



PAY FOR PERFORMANCE IN TANZANIA

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Pay for performance (P4P), consisting of bonuses to health facilities linked to attainment of performance targets, is being implemented in the United Republic of Tanzania with the goal of improving maternal and child health outcomes; strengthening information systems and the use of information for management decisions; and motivating health care providers. After discussions between the government of Tanzania and development partners, the government chose to implement a nationwide P4P program. This decision – to begin on a national scale rather than with a pilot – along with donor concerns about weaknesses in the program, resulted in development partners declining to fund the bonuses out of the health basket. This case study explores the process between donors and the government of moving P4P from concept to design to implementation. It describes key areas of disagreement, and highlights the political tensions inherent in translating high-level interest in P4P into on-the-ground action.



ABOUT THE P4P CASE STUDIES SERIES

Pay-for-performance (P4P) is a strategy that links payment to results. Health sector stakeholders, from international donors to government and health system policymakers, program managers, and health care providers increasingly see P4P as an important complement to investing in inputs such as buildings, drugs, and training when working to strengthen health systems and achieve the Millennium Development Goals (MDGs) and other targets that represent better health status for people. By providing financial incentives that encourage work toward agreed-upon results, P4P helps solve challenges such as increasing the quality of, as well as access to and use of health services.

Many developing countries are piloting or scaling up P4P programs to meet MDGs and other health indicators. Each country's experience with P4P is different, but by sharing approaches and lessons learned, all stakeholders will better understand the processes and challenges involved in P4P program design, implementation, evaluation, and scale-up.

This Health System 20/20 case study series, which profiles maternal and child health-oriented P4P programs in countries in Africa, Asia, and the Americas, is intended to help those countries and donors already engaged in P4P to fine-tune their programs and those that are contemplating P4P to adopt such a program as part of their efforts to strengthen their health system and improve health outcomes.

Annexed to each case study are tools that the country used in its P4P program. The annexes appear in the electronic versions (CD-ROM and Health Systems 20/20 web site) of the case study.

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ACRONYMS

ANC	Antenatal Care
CHMT	Council Health Management Team
DMO	District Medical Officer
DPs	Development Partners
DTP	Diphtheria, Tetanus, and Pertussis
GOT	Government of Tanzania
HB	Hepatitis B
Hib	Haemophilus influenzae type b
HMIS	Health Management Information System
IMCI	Integrated Management of Childhood Illnesses
LGA	Local Government Authority
MDGs	Millennium Development Goals
MOH	Ministry of Health and Social Welfare
MTUHAHMIS data coded in 12 books	
NGO	Nongovernmental Organization
NTPI	Norway Tanzania Partnership Initiative
P4P	Pay for Performance
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
RHMT	Regional Health Management Team
SWAp	Sector-wide Approach
TEHIP	Tanzania Essential Health Interventions Program
Tsh	Tanzanian shillings
USAID	U.S. Agency for International Development
WHO	World Health Organization



INTRODUCTION

A P4P program in Tanzania would target the countries weak health system and health outcomes.

What follows is a brief case study on Tanzania’s experience launching a national pay-for-performance (P4P) program. When data showed that, despite huge increases in health spending and a robust decentralization program, the country had made little progress in reducing maternal and neonatal mortality, the government of Tanzania (GOT) and donors began looking for other solutions. Awareness about the successful P4P scheme in Rwanda, coupled with high-level interest from Norway and Tanzanian President Jakaya Kikwete, spurred a process of consensus

building and program design. After extensive negotiations on the technical design in 2008, the GOT decided to implement a P4P scheme without the endorsement of the country’s health sector development partners. The scheme consists of bonuses to health facilities that attain performance targets related to maternal and newborn health and timely and accurate data collection. Donors felt there were numerous weaknesses in the scheme, and declined to fund bonuses until those weaknesses were addressed. Indeed, there is much confusion about whether P4P is currently really being implemented at all. But Norway and the GOT resumed talks in early 2010, which resulted in the intention to carry out a pilot to strengthen the national program. Prospects are good that this time, a partnership will succeed.





THE P4P CONCEPT: TURNING TRADITIONAL DONOR FINANCING FOR HEALTH ON ITS HEAD

Over the past decade, donors have poured billions of dollars into health programs in low- and middle-income countries: development assistance for health tripled between 1997 and 2007.¹ While these commitments have done much good,² many low-income countries continue to fall short, particularly in areas that require a functioning health system. For example, the World Bank³ estimates that more than 11 million children under five die annually in developing countries from preventable illnesses such as acute malaria, diarrhea, and respiratory infection. Twenty-seven million infants do not receive all three doses of the DTP (diphtheria, tetanus, and pertussis) vaccine even though immunization is one of the most cost-effective ways to prevent life-threatening diseases such as measles and tetanus. The picture is similar for other preventable health problems such as dehydration from diarrhea and complications during pregnancy and childbirth (Eichler and Levine 2009).

¹ Organization for Economic Cooperation and Development.

² More than 3 million people in low- and middle-income countries now have access to life-saving antiretroviral treatment for HIV/AIDS; the percentage of children protected from malaria by insecticide-treated nets has increased almost eightfold in 18 African countries (from 3 percent in 2001 to 23 percent in 2006); and more children than ever are being immunized against life-threatening diseases such as hepatitis B (HB), Haemophilus influenzae type b (Hib), and yellow fever. (According to the GAVI Alliance, over 155 million children were immunized against HB between 2000 and 2007; 28.2 million against Hib; and over 26 million against yellow fever.) See Eichler and Levine (2009).

³ P4P is referred to by the World Bank as “results-based financing,” and other donors describe it as performance-based incentives or performance-based contracting. While there are nuances inherent in these terms, all essentially describe the same concept of linking incentives with results.



Traditionally, governments and donors have funded construction, training, equipment, salaries, and other inputs. But inputs do not automatically translate into improved health. Individuals must demand (and be able to access) services and health workers must be motivated to deliver quality care.

That's where incentives come in. Defined as the transfer of money or material goods conditional on the recipient having taken a measurable action or achieved a predetermined target, performance incentives can target health facilities (or networks of facilities), individual providers, household decision makers, or patients themselves (Eichler and Levine 2009, p. 6). P4P starts with the results – more women giving birth in health facilities, for example – and lets health workers and managers on the ground find creative solutions for achieving them.

The benefits of performance incentives can extend beyond specific interventions to strengthen health systems as well. For example, because performance incentives require accurate monitoring and evaluation, even programs aimed at specific diseases can help improve overall performance by encouraging countries to develop robust information and management systems. P4P can also help countries introduce key reforms that would be difficult to tackle head on. For example, because P4P aims to empower health workers at district and local levels, giving them more decision-making power and control over their budgets, it can contribute to efforts to decentralize power while, at the same time, improving accountability for results.

Interest in P4P is growing. The World Bank, through the Health Results Innovation Trust Fund, is financing the implementation and evaluation of six P4P pilot programs in Africa that target maternal and child health mainly through incentives to service providers. Other countries such as South Africa, Cameroon, and the Central African Republic are initiating P4P programs with funding from the U.S. Agency for International Development (USAID) and other donors, while others are looking for sources of funding so they can give P4P a try. Many are hopeful that these programs will improve health and strengthen capacity in places where, despite huge investments, health status remains extremely poor.



WHY P4P IN TANZANIA?

Tanzania, unlike many of its East African neighbors, has enjoyed decades of peace and stability, but it remains one of the poorest countries in the world. In 2007, more than 33 percent of Tanzanians lived below the national poverty line; only 12 percent had access to electricity (National Bureau of Statistics 2008); and a paltry 10 percent had access to formal financial services.⁴

After independence, Tanzania enjoyed a decade or so of progress, including in health, but a global oil crisis, rapid population growth, a decline in key commodity export prices, along with the economic effects of socialism, and the costs associated with the invasion of Uganda in 1979, led the country to slip backwards in the 1980s and 1990s. Health spending was cut, health worker wages were swamped by inflation, and a donor-enforced hiring freeze of public sector workers, from 1993 to 1999, led to shortages of health workers (which continue today).

Two key developments helped things begin to change. First, between 1999 and 2004, total government health expenditure more than doubled, from US\$4.70 to \$11.70 per person. Total health expenditure, including private expenditure, increased from US\$23 to \$29 per person.⁵

⁴ FinScope survey 2007, <http://www.finscope.co.za/new/pages/Initiatives/Countries/>

⁵ See World Health Organization (WHO) (2007). In 2007, health expenditure constituted 4.5 percent of gross domestic product and 10 percent of total government sector expenditure, which is less than the Abuja target of 15 percent. The total per capita health expenditure per annum is US\$11, of which US\$6 is accounted for by out-of-pocket expenditure. This is well below the more recent estimate of US\$34, as advised by the WHO Commission on Macroeconomics and Health (WHO 2001) and the US\$43 per capita projection to meet the Millennium Development Goals. Tanzania.



Increased public expenditure was accompanied by a shift toward greater decentralization. In 2000, the GOT introduced sector-wide capitation grants that gave districts substantial financial resources. Tanzania also adopted a sector-wide approach (SWAp) for medium- and long-term planning, in which a coherent policy and expenditure program, under GOT leadership, was funded by the government and donors. A so-called basket fund, jointly funded by development partners, was created to provide an additional US\$0.50 per person to districts as recurrent financing support. This approach was implemented in 2000–01 and constituted a major change in the health system that decentralized substantial financial resources for the first time.



Better staffing at health centers and hospitals is needed.

Decentralization facilitated the introduction and scale-up of new interventions. For example, Tanzania started nationwide scale-up of insecticide-treated nets in 1999 and of Integrated Management of Childhood Illnesses (IMCI) in 2000, and changed its drug policy for malaria in 2001 (Masanja et al. 2008). Though the bulk of revenue still arrived from the center, decentralization moved genuine responsibility for planning, resource allocation, and supervision to new bodies known as Council Health Management Teams (CHMTs) (composed of senior district-level health personnel), which plan and budget with knowledge of the actual burden of disease in their districts.

⁶ The national roll-out of IMCI followed a successful prior experience with decentralization in Tanzania known as the Tanzania Essential Health Interventions Program (TEHIP), which set out to test whether health improvements could be had simply from a decentralized budgeting process and the provision of an essential health package of evidence-based, cost-effective interventions. In the TEHIP pilot, CHMTs in two districts were given simple planning tools that allowed them to plan and budget with knowledge of the burden of disease in their district, using data from the Demographic Surveillance System. District health budgets were topped up, by a small increment, on a per capita basis, and health workers were trained in IMCI. The program was a success: child mortality fell by 40 percent over four years, and the lessons of the project were integrated into national policy.



(The IMCI program was piloted during an experiment in the late 1990s with decentralization, and subsequently scaled up after the program showed big success.⁶)

These and other reforms have contributed to Tanzania's status as a donor darling in policy circles. President Jakaya Kikwete, in a major political coup, was the first African head of state to meet with President Obama in Washington, and foreign aid finances on average 40 percent of total government outlays.⁷

The country has seen improvements in recent years in health. Under-five mortality fell by 24 percent between 1999 and 2004 (from 146.6 deaths per 1,000 to 112), and the probability of dying before the first birthday fell by 31 percent over the same period (National Bureau of Statistics, Tanzania, and ORC Macro 2005).⁸ But the same has not been true in other areas. The maternal mortality rate, 578 per 100,000 live births, is one of the highest in sub-Saharan Africa and has changed little in the past 20 years. And neonatal mortality⁹ stood at 43 per 1,000 live births in 2000. Only 46 percent of all births take place in clinics and/or hospitals with qualified personnel in attendance (doctors, clinical officers, nurses, midwives) (National Bureau of Statistics, Tanzania, and ORC Macro 2005). The National Strategy for Growth and Reduction

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⁷World Bank Tanzania country brief, available at: <http://go.worldbank.org/7SUHE823V0>.

⁸According to Masanja et al. (2008), the most noticeable changes were vitamin A supplementation (up from 14 percent in 1999 to 85 percent in 2005), IMCI (up from 19 percent to 73 percent of districts), households with mosquito nets (up from 21 percent to 46 percent), children sleeping under insecticide-treated nets (up from 10 percent to 29 percent), iron supplementation in pregnancy (up from 44 percent to 61 percent), oral rehydration therapy for children (up from 57 percent to 70 percent), and exclusive breastfeeding for those younger than two months of age (up from 58 percent to 70 percent) and younger than six months (up from 32 percent to 41 percent).

⁹The neonatal period is the first month of life.



of Poverty (NSGRP) (United Republic of Tanzania 2005) identifies both maternal and child mortality as priority areas requiring attention from skilled and motivated clinicians.¹⁰ In addition, the Health Management Information System (HMIS) is extremely weak and staffing levels at health facilities and hospitals generally remain far below national targets and international standards.

Tanzania and its development partners have therefore been looking for new ways to spur improvements in the health system, health service delivery, and health outcomes.

¹⁰“The strategy aims at reducing infant mortality, child mortality, malaria related mortality and maternal mortality” (United Republic of Tanzania 2005, p. 11).



FIRST, A HIGH-LEVEL COMMITMENT

Talks between Norway and Tanzania began between the Minister of Health and the Norwegian Prime Minister's Office in December 2006 surrounding ways to address Millennium Development Goals (MDGs) 4 and 5 – which call on countries to reduce the under-five mortality rate by two-thirds, and the maternal mortality ratio by three-quarters, between 1990 and 2015– within a performance incentive framework (Smithson et al. 2007, p. 2).

The talks culminated in the signing of the Norway Tanzania Partnership Initiative (NTPI), a joint statement between the governments of Tanzania and Norway, signed by the respective heads of state during President Kikwete's visit to Norway in February 2007. In the NTPI agreement, Norway agreed to contribute approximately US\$32 million over five years to reduce maternal and child mortality in Tanzania, with P4P as one of the strategies used.



Better collaboration between the GOT and Norway will allow for the development of a stronger, more in-depth P4P pilot program.



SECOND, GENERATING BUY-IN

The February 2007 meeting was on what was then called the Global Business Plan for MDGs 4 and 5. Representatives from the Dar es Salaam-based Ifakara Health Institute, an independent research institution, and the Tanzanian Ministry of Health and Social Welfare (MOH) attended and participated in discussions about how to move from high-level commitment to P4P, to action.

Extensive dialogue with the government and other development partners followed, including a workshop in April 2007, which formed the basis for a draft program document that set out in more detail how Norway's assistance would be manifest.

Development partners on the Basket Fund Committee (Canada, Denmark, Germany, Ireland, Netherlands, Norway, One UN, Switzerland, UNFPA, UNICEF, and the World Bank) were made aware of Norway's interest in P4P at a special meeting held on November 8, 2007, and again, at a basket fund committee meeting in January 2008. Donors refer to the technical committee of the SWAp as the forum in which details about P4P would be discussed and "issues related to basket arrangements should be presented to the basket group for approval" (Lauglo and Swai 2009).

The health basket channeled a whopping US\$234 million in support of the sector between FY02 and FY07 and, "has in general played an increasingly important role in supporting day-to-day operations within the health sector, both through recurrent budget support to MOH headquarters, support to various projects within the development budget, and through the recurrent grants to Local Government Authorities (LGA).¹¹" But with



a relatively large group of sometimes unwieldy donors, each with their own set of priorities and interests, consensus was at times elusive.

According to Jacques Mader of the Swiss Agency for Development and Cooperation, who is the chair of the health development partners group in 2010, most donors, encouraged by promising experiences made with P4P in countries such as Haiti and neighboring Rwanda, were favorably disposed to the P4P concept. The main concerns were that the initiative proposed for Tanzania would end up being “yet another vertical program for MDGs 4 and 5,” and the P4P just another allowance.

There were also political tensions. “The big thing,” says one donor representative, “was donor questions about why Norway was coming into the health basket at all.” Norway had stopped giving aid through the health basket in 2004, and had no health advisor. Health was not seen as Norway’s comparative advantage, and other donors, such as Ireland and UNICEF, with longer histories in maternal and child health in Tanzania, worried their own programs would become overshadowed by P4P. “The feeling was: who are these people, coming in here after one conversation with the president? It was a highly political process.”

In the end it was decided that Norway would channel approximately 80 percent of funds through the basket, while keeping the remaining 20 percent for strengthening the HMIS and monitoring and evaluation. Norway’s contribution would help raise the yearly basket fund allocation for councils from US\$0.75 to US\$1 per capita, and part of this increased funding could be used for the implementation of a jointly endorsed P4P system. It was a “very sensitive decision,” Mader says, because some donors were concerned that setting basket funds aside specifically to pay bonuses would undermine the point of the basket being un-earmarked.

In November 2007, a workshop, facilitated by Ifakara Health Institute on behalf of the Norwegian Embassy and USAID’s Health Systems 20/20 project, was held to build understanding and consensus around P4P. The workshop, in Dar es Salaam, brought together representatives from the MOH, other central ministries, local government, development partners, and civil society to discuss the prospects for the introduction of P4P in Tanzania. Participants shared and discussed previous experience with P4P, including a P4P scheme with faith-based health facilities in Tanzania piloted by the Dutch nongovernmental organization (NGO) Cordaid (the program received mixed reviews [Canavan et al. 2008]), and neighboring Rwanda’s successful national scheme.

¹¹ See <http://hdptz.esealtd.com/index.php?id=17>

¹² In Rwanda, following three successful P4P pilots in the country, the government and its development partners designed and implemented a nationwide scheme, and folded a rigorous impact evaluation into the roll-out. The results of the evaluation showed that the program had a significant impact on the use and quality of maternal and child health services, with initial results indicating improvements in child health outcomes (Morgan 2009).



DESIGNING A SCHEME

In May 2007, the Health Systems 20/20 project led a P4P workshop in Rwanda. Paul Smithson, head of the resource center at Ifakara, developed a draft design for P4P in Tanzania while in Kigali, and subsequently received funding from Norway to conduct a more in-depth feasibility study addressing the practical modalities of a P4P system. The study concluded that: “There is a strong case for introducing P4P [in Tanzania],” but emphasized certain pre-conditions, such as a strengthened HMIS (Smithson et al. 2007).

Meanwhile, the Chr. Michelsen Institute, a Norwegian research institution, conducted a study to assess whether and how a performance-based funding system could be designed in order to contribute to reducing maternal and neonatal mortality in Tanzania, with a focus on the underlying reasons for implementing performance-based funding. The report found that “The present system, where districts have responsibility for the development of health plans, but where their autonomy in the budget allocation process is restricted by a wide set of regulations and where there is little or no accountability for results, is also far from ideal” (Mæstad 2007, p. 30).

Norway subsequently gave funds to Ifakara to lead a design process. Key design considerations included:

- Accelerating progress towards MDGs 4 and 5 in Tanzania
- Working with and through government systems and structures
- Using joint financing mechanisms



- Channeling resources towards front-line essential services
- Increased emphasis on accountability for enhanced performance

When the design was presented to the donor group, it received some support, “but at the same time,” says Rena Eichler, a P4P expert who participated in the design process, “there was resistance to the idea that investments would be needed to sensitize all the district managers and facility-level staff to understand the scheme, as the new incentives would clearly only work if people understood them (we presented a training of trainers model that resulted in roughly a \$1 million budget to train the entire country). We were pressured to find a cheaper way.”

In January 2008, design team members held consultations with key stakeholders at the national level and traveled to the Morogoro region for a workshop with selected regional, district and facility level staff to present, debate, and fine-tune the proposed scheme design. The design report was finalized in mid-February and submitted to the Royal Norwegian Embassy on February 15.

The MOH’s comments on the draft design revealed divergences of views on key issues, which will be discussed in the following section. And in February 2009, after having spent several months with the Ifakara design, the MOH presented its own P4P implementation plan at a basket fund committee meeting. The plan was essentially a highly simplified version of the Ifakara design, and donors would not agree to fund P4P through the basket until the plan was revised.

The basket fund committee meeting concluded that the share of district basket grant kept for bonuses as well as the basket funds already released under P4P for 2008/09 should be reallocated and used for the procurement of medicines and supplies or be transferred as a balance for FY 2009/10. It was also decided that a taskforce should review and fine-tune the scheme. Additionally, the Royal Norwegian Embassy commissioned an independent technical appraisal of the government’s plan, which addressed weaknesses and suggested ways forward.

The taskforce met once, in March 2009. Shortly after, the MOH decided to launch its own plan without changes or donor endorsement or funding.



THE MOH SCHEME

Strengthening the HMIS is necessary before a P4P program can be put in place

The analysis that follows is based on two documents from the MOH: the P4P strategy document (MOH 2008a) and implementation guide (MOH 2008b). The MOH scheme is described as “a simplified version from the Feasibility Study Proposal report” (MOH 2008a, p. 3), but it diverges from the Ifakara plan in key ways. The MOH does not consider the current guidelines final because it intends that learning by doing will inform the final version of the strategy and guideline. It is expected that these will be refined during the first year of rolling out the program.



SCOPE AND SCALE

The MOH P4P initiative covers all health facilities in all councils “that are providing reproductive and child health services” on the Tanzanian mainland, including public dispensaries, public health centers, district and regional hospitals, and faith-based facilities.

The strategy document notes that “Given the variation in the package of services provided in health facilities, council health management teams (CHMTs) will have to make a list of facilities that will be enrolled in the

scheme and update the list annually.” It is unclear whether facilities with unqualified staff (e.g., only health assistants) providing services captured



by the indicators will be included in P4P (Lauglo and Swai 2009, p. 11).

The decision to go national right away was controversial. The design team at Ifakara, along with the donors, wanted to begin with either a pilot or a phased-in approach that would facilitate learning by comparison. Not only was this seen as a smart way to iron out the inevitable program kinks, but donors were concerned about the weak state of the HMIS, some facilities' low levels of capacity, and questions about payment amounts and mechanisms for delivering funds.

But where donors saw due diligence and careful learning and evaluation, the MOH saw micromanagement. One MOH representative, acknowledging the importance of P4P, expressed skepticism that piloting was appropriate for an issue that is “obvious like this one,” and stressed that, rather than getting bogged down in logistical issues, it was best to start nationally right away. There was also a reluctance to pilot among MOH representatives because it would mean choosing some regions over others, and there were concerns about the regions that would be left out and issues of inequity.

But others argued that a phased approach would better reflect the reality of serious gaps in coverage across the country. “The government wants to talk about equality,” says one health policy analyst based in Dar es Salaam. “Mothers are dying everywhere, why should we choose one place to help them?” But there are unequal situations in terms of what services people receive and don't receive. People are not dying everywhere to the same degree. Some places are worse than others.”

RECIPIENTS AND INCENTIVES

The incentive is monetary (see Table 1), and “the distribution of funds for payments earned by a health facility will be shared among the team members equally.” (MOH 2008a, p. 8) Each worker at each facility has the opportunity to earn a total of 200,000 Tanzanian shillings (Tsh) annually. “Allocation of the amount to individuals will be governed by a rule,” the implementation document says, “to avoid that somebody takes the entire allocation,” but it does not specify what this rule is (MOH 2008b, p. 8). At hospitals, “total funds earned will be made to the hospital and its use/distribution [will] be the responsibility of the hospital management team in consultation with all staff to ensure that they all benefit” (MOH 2008b, p. 8). Stakeholders responsible for supervising facilities at district and regional levels are also eligible for bonuses (i.e., CHMTs at the district level; and Regional Health Management Teams [RHMTs] at the regional level) (MOH 2008b, p. 2).



TABLE I. AMOUNTS OF FUNDS PER LEVEL

Level	Initial funds allocated for P4P, first financial year (T.Shs)
Dispensary	1 million
Health center	3 million
District hospital	9 million
Regional hospital	10 million
CHMT	3 million
RHMT	3 million

The MOH implementation guidelines say that performance will be evaluated and payment made once a year, and that “payment for performance will be paid only when selected performance targets are reached.” Specifically: “Achieved targets will be evaluated jointly by the CHMT and the facility in-charge. The exception to this target-setting rule will be the timely and complete HMIS returns, where facilities and councils will be required to make 100% prompt returns. The CHMT’s payment for performance is directly linked to the performance of the facilities they are managing. CHMTs qualify for 50% of their payment for performance when 50% or more of their health facilities reach target and obtain 50% of their payment for timely reporting of the MTUHA to the RHMTs. RHMTs will be paid 50% of their payment for timely reporting of MTUHA to the MOHSW and 50% payment for performance for 50% or more of health facilities in the region meeting their targets” (MOH 2008b, p. 2–5).¹³

How bonuses are actually awarded is unclear. Because targets are high and universal for all facilities (see below) many health facilities are unlikely to achieve them. When they come short, the MOH implementation document says, “Regarding health facilities, CHMTs and RHMTs that fail to reach target, a thorough analysis should be done by the respective validating level on system and individual contributing factors. The report of this analysis will provide among other things recommendations for support and corrective action” (MOH 2008b, p. 2–5). But conversations with MOH representatives suggested that if facilities do not meet the indicators, they can be paid anyway, because it is up to the districts to decide what to do in any given situation.

¹³ Facility in-charge means the person responsible for managing a health facility. The qualifications of the person who is actually “in charge” can vary tremendously, partly because of unfilled posts and the differing levels of care provided at facilities. MTUHA refers to HMIS data, which are coded in 12 books filled out at the health facility level and known collectively as the MTUHA.



Donors felt this made the program little more than a salary top up. Says Jacques Mader: “What was proposed was a nationwide incentive to be shared among all persons at all levels. Criteria for eligibility weren’t clear, so it may have been just a salary bonus across all cadres. A performance-based system makes sense, and managing it at the local level makes sense, but you must ensure fairness in the system and reward those who actually contribute to the better performance.” Arthur Heywood, a professor of public health with the University of Oslo who works on health issues in Tanzania, agrees: “they want to pay everybody whether they’re performing or not.”

INDICATORS AND TARGETS

There are five P4P-linked indicators that are verified through the routine HMIS data collection (Table 2). According to the MOH implementation document, these indicators were chosen, “partly because they are readily available [that is, data to calculate performance in these areas are already collected], [and] will correctly show improvements in maternal, newborn and child health and will attract other system improvements” (MOH 2008b, p. 3).

TABLE 2. P4P INDICATORS

Facility / Team	Indicator
Dispensaries	Immunization - DTP-HB 3 equal or above 80% (The under one year population of the catchment area population is the denominator.)
	Immunization – oral polio vaccine (OPV) 0 equal or above 60% (Number of live births in catchment area is the denominator.)
	Deliveries in health facilities equal to or above 60% (Denominator is number of expected pregnancies in the unit’s catchment area, though it is unclear if antenatal care [ANC] visits are being used as a proxy here – the plan does not specify.)
	Intermittent preventive treatment (IPT) 2 for pregnant women equal or above 60% (Denominator is number of pregnant women in unit receiving ANC.)
	Quarterly MTUHA report timely, complete, and accurate 100% of the time (i.e., delivered within expected timeframe as stipulated in the MTUHA guideline from facility to district; district to region; and region to MOH. And ensure that F004 and F005 [book 2] are properly filled in and completed.)
Health centers	As for dispensaries
Hospitals	As for health centers
CHMTs and co-opted members	Aggregate performance of council on facility indicators (above)
RHMTs and co-opted members	Aggregate performance of region on facility indicators (above)



To qualify for the bonus at the CHMT and RHMT levels, HMIS reporting must be complete and timely in 100 percent of cases and at least 70 percent of facilities will be required to meet their targets at the district level for CHMTs to qualify for bonus payments. At the facility level, attainment of each of the five targets earns the facility one-fifth of the maximum bonus payment.

The MOH favored using the same targets for all facilities for the first year, regardless of their pre-existing performance, which many donors cited as a key concern. Because urban and rural areas differ in capacity, facilities in rural areas are less likely to meet targets. For example, according to the Tanzania Demographic and Health Survey 2004-2005 (National Bureau of Statistics and ORC Macro 2005), in the capital Dar es Salaam, 82.4 percent of women gave birth in a public facility versus just 25 percent in rural Kagera.

Indeed, according to an MOH presentation given to the Joint Annual Health Sector Review in October 2009, baseline information collected showed ¹⁴:

- The percentage of children who received oral polio vaccine varied across regions; 10 regions out of 21 reached the coverage target of 60 percent.
- Twelve regions reached the target of 80 percent or more of children receiving DTP-HB3 vaccine.
- Only two regions reached the target of 60 percent or above of pregnant women receiving IPT2 (intermittent preventive treatment for malaria) and the indicator for women who give birth in a health facility.

This set up – of both knowing that your facility or district has little chance of meeting targets, and that you may in fact be paid a bonus anyway – could be de-motivating to staff.

¹⁴ According to the presentation, given by Anna Nswilla, the MOH sent a letter on December 31, 2008, by fax and email to all CHMTs indicating information they were to report by January 31, 2009. The presentation noted that some facilities had difficulties using email and Excel.

PAYMENT

The performance assessment for the purpose of awarding payment for performance is undertaken annually between the third and fourth quarters based on GOT financial regulations (Table 3) (MOH 2008b, p. 9–10). Bonuses are channeled through the Council Medical Officer of Health Accounts, and it is intended that facility bank accounts will be opened at the dispensary and health center level (only some facilities have done so).

TABLE 3. PROCESS FOR PAYMENT, GOT P4P SCHEME

S/N	Action	Responsible	Time	Expected Product
1.	CHMT compiles and verifies monthly facility data	CHMT & Co-opted members	January–December	Facility monthly reports
2.	CHMT compiles and verifies facility annual data January–December	CHMT & Co-opted members	January	Report on facilities qualifying for P4P payments
3.	CHMT submits annual P4P performance report to RHMT/ District executive director/ Council	DMO	End of first week of February	District P4P annual performance report
4.	RHMT verify and compile the submitted Council P4P performance report	RHMT and Co-opted members	February	Regional annual P4P performance report
5.	RHMT submit the report to MOH & PMO-RALG	Regional medical officer	First week of March	Regional annual P4P performance report
6.	MOH & PMO-RALG verify and compile the submitted regional annual P4P performance report	Ministerial P4P Team	April	National annual P4P performance report
7.	Approval to effect payments to relevant facilities/teams	MOH & PMO-RALG	May	Letter of approval sent to all LGAs and regions
8.	Actual payment to facilities and teams based on performance target reached.	District and regional medical officer; regional administrative secretary; district executive director	May	Qualified facilities, CHMTs, and RHMTs received payment
9.	MOH & PMO-RALG presents the annual P4P performance report in the Annual Joint Health Sector Review (AJHSR)	Ministerial P4P Team	September	National annual P4P performance report

Note: PMO-RALG=Prime Minister's Office – Regional Administration and Local Government

The MOH strategy and implementation documents say that funds that are not disbursed as bonuses will be retained by districts, and can be used to finance strategies to improve performance during the following year. But the documents also say that they “will be carried forward for subsequent years to strengthen P4P Strategy.” A health analyst familiar



with the government's scheme said that while these two phrases mean essentially the same thing, it was acknowledged that what could/is likely to happen in practice is that the funds will go into the overall district budget and may not in fact, be used by the health facilities.

INFORMATION, MEASUREMENT, AND VALIDATION

Performance will be monitored through the routine HMIS data in which performance at the facility level is reported on a monthly basis and performance of the CHMT and RHMT is reported quarterly. The MOH documents state that validation of performance will be carried out by the CHMT; reports submitted by the CHMTs will be validated by the RHMT, and RHMT reports will be validated by the MOH and the Prime Minister's Office Regional Administration and Local Government (PMO-RALG).¹⁵ 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. The RHMTs will follow up on CHMT reports by ensuring that the data reported match the reports coming from the health facilities. They will also undertake periodic random audits at the facility level to check reports against registers.

This validation system holds the potential for a conflict of interest as the validators (CHMT) also serve to benefit from the strong performance of the facilities they are checking. Because of this potential conflict, the strategy and implementation documents say "technical performance external data quality assurance will test internal assurance arrangements...this task will be subcontracted to higher learning institutions/research in the country..." (MOH 2008a, p. 9). But a health analyst familiar with the GOT P4P scheme said that monitoring and evaluation "was one of the weakest parts of the proposal. Audits were identified as one way to monitor but nothing specific was proposed for how to do this."

As noted above (see footnote 13), HMIS data, known as MTUHA, are coded in 12 books filled out at the health facility level. Some are daily registers, some are monthly and quarterly reports. Staff fills out all registers by hand and typically, no one is specially assigned to data collection; rather, it is additional work for staff. Districts consolidate the data and send it to the RHMTs, who consolidate it further and send it to the MOH and PMO-RALG.

¹⁵ As part of decentralization, lower-level health facilities were shifted from central control to the joint control of district governments and the PMO-RALG. Regional and referral hospitals remain under the authority of the MOH.



According to the strategy document, “there are still significant challenges to be dealt with, the most crucial being the lack of a reliable baseline for most of the indicators. These and other challenges will be dealt with during implementation” (MOH 2008a, p. 3). Some baseline data were in fact collected and presented at the Joint Annual Health Sector Review in October 2009. A letter, along with a format for data collection, was sent on December 31, 2008, by fax and email to all local government authorities, explaining which data they needed to collect by January 31, 2009. The CHMTs used the form to compile information and submit electronic reports to the MOH for compilation and analysis. But, as the presentation noted, data collection was challenging in some regions; some CHMTs and RHMTs had difficulty accessing the Internet, using Microsoft Excel, and attaching documents to emails. Many reports were sent late, and those received after June 2009 were not included.

Arthur Heywood, a professor of public health with the University of Oslo who is working on HMIS reform in Tanzania, says: “The vast majority of health facilities fill in that MTUHA at a great cost to themselves... I don’t know of more than a handful of health facilities in this country that has ever received feedback from the districts on how they have performed. The only good data getting through is for the programs that pay for it [i.e., the programs that for example pay district level coordinators to collect it].”

A forthcoming situational analysis from UNICEF confirms, “The HMIS is effectively non-functional and the only data reaching national level is that which comes up through the vertical programs (Expanded Program for Immunization, reproductive and child health, HIV/AIDS, tuberculosis and leprosy). This is a major handicap to evidence-based planning and it makes it impossible for managers at any level to identify problems with health care delivery that affect women and children.”

The Ifakara feasibility study, and indeed most stakeholders interviewed, cited the poor state of the HMIS as the biggest obstacle to effective implementation of P4P in Tanzania. However, being paid based on results may increase interest in tracking information and should strengthen the feedback loop up and down.

MANAGEMENT

What follows is a description of the various management functions within the P4P scheme, as described in the government’s strategy and implementation documents. While this constitutes how the program is supposed to be managed, it is not clear how these functions have worked in practice.

The *Ministry of Health and the PMO-RALG* together are supposed to be responsible for the overall management of P4P implementation. This includes responsibility for developing guidelines, training materials, and



implementation tools for regions and zonal health resource centers. In this role, they would train RHMTs and CHMTs and receive and analyze reports provided by the regions and identify high/low performing councils and regions and provide support. They would also coordinate and oversee capacity building and the provision of technical assistance. The MOH is supposed to ensure that implementation funds are released in a timely manner (funds would be disbursed to LGAs and regional secretariats by the PMO-RALG) and the MOH and PMO-RALG together would review and assess program implementation, evaluate progress on reaching targets, consider refinements to the model and communicate lessons learned.

The *Regional Health Management Teams (RHMTs)* are supposed to train council health management teams (CHMTs) to implement P4P and advise and assist in the negotiation of CHMT targets with their respective council administrations. (In practice this did not happen, as universal targets were set rather than facility-specific targets.) They were also supposed to receive and analyze performance data, and provide feedback to CHMTs. RHMTs would provide technical support and supervision to hospitals in their regions, and provide quarterly RHMT performance reports to the regional administrative secretary and PMO-RALG, copied to Permanent Secretary of the MOH.

At the next level down, *Council Health Management Teams (CHMTs)* are supposed to train health facility workers on P4P, monitor and analyze performance data, provide feedback to every health facility, and validate data by performing spot checks of reports against source registers during their routine supervision visits. The CHMTs would provide quarterly performance reports to the council director and RHMT, and also to help facilities address shortages of equipment, staff and supplies.

At the facility level, *facility managers* are tasked with identifying performance problems, and requesting technical assistance when there are problems. They are supposed to provide quarterly reports to the CHMTs, and also improve outreach to communities to encourage them to seek health services.

Finally, *Health Facility Governing Committees* are supposed to verify performance; ensure that funds for payment for performance are distributed to staff according to the rules; contribute to development and implementation of action plans; and liaise with community leaders to sensitize the population and raise demand.

START-UP SYSTEMS

A three-day training of trainers was held at the zone resource center, and a training manual was provided to health facility and dispensary planning teams in May 2009. The manual covers areas such as how to develop health plans, and budgeting, as well as P4P, and it is written in English.



A DE FACTO LAUNCH

Despite serious donor concerns about the MOH scheme design, a circular dated March 18, 2008, instructed district councils to include the allocation for P4P in their 2008/09 comprehensive council health plan requests and prepare for delivery of the plan. The circular advised the councils to include an activity line for P4P and stated that P4P would increase the basket fund contribution to the district from US\$ 0.75 to 1.00. In addition to the circular, the councils were provided with the Results Based Bonus report from Ifakara and “Annex 3 Background information for Design Parameters” (Lauglo and Swai 2009).

Development partners in the basket fund committee had expected to receive details of the scheme before giving their approval to its inclusion under the basket fund, but details about the program were not provided until late 2008 at the basket fund committee meeting. Minutes from this meeting and another held in February 2009 show that development partners had a number of questions about the government scheme. But again, there was a discrepancy of perspectives: what donors felt was ensuring accountability for their funds, others viewed as a lack of trust in the government. Said one Tanzanian health expert: “When something originates from the MOH, DPs [development partners] look at it critically—and this is what happened.”

The language of the circular allowed for differing interpretations of “pay for motivation,” “P4P,” and “result-based bonus.” Many district medical officers (DMOs) had no idea what P4P was.



One such DMO says he was informed of P4P by way of a telephone call from the PMO in Ddoma instructing him to add P4P to his 2008/09 budget. He was not told what P4P meant and there were no guidelines, although he was told they would be forthcoming. The phone call came after they had already finished planning the next year's budget. Later he received a letter that said that the money budgeted for P4P should be used to purchase equipment, and later he received draft guidelines.

It is a similar story for another DMO in a rural Tanzanian district, who says she was first informed about P4P through a letter from the MOH, informing districts that they would begin P4P for the 2008/09 financial year. Later, however, she received instructions to spend the additional basket money on medicine and equipment, and not on bonuses. P4P, she was told, would commence the following year (2009/10) using funds from the government's block grant.

Currently, this DMO says her district is finishing compiling data for 2009 to see if they meet the performance targets, and awaiting funds for P4P

training, which they were told they would receive at a health facility planning training session in 2009. When asked what will happen if they do not meet the targets, she laughed and said, "It means we have to reallocate it...that is what I understand."

Dr. Godfrey Swai, a public health consultant based in Dar es Salaam, says that "money [intended for bonuses but subsequently diverted] came before understanding." And most of the information/ documentation was in English. "But maybe half of CHMT members understand English well." The MOH "hasn't fully moved from the MOH-donor phase to the health facility implementation phase [of P4P]."



Regional Health Management Teams, (RHMTs), one of five management levels, train Council Health Management Teams (CHMTs) to implement the P4P program

donor phase to the health facility implementation phase [of P4P]."



WHERE THINGS STAND IN EARLY 2010

The MOH approached Norway in early 2010 expressing interest in doing a pilot of P4P. Norway responded positively, but suggested that the Ministry review targets, indicators, and health facility capacity issues, and the two are in the process of beginning discussions on design, organization, and strategy.

Though details are still being ironed out at the time of writing this case, these early discussions indicate that the pilot will be a bilateral program, not funded through the health basket. The pilot is likely to take place in selected districts in Coast region, which was suggested partly because this is a test region for the HMIS strengthening and therefore data are expected to be of higher quality than in other regions.

The indicators will likely stay the same, although they may introduce quality indicators. Targets will be facility-specific and determined in consultations between the Norwegian Embassy, Ifakara, the MOH, and the facilities themselves (with technical assistance from Norad).

Renewed talks between Norway and the MOH were probably the result of a convergence of factors. It is possible that, after a year of implementation that had been far from smooth, the MOH recognized the weaknesses in their own design. A Dar-based health analyst adds that, after two years of discussion, there is much better understanding of what P4P is within the MOH. For example, plans are for the P4P advisory group being organized by the MOH to comprise a wide range of stakeholders: donors, NGOs involved in P4P schemes, the human resources department within the Ministry, along with representatives working on HMIS and reproductive and child health. This demonstrates



an understanding of the cross-cutting nature of P4P. P4P will also be put on the agenda of the district and regional health services technical working group, which is the working group responsible for revising comprehensive council health plan guidelines. P4P, in other words, is a much less alien concept now, and that it requires significant investments seems to be better understood.



LESSONS FROM TANZANIA'S P4P EXPERIENCE

P4P was not an entirely new concept for the GOT. The Expanded Program on Immunization receives performance-based financing from the GAVI Alliance; best-performing councils have been rewarded in-kind with computers, printers, and fax machines, while additional resources have also been devoted to bringing up the poorest performers. Additionally Selected Accelerated Salary Enhancements (SASEs) provided a salary top-up for civil servants in certain sectors linked to individual performance agreements.

But “P4P in the current way...did not originate in Tanzania,” says a staff member of the World Health Organization’s Dar es Salaam office.

And this is one of the first key lessons: that high-level – even presidential – commitment does not automatically translate into an operational program, nor does it result in sufficient understanding at lower levels to inspire hoped for health enhancing actions. This lack of clarity contributed to limited interest or commitment at other levels of government, where it is needed most. This weak understanding and minimal ownership resulted in a sluggish response to donor requests to fine-tune the program design. The team that appraised the government’s scheme said there “was a lack of consistent conceptualization of what P4P stands for. P4P means different things to different people: ‘It is a bonus to individual health workers’; ‘It is a reward to concerted work at the facility level’; ‘It is an incentive to stimulate innovative thinking’.

‘Motivation’ has not been clearly defined” (Lauglo and Swai 2009, p. 9w).



Godfrey Swai agrees: “with the national program, there were high-level meetings, and then consultants were hired to hammer out implementation studies. The concept was never fully understood by most implementers at MOH, regional levels, district councils, and more importantly by services providers at facilities.” Swai says that this undermined ownership and led to inadequate district council health planning and implementation details, such as monitoring and evaluation and baseline data. “Key players were not involved to clearly conceptualize the program.”

Another related lesson is the importance of process for presenting the idea and generating buy-in, both to the government and other donors. Political tensions and the ensuing bureaucratic delays probably damaged goodwill and lessened the chances for a successful program in Tanzania. As one observer said, “the government and DPs [development partners] are divided, and DPs are divided among themselves.” P4P is a massive reform that touches the entire health sector; enthusiasm and commitment from key stakeholders is necessary to see through the complex, messy, time-consuming process of design and implementation. But these ingredients were missing in Tanzania, in some measure because of the perception that the program was mainly Norway’s “thing.”

Another lesson from Tanzania is that P4P is an investment – there are significant costs to beginning a well-designed P4P program (improving data collection systems, for example, and ensuring that facilities have qualified personnel), but the payoff to careful planning is potentially huge, since the whole health system stands to benefit over the long term.

By contrast, neighboring Rwanda, which launched a nationwide P4P scheme in 2006, held extensive consultations in the design phase and repeated sensitization of health workers, both of which helped to create a sense of shared commitment and team spirit among stakeholders. Rwanda’s national program was informed by several years’ worth of experience with P4P pilots (two pilots began in 2002), the lessons of which were incorporated into the national design. And the Rwandan MOH was very much in the lead: “The MOH ‘advanced like a train,’ says Christel Vermeersch, a World Bank economist who helped design and execute the evaluation. Kampeta Sayinzoga, Director of Microeconomics in the Rwandan Ministry of Finance, says: ‘Rather than trying to find the lowest common denominator among donor programs, they determined what the priority was and went ahead’” (Morgan 2009). And not only did they garner donor support and advance they also folded a rigorous impact evaluation into the roll-out so they could carefully test the program and improve it.



CONCLUSION

The good news is that interest in P4P remains strong in Tanzania. Despite years of haggling, there is a high level of convergence among interlocutors on one central point: that P4P is a good way to motivate health workers and stimulate improved quantity and quality of health services – and that it should be tried. One DMO said: “P4P is a good idea for health workers to perform better at health facilities and at the district level...if we are going to get this P4P it will really motivate health workers.”

Jaques Mader agrees: “You visit one district and it’s functioning – the money collected from the patients is used to improve service delivery. You witness a reasonable number of staff who attend their duty, facilities are well maintained, almost no drug shortage, and patients express satisfaction. In the next district, money is also collected from the patients, sent to council, and nothing happens. There are drugs stock-outs, basic equipment isn’t available and patients complain about the way the health professionals treat them... It all very much depends on the persons in charge. A performance system could certainly contribute to motivate frontline workers to improve the situation.”

Tanzania’s current P4P program is far from perfect, but it at least constitutes an attempt to go ahead with a health financing mechanism that is increasingly viewed as having the potential to dramatically improve access to and the quality of health services in countries where, despite being so close to the deadline, are still tragically far from achieving MDGs 4 and 5. And renewed talks between Norway and the GOT may hold promise that a rigorous P4P program that is owned conceptually, not just by donors but by the government itself, will yet emerge.



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