funding for bonuses at the district level will come from the district health basket fund. Thus RBB bonuses will need to be incorporated into every council's CCHP and budget. Funding for the RHMT bonus will need to come from either the PMO_RALG or Central portion of the basket fund. Funding for implementation and training costs will be directly funded by Norway and other partners. Training should be designed and implemented to assure maximum value for money and minimum disruption to routine duties.

The total cost of bonuses (assuming budgetary provision for maximum performance) will be US\$6.5 - \$7 million per year. Provisional estimates of the cost of introduction, training and support for the scheme amount to roughly \$4 million over five years, plus a further \$3 million for external technical assistance.

Two alternative tracks have been outlined for implementation scheduling, of which Track B is considered more realistic and feasible. Track B also provides a window of opportunity for the opening of health facility bank accounts and HMIS strengthening.

Track A: "Fast Track"	Track B: "Phased approach"
<ul style="list-style-type: none">• Decision for "go ahead" February/March 2008• Materials developed and tested by April• RBB National Unit (incl. TA) and Roll-Out teams in place by April• Training all levels by July 2008• Full-scale implementation July 2008 (FY2008/9)	<ul style="list-style-type: none">• Decision for "go ahead" March 2008• Materials developed and tested by June• RBB National Unit (incl. TA) and Roll-Out teams in place by June• Implementation in 1 Region in July 2008/9• Training completed in all remaining Regions by March 2009 for full scale implementation in July 2009

Introduction

The maternal mortality ratio in Tanzania is 578 per 100,000 live births – equivalent to one maternal death per hour. The neonatal mortality rate stands at 32 per 1,000, amounting to 150 newborn deaths per day. No progress has been registered in the maternal mortality ratio over the past decade. In response to this situation, and in line with its commitment to MDG 4 and 5, Tanzania has resolved to place special emphasis on maternal and neonatal health in the immediate future. This priority was articulated by His Excellency, President Jakaya Kikwete in his meeting with the Prime Minister of Norway.

Following consultations between representatives of Norway, Government of Tanzania, other basket partners and other stakeholders in the health sector, it has been decided to design and implement a “results-based bonus” (RBB) scheme, to be funded through the health basket. This report represents the output of a design team, tasked with working out the detailed modalities and the steps required for implementation. The terms of reference can be found at Annex 1.

The RBB scheme is seen as a promising strategy to complement the “technical” strategies that have been developed, notably the Roadmap for Maternal Neonatal and Child Health. Through better motivation and explicit attention to results, RBB is expected to ensure that health workers and their supervisors:

- Are motivated to strive for better service delivery results
- Identify and address local service delivery constraints
- Actively seek ways to increase coverage and quality

The design team view RBB not as a “stand-alone” strategy but part of a broader effort to make the health system more results-oriented.

The team has been guided by feedback received at various consultations to date, including the SWAp Technical Committee, the Seminar conducted in November 2007 and written/verbal comments on the first draft of this report. Key principles of the design include:

- focus on maternal and newborn health at the district level
- inspire results-orientation among health workers and their supervisors
- use existing government systems and structures
- include FBOs
- design as simple as possible for ease and speed of implementation
- commence implementation in FY2008/9 and roll out as rapidly as possible

In addition to document review, interviews and joint design work, the team held a one-day consultation in Morogoro Region with a group of 20 people from health facility, district and regional level, including representatives of facility/council health management committees. A list of all people consulted is at Annex 2.

Table 1 below shows how this report is structured.

Table 1: Structure of the report

Heading	Description
Scope	Facilities / providers / levels of the health system to be included
Performance Agreements	Content of performance agreements & how these are drawn up
Indicators	Indicators to which rewards will be linked at each level
Targets	How targets will be set at each level
Measurement & Verification	How actual performance will be measured and how reported results will be verified
Rewards	Level of rewards and rules for distribution
Roles & Responsibilities	Role of facilities, CHMT, RHMT, National level, local government & health committees
Implementation	Steps involved in actual implementation: what, who, how, when
Budget	Funding requirement & flow of funds
Feasibility	Assessment of feasibility of implementation & risks
Annexes	Supporting annexes with more detailed information & description of background to design recommendations

Scope of the Scheme

The main focus of the scheme will be at the District level. It will provide financial, results-based incentives to health facilities that will, in turn, be shared among staff as individual bonuses. The scheme will include:

- dispensaries
- health centres
- district hospitals
- CHMTs, including co-opted members (eg DMCHCo, DCCO)
- RHMTs, including co-opted members (eg RMCHCo, RCCO)

In addition to government health facilities, the scheme will include all registered non-government, non-profit health providers at council level and below (dispensaries, health centres, district designated hospitals and voluntary agency hospitals). The eligibility rules for staff within these facilities will be identical to government facilities.

Regional hospitals will be included in the scheme as long as they serve a “district hospital” function for the council in which they are based, and are recognized as such by the host council (ie they receive the “district hospital” allocation from that council’s health basket funds). Any regional hospital not meeting these criteria (whether government or non-government) is specifically excluded. Referral and specialist hospitals are excluded.

Other than the health personnel included above, members of the Health Facility Committees, Council Health Service Boards, Councillors, Council Administrations and Diocesan Health Offices are specifically excluded.

A fixed, lump-sum amount (maximum bonus) has been determined for each of these levels of the system. This amount will be shared among eligible staff at that level. The rules governing the allocation of performance payments are described in more detail in the chapter on Rewards.

Table 2: Facilities & Staff Eligible for Incentives

Level / Facility	Eligible Staff	Remarks
Dispensary	All full-time staff	Typically about 5
Health Centre	All full-time staff	Typically about 15
District Hospitals / DDH / VA	Staff of the hospital management team; MCH clinic; labour & maternity wards	Typically about 45
Regional Hospitals (only if also serving as district hospital)	As per district hospitals, above	Typically about 45
CHMT	All members of the CHMT, including co-opted members	Typically about 15
RHMT	As per CHMT, above	Typically about 15

Performance Agreements

For every facility, CHMT and RHMT to receive results-based bonuses, a written performance agreement will be signed. The agreements will have duration of one financial year and will be developed in advance of the performance period. The terms of performance agreements for government and non-government facilities will be identical. To assure credibility of the performance agreement, a clause will state that no renegotiation of targets will be possible during the performance period.

Written performance agreements (contracts) will specify:

1. Roles and responsibilities of facility, CHMT, and RHMT
2. Indicators and targets
3. How results will be measured and validated
4. Frequency, format & procedure for reporting
5. Payment associated with attainment of each target and frequency of payment
6. Rules for the distribution of the bonus among individual staff members
7. Penalties for late reporting
8. Procedures for resolving disputes

The majority of the above terms will be standardized. Contract templates will be developed along with guidelines about how to complete them and training will be incorporated into the RHMT and CHMT sensitization process.

Performance agreement signatories will match lines of formal management accountability under decentralization-by-devolution (D-by-D).

Table 3: Signatories for Performance Agreements

Facility / Team	Signed	Counter-Signed
Dispensary & Health Centre	Facility i/c; DMO	Health Facility Committee
Hospitals	MO i/c; DMO	Hospital Board
CHMT	DMO; DED	RHMT
RHMT	RMO; RAS	CMO (MOHSW)
FBO facilities	Facility i/c; DMO	Diocesan Health Office

Indicators

Indicators have been selected with the following considerations in mind:

- As few and as simple as possible

- Can be measured objectively and verified
- Focus on maternal and newborn health
- “Signal” indicators for Antenatal, Maternity, Post-Natal, Infant Health
- Linkage to actual service delivery results / health impact
- Public health importance / services with greatest room for improvement
- Encourage CHMTs to support their facilities in raising performance
- Avoid indicators that could adversely affect clinical judgment

Table 4: Indicators

Facility / Team	Service Cluster	Indicator
Dispensaries & Health Centres	Antenatal	IPT 2+ doses
	Maternity	Institutional deliveries
	Post-Natal	OPV zero
	Infant Health	ITN vouchers issued
	HMIS	100% timely HMIS returns
Hospitals	As above PLUS partographs correctly filled	
CHMTs	Aggregate performance of council on facility indicators above	
RHMTs	Aggregate performance of region on facility indicators above	

When the HMIS system is strengthened, additional / more complex indicators could be phased in. The inclusion of HMIS reporting as an indicator is expected to provide a solid foundation for further elaboration of the scheme, as well as allowing the tracking of indicators that are not rewarded.

Target Specification

Specific targets for these indicators will be developed for all Facilities, Councils and Regions. The targets should encourage maximum effort while recognizing that conditions vary widely across the country. The targets need to be challenging but achievable. For simplicity, target-setting will be rule-based in the first year.

The rule is based on the principle that targets should encourage IMPROVEMENT for all health facilities. It recognizes that marginal improvements are more difficult when performance is already close to maximum. These rules specify the MINIMUM LEVEL at which targets may be set. At the discretion of local CHMTs / RHMTs, targets for particular facilities / councils may be set at a higher level.

Targets will be annual, specified in writing and agreed to by all parties. Targets cannot be changed during the course of the year.

All data used to calculate population and baseline levels of performance come from routine reporting of information that currently exists and must be verified before setting targets. Methods and data sources for the estimation of denominators (eg number of pregnant women) will be made explicit.

After determining baseline performance (actual performance in the previous year), targets for each of the indicators for all facilities will be set as follows:

- If baseline coverage of the intervention / indicator lies between 0% and 50%, target must require at least 10 percentage point improvement

- If baseline coverage lies between 50% and 75%, target must require at least 7 percentage point improvement.
- If baseline coverage is above 75%, target must require at least 5 percentage point improvement.

Having determined the baseline and target levels, the target for every indicator in a particular performance agreement will be expressed as a number (rather than a coverage rate).

The exception to this target-setting rule will be prompt and complete HMIS returns, where facilities and councils will be required to make 100% prompt returns.

Example of Target-Setting

Last year Mjimwema dispensary carried out 50 deliveries. For its catchment population, this represents 25% of the expected 200 pregnancies. Current performance lies in the 0%-50% range, so the rules require coverage to be increased to at least 35% (25%+10%). This equates to 70 deliveries (35% of 200). So the target for institutional deliveries at this facility will be set at 70 deliveries. In case the CHMT – in discussion with the dispensary team - feels that a much bigger improvement is reasonably attainable, the target may be set higher.

The CHMT’s reward is directly linked to the performance of the facilities they are managing. Because facility targets will be set at a level that requires extra effort but still be attainable, we do not expect facilities to meet all of their targets all of the time. Thus it would be unfair if the CHMT were only rewarded when all facilities meet all of their targets. Instead, we propose that CHMTs qualify for bonus when 70% of their facilities reach target.

The exception to this is the HMIS indicator, where 100% of returns are required from facilities to CHMT and from CHMT to RHMT according to a set schedule. Also, because most districts have only one or two hospitals, the partograph indicator for CHMTs will depend upon every hospital attaining its target (rather than a percentage of hospitals).

The following example may make the CHMT targets more clear:

Table 5: Calculation of Council Target

Indicator	Target
IPT	70% of facilities reach their respective targets
Institutional deliveries	70% of facilities reach their respective targets
OPV 0	70% of facilities reach their respective targets
Infant ITN voucher	70% of facilities reach their respective targets
Partograph	Every hospital reaches respective targets
HMIS Returns (currently form 004, quarterly)	100% of facilities submitted timely return

The indicators for RHMTs will be analogous to those of the CHMTs. In other words, RHMTs will be rewarded for each indicator when 70% of all health facilities in their region meet their targets. Again, the exception to this rule is for partographs and HMIS returns, where 100% performance is required for all facilities and councils.

Measurement & Verification

Data Sources

Source data for measuring performance will come from the routine facility HMIS registers. This data is summarized into monthly/quarterly tallies in Book 2 and into quarterly tallies in Book 10.

The number of indicators included in routine quarterly report (Form 004 of Book 10) is presently very limited⁸. Thus some data for the indicators will need to be extracted from facility registers and reported along with the quarterly return. Data sources are summarized in the table below.

Table 6: Data source for indicators

Indicator	Data Source	Remarks
IPT 2+ doses	ANC registers – presently additional column added by hand	No provision for monthly tally of this data in Book 2 or Book 10. Recommend selection of alternative indicator for ANC services
Deliveries	Book 2, Jedwali 41A	Count facility-based deliveries only, or include “born before arrival”?
Partographs completed	File of partographs & monthly tally maintained by Matron	Not presently included in source registers or tally books. Requires separate record to be kept and compared to total institutional deliveries
OPV 0	Monthly EPI returns	Good quality data, reported monthly, already subject to internal data quality audit
Infant ITN voucher	Voucher stubs (serially numbered)	Recommend counting vouchers issued rather than vouchers redeemed ⁹ . Note this indicator will become unreliable if infant voucher is complemented by free net distribution
HMIS	Councils & Regions will need to maintain a register recording date of receipt of HMIS returns for every facility/council	This process will be automated to generate a report on returns received/pending once the new HMIS software is introduced

Further remarks on alternative indicator selection can be found at Annex 3, based on data that is *currently* included in either Book 2 or Book 10.

The design team was informed that some of the facility HMIS registers (including ANC) have already been revised but that the new books have not yet been printed and distributed. We also note that the intention is to move from quarterly reporting (using Form 004) to monthly reporting (using a new report format derived from the current Book 2). We emphasise that the opportunity to move to alternative / improved indicators for RBB is contingent upon completing these revisions to the HMIS system. We further emphasise the importance of introducing the new software for the input, collation and analysis of HMIS data at the council and regional level. This should greatly improve the quality of HMIS data at all levels and will obviate the need for any separate spreadsheet for collating the data relating to RBB indicators.

⁸ See Annex 4 for details

⁹ Because issue of vouchers to infants is under health-worker control, whereas subsequent redemption of vouchers is largely beyond health worker control.

Reporting

- Facilities report quarterly to CHMT/Facility Committee
- CHMTs report quarterly to RHMT/DED
- RHMTs report quarterly to MOHSW (DPP)/RAS

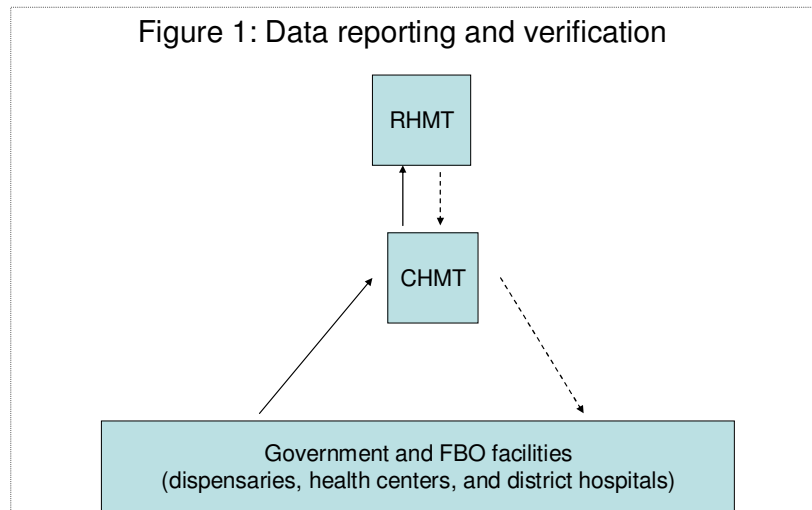
At the facility level, all targets will be divided into monthly targets (1/12), without adjustment for seasonality. Simple tools, like those used for EPI, should be introduced to enable facilities to assess whether they are “on track” for target on a month-by-month basis.

Actual reporting of indicator performance can only be done on a quarterly basis at present. This is because most tally forms¹⁰ in Book 2 are divided into quarters rather than months. The alternative is to introduce a separate, monthly RBB report, based on data extracted from source registers. This separate return would become redundant once the new monthly HMIS returns have been put in place.

Facility data will be entered quarterly into a pre-designed spreadsheet by the HMIS focal person at the CHMT. The spreadsheet should enable easy identification of outlier / questionable data and automatically compare performance against targets.

The performance assessment for the purpose of awarding bonuses will be undertaken on a six-monthly basis. The bonus amount would then be paid out to the facility in-charge. Once facilities have opened their own bank accounts, the intention is to pay the bonus amount direct to facility accounts.

In the following figure, the solid arrows represent the flow of information that is reported and the dashed line represents the entity that will validate and check the information.



¹⁰ Including Jedwali 40 (ANC data) and Jedwali 41 (deliveries data)

The supervision team at the CHMT will validate reported performance during routine supervision visits by checking against the respective quarterly and monthly tallies in the registers. On a sample basis, these data will in turn be checked against the source registers.

In the case of deliveries the monthly/quarterly numbers will be easy to check against source registers because the numbers are relatively small. The completed partograph tally will need to be compared both to the file of partographs and to the recorded number of deliveries at the hospital. This task should be undertaken by the Council Nursing Officer during routine supervision visits. OPV zero data will be taken directly from the EPI register, that is already subject to internal audit by EPI staff. The reported number of ITN vouchers issued for infants should be easy to check against the (serially numbered) voucher stubs as well as the register.

The RHMTs will need to follow up CHMT reports by ensuring that the data reported match the reports coming from the health facilities. They may also undertake periodic random audits at the facility level to check reports against registers.

The RHMT report that collates council results will be reported to and validated by the RAS Audit Committees.

Verification

The introduction of payment for performance runs a risk that reported performance could be artificially inflated. It is therefore essential that reported performance is routinely verified. The internal audit system described above will verify reports between each of the levels. Particular attention should be paid to “questionable” data (that departs radically from previous performance) and “outlier” data (where a facility’s performance differs radically from comparable facilities).

Because CHMTs will be judged on the success of the health facilities that they manage, there is also a risk that CHMTs have insufficient incentive to question/challenge inflated reports. It will therefore be the job of the RHMT to scrutinize the reports coming from the CHMT and to perform spot checks to verify data.

Ideally, this should be supplemented by some form of “external data quality audit” that can test whether internal audit arrangements are working satisfactorily as well as testing a sample of reports. This should include sample testing of the accuracy of data recorded in the source registers¹¹.

Experience of (external) data verification for the RBB system being operated in 5 Catholic Dioceses did find numerous errors in reporting. However, for the most part these represented clerical and arithmetic errors rather than illustrating any deliberate attempt to falsify / inflate data.

At present, source and summary data from the HMIS are far from perfect. There are likely to be many data entry and clerical errors making it hard to justify spending on an independent external audit. This design team recommends implementing and

¹¹ Checking of source register data would mean following up patients recorded in the registered.

strengthening the internal audit systems in the first year and additional safeguards (possibly using an external data quality audit) in the second year.

Where data is found to be erroneous (report >actual) the bonus is not paid for that indicator in the period being reported. We do not recommend introducing additional penalties for reporting errors at this stage. However, this should be considered at a later stage once HMIS has been strengthened and external audit put in place.

Rewards

Allocation of Bonus to Facilities / Teams

The level of reward has been fixed for all facilities / teams of the same type. One advantage of this is that understaffed facilities stand to gain larger individual rewards. It may also help to attract staff to move from over-staffed to under-staffed health facilities.

The maximum annual reward available to each level will be as follows. The calculation and justification of these levels is described in more detail in the Budget section below. The level of bonus for each level may be reviewed in future years based on experience.

Table 7: Maximum bonus per facility/team

Facility	Maximum Annual Bonus (T.Shs)	“Typical” maximum annual bonus per person¹²
Dispensary	1 million	200,000/=
Health Centre	3 million	200,000/=
District Hospital	9 million	200,000/=
CHMT	3 million	200,000/=
Regional Hospital	10 million	200,000/=
RHMT	3 million	200,000/=

Linkage of Reward to Target Achievement

The relationship between performance and rewards needs to be as simple as possible so that the rules are transparent and widely understood. Each of the indicators and targets carry the same weight. The level of reward for FBO facilities will be the same as for government facilities.

Dispensaries and Health Centres have 5 targets. So attainment of each target “earns” a fifth (20%) of the maximum bonus available. In case a facility does not deliver certain services (e.g. deliveries) is not eligible for that bonus unless/until the capacity is put in place to deliver those services

Hospitals, CHMTs and RHMTs have 6 targets. So attainment of each target earns one sixth (17%) of the maximum bonus available.

Bonus allocation to individuals

The distribution of a bonus earned by a health facility / team will be shared among the team members. Allocation of the amount to individuals will be governed by a rule to

¹² Actual individual bonus payments will depend upon seniority. These figures are included only to illustrate the level of individual reward attainable

avoid “capture” of the bonus, assure reward for all team members, to avoid conflicts and to promote transparency.

Our consultations reveal that health workers consider it fairer if reward is linked to levels of skill, training and responsibility¹³. The simplest way to do this is to follow the same rules and differentials as those presently applied for employment allowances¹⁴. This will require the application of a simple formula to calculate the distribution of bonus among eligible staff, weighted according to their salary grade.

The definition of eligible staff will be described unambiguously for each level receiving rewards and this will be checked by the next level in the reporting line. Thus the CHMT will check the list of eligible staff for every facility; the DED will check the list of eligible CHMT staff and the RAS will check the list of eligible RHMT staff.

In case one team member is absent for a part of the performance period, that staff will still be eligible for reward. This ensures that staff absent on official duties or statutory leave are not discriminated against. At the same time, peer pressure among team members is expected to reduce absence from duty.

Frequency

Ideally the performance assessment and reward should be done regularly to keep the incentive alive in people’s minds. To reduce implementation complexity in the first year it is proposed to reward performance twice per year, or each 6 month period. In subsequent years this could be modified to a quarterly basis.

Bonus allocation per council

The councils receive information on the maximum budget available for bonuses for each type of health facility a given year. It calculates the district budget by multiplying the maximum RBB bonus for each facility type by number of units (including FBOs). Thus the level of council health basket funds that needs to be reserved for RBB bonuses will vary from place to place according to the number of facilities.

Table 8: Budget for bonuses – example of a typical district

Unit type	# units	Max per unit	Total budget for RBB, Tsh
CHMT	1	3m	3m
Hospitals	1	9m	9m
Health centres	5	3m	15m
Dispensaries	30	1m	30m
Total			57 million

Notes:

Dollar equivalent approximately \$50,000 (or about \$0.2 per capita in a typical council)

Number of councils approx. 130, so total budget for councils’ \$6.5 million

Plus 21 RHMTs @ T.Shs 3m each = T.Shs 63m = approx \$50,000

¹³ At the consultative meeting in Morogoro, health staff were unanimous that it would not be fair for a sweeper to get the same bonus as a clinical officer in-charge.

¹⁴ For example, a per diem for travel to town is 20,000/= for junior staff, 30,000/= for middle ranks and 45,000/= for senior-ranking officers. Thus the bonus allocation formula will give middle ranks 50% more than junior ranks and senior ranks 50% more than middle ranks.

It is essential that the budgetary requirements for RBB is communicated to CHMTs at the time budget guidelines are issued so that the requisite funds can be allocated for the coming financial year. This has not yet been done for financial year 2008/9. Formal guidelines for CHMTs to be included in year 1 implementation need to be issued as a matter of urgency.

Roles & Responsibilities

What follows is a description of the roles each “actor” in the Tanzanian health system will need to assume to effectively implement RBB. The section that describes “Implementation” will discuss training, external support for implementation, operations research, and institutionalization of a RBB Unit in the Department of Policy and Planning of the MOHSW.

Facility Level

1. Identify performance problems and develop and implement actions to improve performance.
2. Work out baseline performance and negotiate targets with CHMT.
3. Report progress on indicators to CHMT quarterly.
4. Request technical assistance to refine strategies and solve problems when needed.
5. Liaise with Facility health committee and other community members and leaders to improve outreach and achieve results.

Health Facility Committee Roles

1. Open and manage facility bank accounts
2. Counter-sign facility performance agreements.
3. Undertake quarterly review of performance and verify performance reported.
4. Ensure that bonus payment is distributed to staff according to the rules.
5. Contribute to development and implementation of action plans.
6. Liaise with community leaders to sensitize population and raise demand.

CHMT Roles

1. Training & capacity building. Explain RBB to facilities; provide support to help develop action plans, and ongoing assistance to achieve goals.
2. Formalize performance agreements with facilities. Establish written performance agreement with each facility. A performance agreement template and guidelines will be provided.
3. Record, monitor and validate data. Each quarter, facilities report the quantity of each of the RBB services provided. Input data, identify/correct errors¹⁵, produce reports that compare facility progress against targets, determine the low and high performers, and communicate results to the CHMT.
4. Validate reported data by performing spot checks of reports against source registers during their routine supervision visits.
5. Support low performers. Provider targeted TA to identify reasons for poor performance and develop strategies to overcome them.

¹⁵ For example, by checking for unusually high/low figures in the monthly reports

6. Assure responsive support to address shortages of equipment, staff and supplies in health facilities.
7. Sign CHMT performance agreement with DED, countersigned by RHMT
8. Make quarterly CHMT performance report to RHMT (cc DED).

RHMT roles

1. Train CHMTs to implement RBB. Provide ongoing support and quality control in the roll-out of training at the district level.
2. Advise and assist in the negotiation of CHMT targets with their respective Council Administrations.
3. Counter-sign performance agreements with all CHMTs.
4. Aggregate and analyze performance data for the region and provide feedback to every CHMT/Council Administration.
5. Verify that payment for targets achieved per facility reflects targets specified in performance agreements
6. Identify performance problems and provide targeted supervision and support.
7. Provide technical support and supervision to all hospitals to reduce maternal deaths.
8. Convene meetings to share lessons across districts and provide support.
9. Sign RHMT performance agreement with RAS, countersigned by CMO
10. Provide quarterly RHMT performance reports to RAS, cc CMO

National Ministry of Health and Social Welfare Roles

1. Establish national unit under DPP to oversee the implementation of the RBB strategy.
2. Develop guidelines, training materials, implementation tools and templates.
3. Receive quarterly reports from Regions
4. Monitor RBB implementation, identify problems / lessons and refine model for subsequent years
5. Institute ongoing comparative performance assessment to identify high/low performing councils and regions for each indicator.
6. Conduct annual program review to assess implementation of program, consider refinements to the model, evaluate progress on reaching targets and communicate lessons about effective strategies.

PMO-RALG Role

1. The DED and the RAS will have a key role to play in monitoring performance of their respective CHMTs and RHMTs
2. Ideally, a full set of performance indicators (including, but not limited to those rewarded) needs to be put in place and harmonized with the Local Government Monitoring Database¹⁶. This will allow automatic generation of performance reports that are equally useful to the health sector and to PMO-RALG

¹⁶ The current list of 20 council health service indicators (Annex 12 of CCHP guidelines) have some problems since some cannot be measured through routine data systems and most councils do not report on them anyway. The Local Government Monitoring Database has compiled a list of (annual) health sector indicators which is incompatible with the CCHP indicators and also contains indicators not obtainable from routine information systems. We recommend that these indicator sets be reviewed and harmonized.

3. PMO-RALG (Council Administrations) will also have a key role to play in enabling the opening of facility bank accounts, and oversight / audit of the same.

Implementation

This proposed RBB design is guided by the need for a simple approach that can be implemented at national scale as rapidly as possible, commencing in July 2008.

Indicators were chosen based on relative ease of measurement and reporting as well as their relevance to improving maternal, neonatal and child health. Rules to set targets and allocate performance payments are standardized in order to eliminate time that might be spent debating choices if more flexibility was incorporated. As time is limited, a clear implementation plan is needed to put the building blocks in place, develop tools, templates and guidelines, train the relevant actors, determine baseline performance, formalize performance agreements and assume new roles. This section will describe the building blocks that need to be developed to enable national roll-out.

Phasing

While it would be ideal to lay the groundwork for implementation in the entire country before July 1, the design team recognizes that this may not be possible if there are any delays. To allow for the possibility of some delays, the design team is proposing two “tracks: with different timetables for national roll out.

Track A: This is the “fast track” preparation and implementation that will be feasible if decisions are made according to an ambitious timetable, technical assistance is hired and put in place, materials are developed and tested, and training at all levels can occur before July.

Track B: This timetable allows for part of the country to begin implementation on July 1 and phases in additional parts of the country throughout the fiscal year so that RBB is implemented nationwide by July 1, 2009.

As well as being a more realistic timeframe, Track B allows for refinement of the model before roll-out to remaining Regions. It also allows time to undertake the requisite HMIS strengthening and the opening of facility bank accounts.

Track A: “Fast Track”	Track B: “Phased approach”
<ul style="list-style-type: none"> • Decision for “go ahead” February/March 2008 • Materials developed and tested by April • RBB National Unit (incl. TA) and Roll-Out teams in place by April • Training all levels by July 2008 • Full-scale implementation July 2008 (FY2008/9) 	<ul style="list-style-type: none"> • Decision for “go ahead” March 2008 • Materials developed and tested by June • RBB National Unit (incl. TA) and Roll-Out teams in place by June • Implementation in 1 Region in July 2008/9 • Training completed in all remaining Regions by March 2009 for full scale implementation in July 2009

Tasks

The tasks required for successful implementation of the scheme are summarized below:

- Reach consensus on the scheme design and decision made to proceed
- Notify councils to reserve a portion of their CCHP & budget for RBB payments
- Include RBB guidance in next issue of CCHP guidelines and budget guidelines for 2009/10
- Develop and pre-test all templates, forms, guidelines, tools, training materials
- Put in place National RBB Unit (long-term technical assistance plus MOHSW counterparts)
- Put in place RBB Roll-Out team(s)
- National level trains Regions (in zones)
- Regions train Councils
- Councils train Facilities
- Develop and implement programme of operations research to monitor impact, identify best practice, document results
- Ongoing operational support and monitoring
- Disseminate information on comparative performance and on the impact of the scheme
- Include scrutiny of RBB payments in TOR for future Basket Fund audits.

In parallel with this process, HMIS strengthening and the devolution of budgetary authority to health facilities (facility bank accounts) should be underway.

In the interest of brevity, the more detailed narrative description of the tasks and their timing is based on the “fast track” scenario. In case the “phased approach” is selected, the timeframe would need to be adjusted accordingly.

Phase 1: Preparation (March through July 1, 2008)

The four months that precede the operationalisation in July, 2008 will be the time to start recruitment of the RBB International Expert & support team to be located in the MOHSW, assign the Ministry counterpart to work with this team, assign the members of the RBB Roll Out team, train the many actors that comprise the health system, establish the performance agreements and tracking and monitoring system, develop the necessary materials, and assign the roles at each level to implement RBB.

Establish RBB unit in the DPP

Coordination of RBB will be needed at the national level. Although responsibility for RBB will be placed in the Policy and Planning Department in MOHSW, experiences show that the multitude of technical, operational and managerial tasks during implementation will require additional support. The design team proposes that three *temporary resource people* should be placed in the Policy and Planning Department for *up to three years* with the aim of *making themselves redundant* by transferring skills to their counterparts. In due course, these counterparts should be able to assume the RBB co-ordination role.

The following temporary resource people will be needed to staff the RBB Coordinating Unit:

- One International RBB Expert (international hire)
- One Financial Expert (local hire- external to the MOHSW)
- One Administrative Officer (local hire- external to the MOWSW)

The Policy and Planning Department should assign a fully dedicated counterpart who is a Policy and Planning Expert with in-depth knowledge of the health sector to work with a donor-funded team that works in the MOHSW to build a RBB Unit. If possible, two additional assigned counterparts to assume the tracking, coordination, and administrative roles would help assure that the capacity is institutionalized within the MOHSW. This unit will track progress for the country, oversee annual assessment of progress and impact. It will commission targeted operations research to study impact on performance (both rewarded and non-rewarded indicators) and to identify, document and disseminate best practices. The Unit will also assemble national data that permits comparative performance assessment across Councils and Regions.

If possible, the following counterparts from the MOHSW should be assigned to assume the functions of the RBB Coordinating Unit of the Policy and Planning Department.

- One Policy and Planning Expert.
- One Operations Research Coordinator
- One Administrative Officer

Materials needed to implement RBB

While plans for training are underway, the following materials will be developed by a small team of consultants:

1. Written guidelines that specify the roles and responsibilities of the RHMT, CHMT, and facilities.
2. Performance agreement templates for the RHMT, CHMT, hospitals, health centres and dispensaries.
3. Guidelines for how to determine baseline performance levels.
4. Guidelines for how to develop facility level action plans and a template.
5. Guidelines on how to open & operate facility bank accounts.
6. Data forms for quarterly (or monthly) reporting on the rewarded indicators. Formats to track performance indicators will be incorporated into revisions of the MTUHA in subsequent periods.¹⁷
7. National, regional and district level performance monitoring and tracking tools (excel spread sheet tool).
8. Training materials for the TOT programs that will include:
 - PowerPoint presentation to describe the new model
 - Stylized case study to use in hands-on group work to help understand how to develop an action plan and what facilities might do to achieve results
 - Menu of potential strategies to increase performance.
 - Guidance on where resources might come from to finance the interventions needed to attain results (existing funding sources)

¹⁷ These forms would report on the 5-6 indicators that are part of the performance based bonus system. Reporting on progress quarterly will enable district and regional teams to track progress, identify facilities that are off track, and enable them to provide support to improve results early enough to make a difference.

- Training on how to use performance monitoring and tracking tool to identify low performers, and assess district and region progress toward achieving performance targets.

Training to implement RBB

The training will follow a cascade approach. RHMTs will be trained in zonal groups. Using a training of trainers (TOT) model, regional teams will learn to train the CHMTs in their region to roll out the model. CHMTs will organize training of the facility-level staff. ***Effective training is critical- if people don't understand the new system they won't be motivated to achieve results. At the same time, training should be designed and implemented to assure maximum value for money and minimum disruption to routine duties.***

The training approach proposed has been substantially revised based on comments received earlier. The costs of training presented here are based on:

- 7 zonal training sessions for regions; 2 day training, 5 participants from each region
- 130 councils trained (in their respective regions); 1 day training, 10 participants from each council
- Approx 40 facilities per council trained (in their respective councils); 1 day training for 2 participants per facility.

On the basis of comments from MOHSW, the design team understands that all training costs, including contracted staff and trainee per diems, will need to be met from donor funds.

1. Establish national “RBB Roll-Out Team” by March 15 to develop the training approach and to implement the TOT model. This team will be comprised of two teams of five people who understand RBB, have demonstrated commitment to maternal health, and believe that changing incentives through RBB will make a difference. Each team will comprise:
 - 1 Medical expert
 - 1 with expertise in HMIS
 - 1 with expertise in the financing mechanisms used in Tanzania at the district level
 - 1 from the FBO sector.
 - 1 from external entity contracted to facilitate roll out and implementation.

In addition to meeting above requirements, the team members need to be good trainers. Profiles of members of the RBB Roll Out team will be developed to help the Government identify appropriate people to assign, with help from the International RBB Expert. Each member of the RBB Roll Out team will be expected to dedicate 25 days per quarter to support effective implementation of RBB.

2. The RBB Roll-Out Team will train RHMTs at the zonal training centers where regional health teams will learn about RBB and how to train the CHMTs in their region to implement the model in their facilities. This training will be completed by the end of April, 2008.

3. CHMTs will train facilities with support from RHMTs. This will include establishing baseline performance levels and targets, signing performance agreements, and developing action plans to achieve results.

Track A: CHMTs will train all facilities, operationalise action plans and finalize performance agreements by the end of June, 2008.

Track B: Training of 1 Region only by June 2008. Phased training of all remaining regions completed by March 2009.

Operations research

Identify selected districts in two Regions to follow the design and implementation process closely. Qualitative research can be concentrated in these areas (complemented by nationwide quantitative research).

A structured program of operations research will be needed to document what is effective in the training and roll out process and what might need to be revised in the approach to training in subsequent years.

The newly formed RBB Unit in the Policy and Planning Department will craft a program of operations and impact research with the International RBB Expert that might include:

Track baseline performance levels and targets and monitor national progress: A top priority for this national RBB unit will be to assess performance and progress toward improvement. The RBB unit will collect baseline performance levels by district and monitor progress toward attainment of targets.

Effect of RBB on the distribution of human resources: One hypothesis is that providing a fixed maximum bonus sum per facility type will encourage health workers to be posted at under-staffed facilities. Assessing whether this reallocation occurs and the impact on performance in both the facilities they leave and the facilities they move to will be one priority area for OR.

Assessment of the quality of data reporting and data verification: In the first year, line supervisors (CHMT for facilities and RHMT for CHMTs) will be responsible to validate data and verify performance. Since line supervisors also benefit from attaining performance targets, incentives may result in supervisors “looking the other way” if high but incorrect performance is reported. A program of OR is needed to assess the challenges with this approach to data verification and to propose refinements for subsequent years.

Document what facilities, CHMTs and RHMTs actually do in response to altered incentives: Qualitative assessments of the responses to changed incentives and the impact perceived by health system actors on results need to be documented. Through interviews and focus groups, a group of successful and failed innovations can be documented and shared.

Assess the impact of RBB on services that are not being rewarded: One of the dangers of RBB is that services that are not being rewarded might be neglected. Care was

devoted to choosing indicators for this first phase that reach each priority group with the goal of mitigating against this potential adverse effect. It will be important to monitor overall production to determine if there are positive (likely) or negative spillover effects on the system.

Assess the degree of civil society engagement: The proposed design includes a specific role for Health Facility Committees to hold facilities accountable for results and to help achieve results. Understanding whether facility committees become more involved and documenting the success stories will be one important area for OR.

Phase 2: Implementation (July 2008 onward)

Once RHMTs and CHMTs are trained, facilities have action plans, and performance agreements are signed and in place, operationalization can begin. As described in earlier sections, RHMTs and CHMTS will track progress toward attaining targets and identify low performers for focused technical assistance. Both qualitative and quantitative Operations Research will be conducted, involving the health system research unit in DPP department, teaching & research institutions in the country, to “get the stories behind the numbers” as well as to track national progress. By November, 2008, plans will begin to revise the approach for the fiscal year beginning in July 2009. Lesson learned through implementation in the first year and progress on development of the HMIS will be incorporated to refine the approach.

Ongoing Implementation Support

In each quarter, 10 regions will be randomly selected to receive focused assistance from the RBB Roll out team (each team will work with 5-6 regions and each region will receive 5 days of intensive assistance). This team will begin with the RHMT to assess their understanding, to answer questions, address concerns, and provide needed assistance to strengthen understanding. The RBB Roll out team along with the RHMT will visit a select group of districts (either randomly chosen or identified as poor performers) to provide additional support. They will then provide targeted assistance to a select group of facilities. Through this process, the RBB Rollout team will provide ongoing assistance to strengthen understanding and support implementation in an ongoing way throughout the first year.

Monitoring

The new RBB unit established in the Department of Planning of the MOHSW will receive quarterly reports from CHMTs and RHMTs on performance achieved throughout the country. This unit will manage a national data base that tracks ongoing progress toward attainment of targets. This ongoing monitoring process will identify what is working and areas of the approach that could benefit from future refinements.

Communication of Performance Information

The design team recommends that performance data from health facilities should be in the public domain. This will help Health Facility Committees and Council Health Service Boards to play an effective oversight role. It will assist the MOHSW and PMO-RALG to undertake comparative performance assessment across regions, councils and facilities. Public / media access to performance comparisons should offer a powerful incentive for under-performers to raise their standards.

Refinements to RBB for Year 2:

The RBB Unit of the MOHSW will have the responsibility to advise and recommend changes to the RBB approach. Guided by the International RBB Expert and by the RBB Roll Out Team, they will analyze national performance data, examine results of operations research, and suggest refinements to the year 1 model. In particular, scope for refinement of the model will depend upon progress in the opening of facility bank accounts and on the strengthening of the HMIS system and a broader emphasis on “results-based management”.

Annual Review

Incorporated into the annual review of the SWAP will be an assessment of the impact of RBB. This assessment will draw on the data monitoring system managed by the RBB unit of the MOHSW and will incorporate results of both qualitative and quantitative operations research described above.

Document implementation experiences through video

To complement quantitative and qualitative research, visual documentation of implementation of RBB will be a powerful means to capture the behavioral responses of the many actors in the health system in Tanzania. This design team recommends that interviews to capture the responses to new incentives would be a powerful tool to inform further scale up, communicate to civil society in Tanzania, and to share experiences on a global scale.

Budget requirements

As the RBB scheme will be operated within existing systems and structures, the majority of the costs are already covered by the Government and Development Partners through the different financing channels of the system. However, there are *additional* or *marginal costs* that need to be identified and funded in one way or the other. These additional costs of introducing and implementing the RBB scheme are categorised and elaborated below. It is important to acknowledge that these will be *estimates* based on existing knowledge, unit costs and exchange rates.

Ongoing operational costs are challenging to estimate because they will be affected by factors such as how well the introduction has worked, how well it is understood, and the obstacles that occur. They will also be affected by whether future refinements progressively incorporate additional indicators and the capacity of the HMIS that will be strengthened in the coming years.

Some of the costs presented in the following table are one-time costs of design and implementation, while others will be recurrent costs that will be eventually assumed as part of government operations if the approach is successful and becomes institutionalized.

The following table summarises estimated costs to design, roll out, implement and monitor RBB.

Table 9: Summary of Implementation Budget, excl. Bonus payments (US\$ ‘000s)

Note: Budget schedule based on “Fast Track” approach

Cost Element	2007/08	2008/09	2009/10	2010/11	2011/12	Total
RBB Coordination Team	\$300	\$900	\$900	\$900	0	\$3,000
Materials	\$150	\$50	\$50	\$50	\$50	\$350
Initial Training	\$90					\$90
Ongoing training support		\$45	\$45	\$45	\$45	\$180
Operations Research		\$100	\$100	\$50	\$150	\$400
Other operational costs	\$50	\$50	\$50	\$50	\$50	\$250
Communication/ documentation	\$50	\$50	\$50	\$50	\$50	\$250
Other TA	\$100	\$100	\$100	\$100	\$100	\$500
TOTAL (excl. per diems for all levels)	\$740	\$1,295	\$1,295	\$1,245	\$445	\$5,020
Per diems for training	\$880	\$250	\$250	\$250	\$250	\$1,880
Total 2	\$1,620	\$1,545	\$1,545	\$1,495	\$695	\$6,900

The design team understands that plans are underway to strengthen the HMIS. A more robust system to track and report on health information will enable additional indicators to be included as RBB evolves. It will also remove the necessity for any additional reporting tools; improve data quality and timeliness and allow routine comparative assessment of all performance indicators – not only those that are rewarded.

At the same time, the introduction of RBB is expected to add impetus to the strengthening of the HMIS because bonuses cannot be earned without reports; because full HMIS reporting is one of the indicators; and because it will pioneer a “results-based management” culture.

The design team strongly advocates the prompt implementation of HMIS strengthening efforts as a mutually reinforcing strategy. We also envisage potential economies of scale if the introduction and training on the revised HMIS can be combined with RBB roll-out.

Value for Money

Tanzania has not made progress in reducing maternal mortality. It is clear that continuing with “business as usual” is not working. Experience from other countries has demonstrated the potential of pay-for-performance to leverage rapid improvements in service delivery results. By promoting a results-orientation at all levels, RBB is expected to encourage more efficient utilisation of health resources, with a primary focus on achieving better service delivery, particularly with regard to maternal and neonatal health.

Additional benefits that are difficult to quantify will likely be a strengthening of the health system from the bottom up as the many health system actors become empowered to implement interventions that lead to improved maternal and child health outcomes. This strengthening of the health system will likely have spillover effects that will benefit other health priorities.

It will take several years to fully assess whether the benefits will be worth the up-front investments and ongoing costs of implementation. Operations research will provide information along the way and more rigorous evaluation of impact will provide the evidence.

Assessment of the Feasibility for the Next Fiscal Year

This design team believes that it will be feasible to implement RBB nationwide. As the previous chapter described, there is a great deal of work involved in preparation and implementation. Much of this is time sensitive since the design of the scheme relies upon Councils planning and budgeting for bonuses, and obtaining their training in time for implementation in the coming financial year. ***It should be noted that the timeframe and the cost of implementation will be largely unaffected even if the RBB design were further simplified (e.g. by adopting a single indicator instead of multiple indicators).***

Track A (Fast track) involves an extremely short timeframe for preparation and implementation. Any delay over the coming months will inevitably mean that implementation could not be achieved on a national basis in time for July 2008. Even without delays, the timescale looks to us to be too ambitious.

Track B (Phased approach) would still require very rapid mobilization of human resources and training implementation. However, the task is more manageable if it is confined to a single region in year 1. This permits training for the remaining regions to be scheduled over a more realistic timeframe. It would allow the model to be refined before national roll out. It would also provide time for mutually reinforcing strategies (opening facility bank accounts, strengthening of HMIS) to be undertaken. Depending on the timing (and donor support), there may be a possibility of combining RBB training with HMIS training, thus providing a double benefit.

Preparation, roll out, and institutionalization in the MOHSW will require commitments of funding and determination of the mechanisms used by the different donors who agree to support implementation. For example, if donor procedures mandate competitive processes to procure assistance, extra time would need to be factored in. If this process can be streamlined and needed technical assistance can be put in place rapidly, this potential source of delay can be minimized.