

Pay for Performance in Maternal Health in Tanzania: Perceptions, Expectations and Experiences in Mvomero district

By

Victor Chimhutu



(Source: fieldwork photo, July 2010-Sept 2010)

Thesis submitted in partial fulfilment of the requirements for the degree
of Master of Philosophy in Gender and Development (GAD)

Department of Health Promotion and Development

Faculty of Psychology



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Dedication:

To Victoria Mushaba Chimhutu

“The world contains inequalities that are morally alarming, and the gap between richer and poorer nations is widening. The chance of being born in one nation rather than another pervasively determines the life chances of every child who is born.” (Martha C. Nussbaum)

For your painful journey to become a mother, and the joy the perseverance has brought us!

Abstract

In 2008, Tanzania was one of the 11 countries responsible for 65% of all maternal deaths in the world. The Ministry of Health and Social Welfare of Tanzania in 2008 acknowledged lack of commendable progress in reducing maternal deaths. At the heart of the lack of progress are challenges in human resources for health, including poor motivation among health workers.

In 2009, the Government of Tanzania decided to introduce P4P in mother, newborn and child health (MNCH), in order to bring down the MMR and accelerate progress towards Millennium Development Goals 5&4 addressing mother and child health. Pay for performance links incentives with performance and assumes that better health worker performance improves acceptability, utilisation and quality of health services. The study explores how service provision and the use of incentives in maternal health is perceived by health practitioners and community members

The study was carried out in Mvomero district in Tanzania, at 5 health facilities. The study's approach was qualitative. Twelve in-depth interviews were conducted with health workers and 3 focus group discussions were also conducted with community members. A number of perceived barriers to the access of health services were reported. The barriers existed on both the provider and the user side. By and large, provider side factors seemed to play a major role in the low-utilisation of health services and of these, supply shortages were the mostly cited impediment to the provision of health services. Health workers reported dissatisfaction and demotivation with the current working conditions citing mainly the perceived unfair remuneration system and supply shortages as major factors.

Mixed views to the use of incentives in health care were reported. There were some concerns that P4P might undermine the quality of health services by promoting unethical behaviours such cheating, emphasis on quantity against quality or prioritisation of rewarded services. On the other hand P4P was perceived to have the potential of increasing health worker motivation, cooperation and teamwork at facility level.

The study concluded that in view of health workers and community members' perceptions and experiences related to incentives and service provision, steps should be taken to ensure that the conditions for successful implementation should be in place before the P4P programme is scaled up. This involves ensuring the availability of basic equipments, staff and routines at facility level.

Acknowledgements

They say *'a journey of a thousand miles begins with a single step'*. Writing this thesis has been a time consuming and challenging process, yet an episode in my life that I will always remember and cherish. With my academic background in Psychology, Public Administration and Gender, venturing in this topic that blends the use of incentive rewarding system and maternal health, was a tall order in the beginning. I had to learn and read around the topic so much in order to position myself to come up with a document like this. Regardless, the process has been thought provoking, self-reflecting and self-rewarding.

Not only was I born in Zvoushe village somewhere in Zimbabwe far from a health facility, but that my journey to be a parent was littered with obstacles and challenges. I lost prematurely born babies from causes that could have been easily prevented if quality care was accessed at health facilities. Life, its longevity and death for infants and mothers pretty much depends on where and how you are born, as much as we console ourselves as destiny.

Along this journey of self-discovery, many people have offered their support. It started with Haldis Haukanes who picked up a phone one July afternoon to ask if I was still interested to join the department for studies in Gender and Development. With some hesitation and encouragement from Haldis I decided to be part of this experience where my inner self as a man was always at test in defining my position. Together with Marit Tjomsland, I witnessed two dedicated lecturers in their work at work. I owe a lot to the department of Gender and Development at UiB, Hilde Jakobsen, Cecilie Odegaard, Thera Mjaaland and Kristin Senneset you made my life at GAD easier by your encouragement and help. In my class GAD 2009-11, I was privileged to meet great minds and best of friends. I wish my classmates best of luck and a great future and if anyone of them is going to read this- they should know that the episode we shared was short but life-changing.

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Acronyms

AAAQ- Availability, accessibility, acceptability of quality care
AIG- Safe Motherhood Inter-Agency Group
ANC- Antenatal Care
BEmOC- Basic emergency obstetric care
CEDAW- The Convention on the Elimination of All Forms of Discrimination Against Women
CEmOC- Comprehensive emergency obstetric care
CIH- Centre for International Health
CHAI- Clinton Health Access Initiative
CHMT- Council health management team
CMI- Chr. Michelsen Institute
DHPb3- Diphtheria, Tetanus, Pertussis, Hepatitis B 3
DHS- Demographic Health Survey
HDI- Human Development Index
HMIS- Health management information systems
HNI- HealthNet International
ICESCR- The International Covenant on Economic, Social and Cultural Rights
ICPD- International Conference on Population and Development
IHI- Ifakara Health Institute
ILO- International Labour Organisation
IPPF- International Planned Parenthood Federation
IPT 2- Intermittent Presumptive Treatment 2
ITN- Insecticide Treated Nets
MMR- Maternal mortality ratio
MCH- Mother and child health
MNCH- Mother, newborn and child health
MDGs- Millennium development goals
MOHSW- Ministry of Health and Social Welfare of Tanzania
MTUHA- Mfumo wa Taarifi na Utoaji wa Habari wa Afya (Swahili acronym for HMIS)
NIMR- National Institute for Medical Research in Tanzania
NIPI- Norway-India Partnership Initiative

NTPI- Norway-Tanzania Partnership Initiative
NORAD- Norwegian Agency for Development Cooperation
OPV - Oral Polio Vaccine
PHC -Primary health care
P4P- Pay for performance
RHMT- Regional health management team
RCC- Roman Catholic Church
TANESCO- Tanzania Electricity Supply Company Limited
TBA- Traditional Birth Attendant
UNICEF- United Nations Children's Fund
UNDP- United Nations Development Programme
UNFPA- United Nations Fund for Population Activities
UMATI- Uzazi na Malezi Bora Tanzania (Family Planning Association of Tanzania)
USAID- United States Agency for International Development
WHO- World Health Organisation

Chapter 1

Introduction

In 1985 Rosenfield and Maine, asked ‘where is the ‘M’ in Maternal and Child Health (MCH)’. They asserted that the ‘M’ in MCH is neglected. It is rather disturbing that after 25 years the same question and argument is still relevant. The ‘M’ in Mother and Child Health which increasingly is referred to as Mother, Newborn and Child Health (MNCH) in recent years is still weak. In 1985 the World Health Organisation (WHO) estimated that more than 500 000 women in developing countries were dying every year from pregnancy related causes (Rosenfield & Maine, 1985).

Maternal mortality has been reducing albeit at an unsatisfactory rate. The World Health Organisation estimated that in 2008, 358 000 maternal deaths occurred worldwide. This figure represents a 34% decline from the 1990s level (WHO, UNICEF, UNFPA, & WB, 2010). The Countdown to 2015 report in the lancet series, acknowledged the lack of commendable progress toward the achievement of Millennium Development Goal (MDG) 5, addressing maternal health. The report noted some progress in MDG 4, which addresses child health although the progress is considered insufficient to achieve the goal’s target (Bhutta et al., 2010). This is not encouraging considering that almost all countries and their partners in development have committed themselves to achieve MDGs. It is therefore arguable that of all MDGs particularly in Sub-Saharan Africa, goal number 5 whose general target is to improve maternal health and bring down maternal mortality, has the least progress since its inception.

Maternal mortality is one of the leading causes of death of women in their reproductive age in most developing countries. The developed countries account for 1% of maternal deaths and 99% occurs in the developing countries, underscoring the essentially preventable nature of these deaths (WHO, 2008). The percentage difference also underscores the inequity throughout the world and reflects the gap between the rich and poor. It is estimated that women in Africa are at the greatest risk when pregnant of dying from pregnancy related complications.

The lifetime risk of dying in pregnancy and childbirth in Africa is 1 in 22, while it is 1 in 120 in Asia and 1 in 7 300 in developed countries (WHO, 2008). While giving birth is considered a major event in a woman's life and her family's, it is also an event of great risk to the life of the mother and her infant. According to the World Health Organisation, there are four major causes of maternal deaths which are: postpartum bleeding, sepsis/infections, eclampsia and obstructed labour (2008). Deaths due to childbearing are not only personal tragedies to women, but can be catastrophic to the husband, children, families, community and country (Barnes-Josiah, Myntti, & Augustin, 1998).

Context and Scope of study

Geography and Population Situation

The United Republic of Tanzania is located in East Africa and it is the largest country in the region. The country was formed by the union between Tanganyika and Zanzibar in April 1964 under the presidency of Julius Nyerere. The country covers 945,087 sq. Km and it is bordered by 8 countries (MOHSW, 2009). Mainland Tanzania is bordered to the west by the Democratic Republic of Congo, Burundi, and Rwanda; on the south by Mozambique, Malawi, and Zambia; on north by Uganda and Kenya; and to the east by the Indian Ocean. The estimate population of Tanzania in July 2008 was 37, 990,563 and the total fertility rate (TFR) is 5.7 per woman (MOHSW, 2009).

Tanzania is classified by UN as least developed, with the average national income (GNI) per person being USD 350 per person per year. In 2007, 25% of Tanzanians were living below the poverty datum line. For the majority of the rural population, agriculture forms the main basis of subsistence. In 2006-2007 the real GDP growth in Tanzania was around 6%, however, this growth did not result in the reduction of poverty in an equitable manner. Smallholder farmers who constitute the majority of agricultural producers in Tanzania are the most affected by this lack of poverty reduction (MOHSW, 2009).

Mother Newborn and Child Health (MNCH) Situation

Tanzania is one of the countries in the world with a high maternity mortality ratio (MMR) estimated at 578 per 100 000 live births. This translates to approximately 22 maternal deaths per day or 1 maternal death per hour (MOHSW, 2008c). In 2008, Tanzania was one of the 11 countries responsible for 65% of all maternal deaths in the world. The other countries are

Nigeria, Democratic Republic of Congo (DRC), Sudan, Ethiopia, Kenya, Afghanistan, Pakistan, India, Bangladesh and Indonesia (WHO, UNICEF, UNFPA, & WB, 2010). World Health Organisation defines maternal mortality as *“the death of a woman while pregnant or within 42 days of termination of a pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”* (WHO, UNICEF, UNFPA, & WB, 2010).

However, there seems to be a gap between figures and policy action when it comes to the Tanzanian maternal health situation. Tanzania has a well established network of health facilities and referral systems compared to many African countries (Mrisho et al 2007; Mosha et al, 2005). About 90% of the population in Tanzania lives within 5 kilometres of a primary health facility (MOHSW, 2009). In addition the government of Tanzania introduced an exemption policy from fees on all MNCH services at all government health facility (MOHSW, 2005). However in practice, pregnant women are asked to contribute to the delivery kit or to buy provisions that are not available such as cotton wool, gloves and razor blades (Mrisho et al., 2008).

There has been some marked progress in child health over the past ten years. However, the progress is much more noticeable in post-natal mortality while there is little progress in neonatal mortality (MOHWS 2009; MOHSW 2008). The marked progress in post-natal mortality is mainly due to high level coverage of vaccination which currently stands at 75% and the increased coverage of effective interventions such as the distribution of vitamin A (MOHSW, 2009). According to the MOHSW in 2009, the lack of progress in neonatal-mortality in Tanzania is worrying especially considering its close link with maternal health.

Policy Action

In 2008, the MOHSW acknowledged lack of progress in efforts to bring down maternal mortality rate (MMR) between 1998-2008 in Tanzania (MOHSW, 2008c). Lack of progress in bringing down the MMR in Tanzania is very much perceived as a health system problem. This perception is supported by the demographic health survey (DHS) in Tanzania of 2004/05, according to the DHS; there is a great difference in ante-natal care (ANC) figures and facility deliveries. ANC in Tanzania is 94% while only 47% deliveries take place at health facilities (DHS, 2005).

While there are many perceived causes for this discrepancy, Mæstad (2007), cited the acute shortage of and lack of essential equipment and supplies for emergency obstetric care as contributory to the low utilisation of delivery services in Tanzania. In addition to supply shortages, Tanzania had experienced a decline of its active workforce in the health care (Mæstad, 2006). At the same time, the population of Tanzania has been increasing at an annual growth rate of 2.9% according to the 2002 national census in Tanzania (Lorenz & Mpemba, 2005). The human resources shortage in the health sector has been acknowledged as a crisis situation by the ministry of health in Tanzania (MOHSW, 2008a).

This indicates that health system factors seem to play a major role in the low utilisation of delivery services and lack of progress in bringing down the MMR in Tanzania. In response to this unacceptable situation, the government of Tanzania decided to introduce Payment for Performance (P4P), an out-put based financing strategy, as a strategy of motivating health workers to increase their performance which presumably augers well for maternal health services utilisation and quality . P4P is defined as:

“A payment (monetary and/or non monetary) which is issued based upon achievement of a predetermined performance target. Performance payments may target supply-side (e.g., health center, health worker) and/or demand-side (e.g., pregnant women) recipients” (Eichler & De, 2008, p. 2)

The main aim of P4P in Tanzania is to stimulate and improve service outputs and outcomes in maternal health (MOHSW, 2008). P4P assumes that the motivation of health workers is crucial for their performance. Good performance of health worker improves the quality and utilisation health services. One of MOHSW’s P4P objectives explicitly aims for the link between motivation, performance and outputs:

“To provide better motivation and explicit attention to results, by ensuring that health workers and their supervisors are motivated to strive for better results in Maternal Newborn and Child Health services and other health services in the districts” (MOHSW, 2008c, p. 2)

Aim of the Study

Given the above scenario, my motivation for doing this research was guided by the overarching purpose of exploring the contribution of incentives to maternal health care. My main objective of the study is: **to explore how service provision and the use of incentives in maternal health is perceived by health practitioners and community members.** The specific objectives of the study are:

- To explore community members' perceptions of and experiences with maternal health services and the perceived barriers to utilisation of these services
- To explore nurses perceptions of and experiences with midwifery as work and as care giving
- To explore nurses' perceptions of and expectations to P4P
- To explore how health workers view P4P as a strategy of improving service utilisation and outcomes

Thesis Outline

Whereas Chapter 1 provides a general introduction of the epidemiological perspective on maternal health in Tanzania, Chapter 2 is policy oriented. It takes a historical perspective and maps the major global initiatives and policy action in Tanzania in MNCH. The aim of the chapter is to provide the basis for understanding the rationale of introducing P4P in MNCH.

Chapter 3 presents the literature review of the thesis, while chapter 4 presents the theoretical frameworks used in the analysis and discussion of research findings. Chapter 5 presents the methodology of the study and methods used for gathering data of this study. The thesis has 3 empirical chapters, which are 6, 7, and 8. Chapter 6 presents the views of community members and health workers on health service provision. The second empirical chapter presents the experiences and views of health workers on their work. The final empirical chapter shows the perception, experiences and expectations of health workers on P4P as a strategy of improving their motivation and service outputs and outcomes. Chapter 9 provides some final remarks and discussion of major issues raised throughout the thesis.

Chapter 2

Global Historical Perspective and Agenda Setting in MNCH

“This [maternal mortality] has been a seriously neglected problem, largely because its victims are those with the least power and influence in society – they are poor, rural peasants, and female. The roots of much maternal mortality lie in discrimination against women, in terms of legal status and access to education, financial resources and health care, including family planning” (Mahler, 1987)

Halfdan Mahler gave this statement in 1987, and it is sad that after nearly 25 years, the assertion is still largely true. While a lot has been going on in mother and child health for the past 30 years, it is arguable if any tangible results have been achieved in maternal health. This chapter is looking at the efforts that have been made in the past thirty years to reduce maternal deaths in developing countries. It looks at various organisations that contribute in setting the agenda in MNCH. Agenda setters in maternal health inform the types of policies, strategies and financing options of a particular time in MNCH, while the successes, failures and challenges of previous policies, strategies and funding options further informs new and innovative strategies. This has been demonstrated in MCH from Alma Ata in 1978 to the MDGs’ Summit 2010.

Historical perspective in MCH

The Alma Ata Conference

The Alma Ata conference of 1978 is credited for the reorientation of medical systems in increasing the interest in primary health care (PHC). The conference marked the end of the ‘big hospitals’ era to a more demand driven approach in PHC. It advocated for a more comprehensive PHC on a more holistic and integrated approach that includes addressing “social and environmental determinants of health” (McCoy et al., 2010) . However, marked progress in primary health care did not result in improvements in maternal mortality rate (MMR) in many developing countries. Olsen and colleagues (2002) have argued that this is so because the maternal health component was not given emphasis in its own right but rather as a vehicle for child health. The neglect of the mother was justified by the data that supports that

global infant mortality rates are higher than maternal mortality rates, while infant mortality rate in sub-Saharan Africa averages at 89 per 1000 live births, maternal mortality averages at 0.9 deaths per 1000 live births (McCoy et al., 2010).

However, maternal and child health services are inter-connected to the extent that relying on statistics is misleading as maternal health is a significant determinant of newborn and child health. This is demonstrated by the fact that mortality rates are significantly higher for orphaned children than those with mothers (Van den Broeck, Eeckels, & Massa, 1996). Regardless, the assumption in “mother and child health” (MCH), as a package of PHC, was that “what is good for the child is good for the mother” (Rosenfield & Maine, 1985, p. 1130). As a result of this, Allan Rosenfield and Deborah Maine in their classical paper argued that most packages in MCH are beneficial to the child and not the mother except for family planning services.

The Alma Ata coupled with the efforts in the academia and the announcement by WHO in 1985 on the number of maternal deaths at the conference marking the end of the UN Decade for Women, raised concerns for both individual and institutional players in maternal health (Starrs, 2006). These events caluminate in the realisation despite great efforts in perinatal and child health, the ‘M’ in MCH was still neglected.

The Safe Motherhood Initiative

“We must confront the challenge with a multiple strategy: we must stop behaving as if there were a single magic bullet that could slay this dragon” (Mahler, 1987).

Halfdan Mahler, the then WHO Secretary General, was instrumental in the launching of the Safe Motherhood Initiative in Nairobi, Kenya in 1987. This launch was prompted by the realisation that maternal health in lower-income countries was neglected. In fact, the maternal mortality in lower-income countries proved to be the single most human development indicator showing widest disparities between high and low-income countries. The World Health Organisation (WHO), United Nations Fund for Population Activities (UNFPA) and the World Bank took the initiative of launching the Safe Motherhood Initiative with the help of many other organisations to form what was to be called the Safe Motherhood Inter-Agency Group (AIG). This group notably included organisation such as the United Nations Children’s

Fund (UNICEF), the United Nations Development Programme (UNDP), the Population Council, the International Planned Parenthood Federation (IPPF) and several other agencies from around 45 countries (Olsen, 2002). The Safe Motherhood Inter Agency Group’s goal was to halve maternal illness and death by the year 2000 (Mahler, 1987). This initiative was a major step in directing global attention towards maternal health policy and funding.

Figure 1.0: Some members of the Safe Motherhood Inter-Agency Group



(Source: www.womendeliver.org)

Starrs notes that the Safe Motherhood Initiative’s first ten year strategies to combat maternal deaths were greatly influenced by the Alma Ata’s position that emphasises community based preventive interventions (2006). According to Starrs, the first decade focused on “- *antenatal care , with a focus on screening women to identify those at risk of complications, and training of traditional birth attendants to improve delivery care at the community level*”(2006, p. 1130). At the conference marking the 10th anniversary of the Safe Motherhood Initiative, there was a general consensus that the strategies used during the first decade did not yield desired results. This realisation led to many donors and their development partner countries to de-emphasise large scale community based approaches such as training of TBAs to a health-sector intervention approach that emphasised women’s access to professional medical care.

According to McCoy and colleagues (2010), the current development assistance is informed by a selective PHC approach as opposed to the comprehensive approach after Alma Ata, this is particularly evident in the current rise in a number of “selective or disease specific global health initiatives”. P4P can be seen as one such initiative with a selective approach to PHC.

International Conference on Population and Development (ICPD)

The UN International Conference on Population and Development (ICPD) in Cairo in 1994 was crucial in shaping the maternal health agenda. The Program of Action (PoA) of the ICPD was comprehensive and provided the turning point in how the mother, women and family were considered in MCH (Abrejo, Shaikh, & Saleem, 2008). The conference's program of action focused on many themes such as reproductive rights and reproductive health, family and its roles and rights as well as gender equality, equity and the empowerment of women among others ("ICPD '94- Summary of the Programme of Action").

Gender equality and equal participation of women and men in household and family responsibilities were seen as cornerstone to the achievement of universal reproductive health. The inclusion of men in reproductive health issues was perceived as critical in changing the perceptions of reproductive health being considered a 'female' problem. In addition, the participation of both parents in encouraging children especially boys to respect women and girls was seen as crucial in shaping their perceptions of gender and family roles in future ("ICPD '94- Summary of the Programme of Action").

The conference targeted many issues relating to women's well-being and empowerment. Maternal health was one of the topics that were prioritised at the conference. There was a general consensus by the stakeholders to *"shift away from pursuing demographic targets via family planning to the achievement of universal access to safe, affordable, and effective reproductive health care and services that are not gender blind"* (Langer, 2006).

At a review meeting of the ICPD-PoA, called the ICPD+5 in 1999, stakeholders agreed that there was need for sufficient funding to achieve universal reproductive health. At the same meeting among others, the idea of having goals that measure particular countries' progress was hatched (Abrejo, Shaikh, & Saleem, 2008). The UN millennium summit in 2000 perfected this idea into MDGs.

UN Millennium Declaration 2000

Macleane (2010) argues that around the late 1990s, there was an understanding that the efforts to reduce maternal mortality were not bringing desired results, in fact due to better methods in

counting the estimates in the MMR was rising. Many factors had been impeding the realisation of the Safe Motherhood Initiative's goal of year 2000 which include the lack of adequate political commitments and resources to finance maternal health initiatives (Olsen, 2002). In September 2000, world leaders in New York adopted the UN Millennium Declaration. 189 UN member states and at least 23 international organisations were part of the declaration ("End Poverty 2015 Millennium Campaign", 2010).

The declaration gave birth to the Millennium Development Goals (MDGs). Goal number 5 specifically focuses on maternal health. In MDG5, countries have committed themselves to reducing the maternal mortality ratio by three quarters between 1990 and 2015, which is target 5a in MDG 5. Target 5b is concerned with universal access to reproductive health (UNDP, 2010). It can be argued that the UN Millennium Declaration provides a multi-faceted approach to the problem of maternal death. The efforts to improve maternal survival and health (MDG5), is linked to other MDGs, notably MDG 1, 3, 4 and 6. Maclean (2010), notes that *"goals associated with poverty reduction, empowerment of women as well as addressing infections such as HIV/AIDS and malaria are inseparable from MDG5 whilst the improved health of mothers enhance child survival and health"*. MDGs arguably made funding focused and directed towards specific goals in their own right. For example, the MDGs Summit held in September 2010 in New York, pledged more than US\$40 billion to the Global Strategy for Women's and Children's Health (The World Bank, 2010).

The Global Strategy for Women's and Children's Health's main focus is policy changes in women and children's health, funding initiatives that save lives of women and children as well as ensuring the access for women and children to quality facilities and skilled health workers (The World Bank, 2010). This study is looking at one such initiative that is aimed at ensuring that health workers are motivated so as to ensure that women and children have access to health facilities that offer quality services.

Tanzania's efforts in MNCH

Mwalimu Nyerere, who became the first President of United Republic of Tanzania in 1964, wrote a paper called *Ujamaa—The Basis for African Socialism* in 1962. This became the basis for the Arusha Declaration of 1967. The declaration emphasized central planning and equitable accessibility of services to the people (Nyerere, 1967). Among the services

prioritized, health care was one. As part of this process, the health service system in Tanzania was aimed at equitable distribution of health facilities. Arguably, Tanzania's health policy reflects a more rural bias than many African countries and this can be credited to the Arusha Declaration (Van Etten & Raikes, 1975). However, the availability of health facilities did not guarantee the accessibility, acceptability and quality of those health services due to many factors. The economic recessions of the 1970s and 1980s in Tanzania is mainly attributed as a major factor that contributed to the lack of adequate financing of health services (MOHSW, 2003).

Maternal, newborn and child health - an essential component

There has been an increased emphasis on reproductive health and safe motherhood in recent years in Tanzania. The National Health Policy for Tanzania (2003) states that women of child bearing age and children are their prime targets. This is evidenced by the fee exemption policy of 2005 on all MNCH services in government health facilities (MOHSW, 2005).

At the core of the National Health Policy of Tanzania is the need for health facilities to be well equipped and at the same time have qualified health personnel that is continually trained and this is emphasized in the Human Resources for Health Strategic Plan of 2008-2013 (MOHSW, 2008a). MNCH has been a priority in the national health policy of Tanzania and many strategies have been adopted throughout the years. According to Canavan and Swai (2008), Tanzania has witnessed a proliferation of policy and strategic documents that promote poverty reduction and associated globally agreed targets. Far back as 1959, Tanzania's main strategy in reproductive health was family planning. The formation of the Family Planning Association of Tanzania (Uzazi na Malezi Bora Tanzania- UMATI) a non-governmental organization in 1959 was instrumental in driving the national family planning strategy in Tanzania¹.

In 1974, Tanzania launched an integrated Maternal and Child Health programme and the programme necessitated the expansion of family planning services in the country (Olsen 2002). In 1997, Tanzania formally stated its need to meet the goal of halving maternal deaths by 2000 set by the Safe Motherhood Inter-Agency Group in Nairobi, Kenya in 1987 (Olsen 2000). Although the formal adopting of the global goal was too late considering the time left,

¹ www.umati.or.tz

it demonstrated the political will to deal with maternal health. Tanzania's main strategy to meet the global goal was to integrate curative, promotive and preventive services with a gender sensitive dimension (Olsen 2002). In order for the government of Tanzania to meet its goals and objectives of the health policy, there is need to increase human resource capacity in the health sector (MOHSW, 2008a). The focus on human resources in maternal care underlies the main rationale behind the current pay for performance strategy in maternal health in Tanzania which is the subject of this study (MOHSW, 2008c).

A decade of no progress- what now?

In spite of all these policy efforts, the MMR in Tanzania had not declined as anticipated. In fact, in 2008, the Ministry of Health and Social Welfare of Tanzania admitted that there was no progress for the past decade to bring down the maternal mortality ratio (MOHSW, 2008c). Bringing down the MMR was not only Tanzania's problem, but a challenge to many developing countries. WHO, UNICEF, UNFPA and the World Bank in 2010 reported that as of 2008, Eastern Asia was the only MDG broad region on track with the required average of 5.5% annual decline of the maternal mortality rate. Sub-Saharan Africa and the Oceania had least progress at 1.4% and 1.7% respectively (2010). Map 1 below shows a global pattern of the MMR. The lack of progress demonstrated that new strategies had to be developed in maternal health care. As such, pay for performance, has emerged as one of the most widely used strategies in MNCH in the effort to improve service outputs and outcomes.

Pay for Performance- the new strategy

As a response to poor health service delivery and utilisation in general and lack of commendable progress in MDG 5, incentives have been introduced as a tool to enhance performance among health workers and to increase utilisation of these services. Pay for performance links incentives to performance. The basic principle of P4P is that "*money follows the patient*", meaning that if health facilities manage to increase the utilisation of health services, the result is more incentive payments (Toonen, Canavan, & Elovainio, 2008).

P4P initiatives transfer money or material goods to providers and recipients of health services if they take action in improving health services, utilisation and quality of such services (Eichler & De, 2008). The unique feature of P4P is that it transfers the incentive only if a result is achieved. By this, P4P possesses the potential to influence health actors in a variety

of ways. It may influence health workers and patients and groups/communities equally (Eichler & De, 2008).

Some cases of P4P around the world

Pay for Performance is a strategy currently used in many developing countries such as India, Pakistan, Cambodia, Egypt, Nigeria, Benin, Ghana, Rwanda, Tanzania, DRC, Malawi, Zambia and Haiti. The naming, nature and form of these strategies can be different but with almost similar goals and aims. The nature of interventions differs variably from region to region and country to country according to the particular social context and the health policy of the country. The table below shows some cases of P4P around the world.

Table 1.0: Cases and forms of Pay for Performance in Practice

Countries	Health Target	Incentive Recipient	Incentive type (s)
Tanzania, Zambia ,Ghana	Improve Service Outputs	District Health Authorities, Health Facilities, Health workers	Performance bonus
Benin, Brazil, DRC, Philippines	Improve Service utilisation and quality	Health Facilities, Health workers	Performance bonus
Cambodia, India	Visit to Health Centres, Improve Service utilisation	Patients, Accredited Social Health Activists (ASHAs), Yashodas (Auxiliary nurses)	Financial support to cover costs for patients, Performance bonus for ASHAs and Yashoda
Malawi	Visit to Health Centres, Improve Service utilisation, Improved outputs	Community leaders, Patients, Health Workers	Conditional Cash Transfer, Full voucher Scheme for Safe Delivery

Adapted from Health Systems 20/20, Norway India Partnership Initiative (NIPI) and the Norwegian-German Initiative to Support MDGs 4 and 5 report in Malawi.

In India for example the incentives in form of financial rewards are paid to patients (expectant mothers) and community health workers, the ASHAs² and Yashodas³ (Maal & Wadehra, 2008), while in Tanzania the incentives are paid to health workers and not patients. These differences could be explained by the fact that women in India especially from the Dalit Communities arguably face greater social discrimination in service provision than their counterparts in Tanzania, hence the need for incentives to visit health facilities (Maal & Wadehra, 2008). In both countries, primary health services are principally free of charge

² Accredited Social Health Activists

³ Auxiliary nurses

although women normally contribute to the delivery kit with provisions such as gloves, razor blades, and cotton wool (Mrisho et al., 2007). Regardless, incentives in Tanzania targets health workers. It is therefore the objective of this study to explore how health workers perceive these incentives.

P4P in Tanzania

In Tanzania the main aim of P4P is to improve maternal, newborn and child health (MNCH) by increasing health worker motivation through supplement payments (Lauglo & Swai, 2009). The targets for MNCH are described in the Tanzania Roadmap for Maternal and Newborn Health (2008-2015) of 2007 and in the Health Sector Strategic Plan III (2009-2015) of 2008 (MOHSW, 2008b).

Performance indicators and rewarding mechanism in Tanzania

The indicators for pay for performance in Tanzania are on antenatal care, institutional deliveries, and post-natal care and on the reporting system known as the health management information systems (HMIS). Health facilities use 5 indicators covering areas of MNCH mentioned above, the table below lists the performance indicators.

While the council health management teams (CHMTs) will get 50 % of their bonus payment when 50% of the health facilities in their mandated area reach their targets and the other 50% for the timely report of HMIS to the regional health management team (RHMT). The regional health management teams (RHMTs) qualify for 50% of their performance bonuses for timely reporting of HMIS to the MOHSW and the other half when 50% or more of health facilities in their region meets their targets (MOHSW, 2008B; Eichler and Morgan, 2011). The main role of RHMTs is to monitor and ensure that health facilities and councils are adhering to timely submission of reports, review the submitted reports as well as verifying such reports (Smithson et al., 2008).

Table 2.0: Performance indicators in Tanzania

Facility/Team	Indicator
Dispensaries	Immunization- DTPHb ⁴ 3 equal or above 80%
	Immunization- OPV ⁵ 0 equal or above 60%
	Deliveries in the health facility equal or above 60%
	IPT ⁶ 2 for pregnant women equal or above 60%
	Quarterly HMIS ⁷ /MTUHA report timely, complete and accurate 100%
Health Centres	As for dispensaries
Hospitals	As for Health Centres
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)

Source: Pay for Performance Strategy 2008-2015, MOHSW. Agenda 5.1 (Dec 2008)

Achieving one target is considered 1/5 of the possible 5/5 if a health facility has met all the targets for all indicators. This means that a health facility with 5/5 will get the maximum annual bonus, whereas the one with less than 5/5 gets a partial bonus. Targets are set at the beginning of each year and the basic rule for targets setting is the requirement of improvements from the previous performance. Set targets cannot be changed during the course of the year (Smithson et al., 2008).

The bonuses are different according to the facility type, that is, dispensaries' maximum annual bonuses are lower than health centres and hospitals. Dispensaries have a maximum bonus limit of T.Shs 1 million (approx USD 676), while health centres, CHMTs and RHMTs' maximum annual bonus is T.Shs 3 million (approx USD 2000). Hospitals have the highest maximum annual bonus of T.Shs 9 million (approx USD 6000). Payments at the health facility are shared equally among the members regardless of grade, qualifications or position. If a health facility reaches all targets each individual get a maximum bonus of approximately annual T.Shs 200 000 (approx USD 136) (Smithson et al., 2008). The individual maximum bonus translates approximately to USD 11.40 per month which is around T.Shs 16 000.

⁴ Diphtheria, Tetanus, Pertussis, Hepatitis B 3

⁵ Oral Polio Vaccine

⁶ Intermittent Presumptive Treatment 2

⁷ Health Management Information System

The Role of Norway in MNCH

The Prime Minister of Norway, Mr Jens Stoltenberg, and the then UK Prime Minister, Mr Gordon Brown as well as Bill and Melinda Gates, have been influential in the launching of the Global Business Plan, which outlines the support for Output Based Financing (OBF)⁸. In 2006, Stoltenberg launched his MDG 4 Initiative for Child Survival and this initiative has grown to become The Partnership for Maternal, Newborn & Child Health (Godal, 2007).

Norwegian-Partnership Initiatives in MNCH

As a result, Norway has launched several partnerships in order to meet its commitments in the Partnership for Maternal, Newborn & Child Health (PMNCH). Some of these initiatives include the Norway-India Partnership Initiative (NIPI), the Norway-Tanzania Partnership Initiative (NTPI), and the Norwegian-German Initiative in Malawi (NGIM). It is the Norway-Tanzania Partnership Initiative (NTPI) that gave birth to the idea of implementing a pay for performance strategy in Tanzania. The Norway-Tanzania Partnership Initiative (NTPI) is a five year programme from 2007 to 2012. The Initiative is worth NOK 225 million (approx USD 36.6 million). The initiative's main aim is:

“to provide additional flexible funding to district health services to support the implementation of interventions guided by the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (the One Plan), and to contribute to innovation and strengthened result focus through performance based financing approaches for achieving MDG 4 and 5 in Tanzania”⁹.

The status of NTPI and P4P implementation in Tanzania

The NTPI's programme, however, did not start in 2007 as planned; neither had it started during the writing of this thesis. The major reason for this is on the implementation challenges between the two partners. The MOHSW preferred an accelerated approach while NORAD preferred an implementation framework to be designed by the Ifakara Health Institute (IHI). NORAD's major worry is that if the implementation goes ahead without the framework, it

⁸ <http://www.who.int/pmnch/activities/globalbusinessplan/en/index.html>

⁹ http://www.norway.go.tz/News_and_events/Maternal-and-Child-Health/NTPI/

will result in lack of standardization on allocations and monitoring of performance and some other unforeseen challenges (Canavan & Swai, 2008).

The United Republic of Tanzania's government in 2009 decided to go ahead with the implementation of pay for performance regardless of Norway's concern. The MOHSW preferred a "*learning by doing*" strategy which does not necessarily requires perfect implementation conditions (MOHSW, 2008c). Health workers in Mvomero district where the fieldwork for this study was conducted received their first P4P bonuses in October 2010, a month after my fieldwork. In addition, there had been plans to launch another 'official pilot' during the first half of 2011 in Pwani region which will be headed by the MOHSW and the Clinton Health Access Initiative (CHAI).

Clarification of the term P4P

In different contexts, different terms are used for pay for performance. In other words, there are many concepts that are closely related to pay for performance. While in theory the principles behind these concepts are similar, some slight distinctions do apply. The following are some concepts that can be used almost similarly with pay for performance: Performance-Based Financing (PBF), Performance-Based Incentives (PBIs), Results- Based Financing (RBF), Performance Based Contracting (PBC), Conditional Cash Payments (CCPs), Output Based Financing (OBF) and Vouchers. These mentioned are either synonyms or types of pay for performance, whereas the following have a different meaning from pay for performance: Output Based Aid (OBA), Conditional Cash Transfer Programmes (CCTPs), and Fee for Service (FFS). These strategies have recently gained attention among developing countries and their partners as potential mechanism for making progress towards the attainment of MDG 5 and 4 (Eichler & De, 2008). The support for the RBF is found in the Global Business Plan for MDG 4 and 5 with the imbedded assumption that RBF significantly improves health outputs and outcomes (Lauglo & Swai, 2009)

Chapter 3

Literature Review

While a lot of efforts have been going on in the health policy field with particular reference to maternal health financing as shown in chapter 2, researchers have been burning the midnight oil in contributing to the knowledge bank, coming up with empirical evidence and highlighting causes, pitfalls, successes and recommendations in maternal health care. This chapter will explore contributions made by researchers in health care in general and maternal health in particular. It will firstly look at factors that affect maternal health utilisation, human resources factors in health care, findings from recent and current P4P programmes as well as the contribution of this study. Secondly, the chapter presents the theoretical framework of the study.

Factors affecting the utilisation of maternal health services

Several researches have been carried out on the availability, accessibility and acceptability of mother, newborn and child health care and many factors have been identified as barriers to health facility delivery. These include factors both on the provider side and user side. Mrisho and colleagues' study in 2008, which investigated factors that affect home delivery in rural Tanzania, discovered that both provider and user side factors are crucial in shaping a woman's decision of a place of delivery. The study was carried out in 5 districts in southern Tanzania which are: Nachingwea, Lindi rural, Ruangwa, Tandahimba and Newala. Some of the factors Mrisho and colleagues found to be barriers for facility delivery are lack of transport, staff attitudes, traditions and culture, decision making and lack of privacy at health facilities (Mrisho et al., 2008).

The same factors were also noted in Mæstad (2007) study in Tanzania; however, Mæstad's study emphasized financial costs as a major barrier on the user side. In a study in rural India on factors that affect care seeking behaviour by Kesterton and colleagues, they found that economic factors were important in shaping the decision to seek care. Financial constraints emerged to be the major barrier in care seeking in their study (Kesterton, Cleland, Sloggett, & Ronsmans, 2010). Mæstad's study also highlighted the significance of provider side factors as

major barriers for the accessibility of maternal services, the study points at the poor quality of services as a major cause of low utilization of maternal health services in Tanzania. According to Mæstad, many low-level health facilities face an acute shortage of supplies for emergency obstetric care.

Contrary to Mrisho and colleagues and Mæstad's findings in Tanzania on the importance of economic factors, Bolam and colleagues' study in Nepal in 1998, looking at factors that affect home delivery in Kathmandu Valley, dismisses economic factors as of little importance in determining the place of delivery and utilization of maternal services. According to their study the level of education was more significant than economic factors (Bolam et al., 1998) .

Amooti-Kaguna and Nuwaha's study in the Rakai district of Uganda find that immediate onset of labour and lacks of money were major factors affecting the women's choice of a delivery place. The other factors they cited as affecting the accessibility and acceptability of maternal services were lack of transport, the availability of TBAs, unexpected labour, long distance from health facilities and fear of being ridiculed or verbally abused by health workers especially for young mothers.

Brieger and colleagues in their study in a small Nigerian community, find that economic factors such as level of income, education and cultural beliefs were factors acting as barriers for facility delivery. They concluded that provision of relatively accessible maternal services is not a guarantee to their use. Considerations of social and cultural factors was important in the utilization of maternal health services (Brieger, Luchock, Eng, & Earp, 1994).

Barnes-Josiah and colleagues' longitudinal cohort study on maternal mortality in Haiti on 12 maternal death cases concluded that a delay to make a decision to seek medical care was noted in 8 cases, in two cases transport was the main significant factor and in 7 cases inadequate care at the facility was a factor. In the interviews they carried out with the family members and friends of the deceased, a lack of confidence in the existing medical options was a crucial factor in delaying or not seeking medical care. Barnes-Josiah and colleagues concluded that improving quality and scope of care in Haiti's maternity care system will go a long way in reducing needless maternal deaths (Barnes-Josiah, Myntti, & Augustin, 1998). These findings resonates with Mæstad's study in that the provider side factors plays a major role in shaping community members' perceptions on maternal services and their utilisation.

Mbaruka and Bergström in 1995 carried out a retrospective study using records of maternal deaths in the Maweni Regional hospital, Kigoma, Tanzania of 1984-1986. The review of the records was aimed at determining maternal mortality rate and contributory or medical causes of death, among the causes were: a lack of basic equipment, poor staff attitude, absent hospital staff during working hours, prescriptions without physically seeing the patients, low supply of drugs, acute shortage of blood, and lack of trained anesthetist (Mbaruka & Bergström, 1995). These causes are all related with the availability, accessibility, acceptability and quality of health care at a facility level. These factors points to the low quality of maternal service provision.

Human resources in health care

The availability of adequate number of health personnel, with the right skills and knowledge as well as enough motivation is very crucial for a health system to function properly (Mæstad, 2006). In many cases, health workers are demotivated, understaffed and poorly remunerated. Tanzania has faced a decline in its active workforce in the health care. Active health workforce per capita declined by 40% between 1994-95 and 2001-02 whilst the population of Tanzania grew by 20% during the same period (Mæstad, 2006). According to the 2002 census in Tanzania, the annual population growth rate stands at 2.9% (Lorenz & Mpemba, 2005). Due to this negative trend, Tanzania's human resources in health care was declared a crisis situation by the Ministry of Health and Social Welfare (MOHSW, 2008a). The document cited the retrenchment policy and the employment freeze that was implemented between 1993 until 1999 as a major factor for the acute shortage of health workers.

Mæstad (2006) claims that the problem of health worker shortage is compounded by the fact that there is low productivity among the few available health workers, with 57% of the working hours used for productive activities. Rural health facilities are the most affected by health worker shortages in Tanzania. However the shortage of health workers is not only a problem of Tanzania but many developing countries. In fact Tanzania ranks in the top five countries in sub-Saharan Africa in terms of combined medical doctor and nurse density (Kurowski, Wyss, Abdulla, & Mills, 2007).

Research in Tanzania and elsewhere seems to support the claim of a human resources crisis in health care in the developing world. Manongi and colleagues (2006) found that understaffing

was a major issue in most primary health facilities in the three districts of Moshi urban, Moshi rural and Hai in the Kilimanjaro region of northern Tanzania. Serneels and Lievens (2008) in their research in Rwanda discovered that higher educated health workers are more scarce and therefore can have the opportunity to choose where they want to be posted. They found that only 17% of health workers in 2006 took up rural jobs. In general, highly educated health workers would prefer urban to peri-urban jobs as these jobs provide them with the opportunity to learn more about their jobs and also offer better prospects to career growth (Serneels & Lievens, 2008; Manongi et.al, 2006).

Dieleman and Harnmeijer 2006 listed many elements that affect staff retention in the health sector under two major categories. The categories are personal and lifestyle-related factors and work-related factors. Under personal and lifestyle- related category they are factors like personal values and beliefs, gender related factors and personal background. Lehmann and colleagues, 2008 found that women's choice of a place to work was mainly influenced by family reasons. Mumtaz and colleagues (2003) in their study in Pakistan found that a woman's traditional role as the family caretaker and their reproductive roles were more influential in choosing their work place. In many cases, the husband's work area influences the woman's choice of her work place (Standing & Baume, 2003) this is probably true to the Tanzanian context considering that Standing and Baume acknowledged a bias toward advanced market economies in their study. Due to this phenomenon, Dussault and Franceschini (2006) argued that there is need to address staffing needs as women constitute the majority of health working force in most countries.

Under the work-related needs category, Dieleman and Harnmeijer (2006), noted factors such as preparation for employment, job satisfaction and health systems as factors determinant to the choice of place of work. They argued that most pre-service training courses to medical students are curative-oriented and not preventative and therefore suitable for urban areas. In other words, because of the training they get, medical and nursing students feel comfortable to work in urban areas where there are mostly secondary to tertiary health facilities. Hongoro and Normand (2006) argued that staff deployment policies lead to bad distribution of staff. This default in deployment negatively affects rural areas. The same sentiments were echoed by Aiken and colleagues (2004) and Dussault and Franceschini (2006). Financial factors have also proved to be important in staff retention although Lehmann and colleagues (2008) concluded that the evidence on the impact of financial benefits had been inconclusive

especially in the context of rich countries where organizational and professional support had proved to be more important factors in staff retention (Lynn & Redman, 2005). However, in developing countries where salaries are low, financial factors attached to the job matters a lot (Serneels & Lievens, 2008).

When health workers are not satisfied with their working conditions and rewards they get from their work, several practices not beneficial to health systems and patients emerges such as bribes, corruption and discrimination acts. Serneels and Lievens' study (2008) revealed corruption and embezzlement at public health facilities in Rwanda. The embezzlements of drugs were linked to low salaries and monitoring mechanisms in these public facilities. In addition, poor attitudes towards patients are also influenced by working conditions, especially in cases where health workers lack protective clothing against HIV infection.

Reis and colleagues' (2005), research in Nigeria concluded that the staff tended to show poor attitudes and discriminatory tendencies toward HIV positive patients. They identified lack of protective and treatment materials as the major reason for this phenomenon. In their study in Nigeria, Ezedinachi and colleagues (2002), noted poor staff attitude as a major problem in the health sector. Fear of infection was also revealed among their subjects (health workers). Dieleman and Harnmeijer identified protection from HIV infection as a major issue especially in countries in sub-Saharan Africa. They noted that lack of protective measures increases the fear of workers and this negatively impacted in the quality of services offered. In addition, they discovered that senior qualified staff might end up delegating duties to non-qualified health personnel as a coping strategy and this obviously affects the quality of maternal services (Dieleman & Harnmeijer, 2006).

Pay for Performance in practice

Rwanda is one of the countries that have been using P4P strategy for a number of years to date. Rwanda introduced a P4P pilot in 2002. The national roll-out of the programme followed in 2006. In 2010, Basinga and colleagues carried an evaluation study of the programme. They attributed limited improvements in health in low and middle income countries to low productivity and morale of health workers which often lead to absenteeism. P4P is considered one strategy to offset these negative attitudes of health workers toward their work and patients. Basinga and colleagues (2010) found that the P4P programme in Rwanda

has significantly increased the use of a number of critical maternal and child health services. In general, the impact was great in services with high incentives and in direct control of facilities and depend less on patients' decision, such as tetanus vaccination and prenatal care quality. For prenatal visits, it is the mother that decides and all the facility can do is to lobby and nothing more. Basinga and colleagues discovers that health facilities used prenatal visits to lobby for women to come for facility delivery which is very lucrative.

In Rwanda deliveries have the highest unit payment rate of \$4.59 and providers find them so lucrative that they not only encourage women to deliver in the facility during prenatal care, but some actually send out community health workers for outreach in the community to find pregnant women to deliver in the facility (Basinga et al., 2010). In Rwanda, prenatal care utilisation is the least impacted by P4Ps and this could be explained by low incentives attached to it which is \$0.09 per visit.

The evaluation in Rwanda did not find any P4P impact on child vaccination. The reason behind this is probably because the government of Rwanda had launched a national programme in 2006 which had raised the child immunisation rates to 65% (Basinga et al., 2010). Another study in Kabutare district in Rwanda by Meessen and colleagues find out that output-based financing in the health sector boost staff productivity. They acknowledged that when it comes to poor quality of care, some aspects cannot be remedied by the health staff at a facility but they cited some elements which can be controlled by health workers such as poor management of recourses, disrespect of users and disinterest in work (Meessen, Kashala, & Musango, 2007).

Kabutare district's performance rate in terms of coverage was declining during the period of 1999 to 2001. In order to arrest this negative trend, the Rwandan Ministry of Health and the HealthNet International (HNI), decided to reformulate their strategy of supporting health facilities. In 2002, they launched a performance initiative which replaced a fixed bonus by an output-based remuneration (Meessen, Kashala, & Musango, 2007). The study find out that health staff had much more control over the number of patients they treat at their health facilities than previously thought. Meessen, Kashala and Musango concluded that output-based financing in poor countries is a feasible option as it increases staff productivity.

However, they noted five major risks associated with performance initiatives. The risks include: increased quantity at the expense of quality, a total neglect of unremunerated services, provision of remunerated services despite the lack of competence, reporting of an inflated rate of delivery of remunerated services and inducement of unnecessary demand by the users for the remunerated services (Meessen, Kashala, & Musango, 2007). Despite these risks, the researchers maintained that the risks were worth the benefits as the scarcity of health workers is a problem of great dimension in poor countries. Hence increasing productivity among the available staff becomes a necessity. The other benefit of P4P despite the mentioned risks attached to it is that it yield results with limited financial resources within a short period of time and this greatly benefits developing countries where health financing is always almost a problem (Loevinsohn & Harding, 2005).

Soeters and colleagues claimed that studies from low-income Asian countries, has shown that performance-based financing had better outcomes for improving health services than the traditional 'input' approaches which are influenced by central planning (Soeters, Habineza, & Peerenboom, 2006). In their study on experiences with performance-based contractual relationships in Cyungugu province in Rwanda, Soeters, Habineza and Peerenboom found that performance-based financing showed good results in terms of use of services, financial accessibility and motivation of health workers. However, they recommended that for performance initiatives to work there should be decentralisation of power as well as verification of results balancing indicators with the quality of care (Soeters, Habineza, & Peerenboom, 2006).

Cordaid, a Dutch international development organisation, introduced a three year (2006-2008) performance based financing scheme in Tanzania's catholic diocesan health facilities in the five dioceses of Tanzania, which include Bukoba, Rulenge, Kigoma, Arusha and Sumbawanga dioceses. This pay for performance programme was evaluated in 2008 by Canavan and Swai. Unlike the Rwandan studies above that showed some positive effects of P4P, Cordaid's pay for performance programme did not yield so much in terms of utilisation of services or improvement in quality of care, neither did it achieve so much in staff motivation. Canavan and Swai discovered no significant improvements in targeted indicators. In fact there was a decline in some of the indicator for the three year period. However, this could have been caused by the preference showed by users for government hospitals which are more affordable than the catholic diocesan health facilities (Canavan & Swai, 2008).

In terms of overall satisfaction with the quality of care, the Cordaid supported health facilities scored 84% compared to government non-P4P health facilities which scored 74%. The users, who were satisfied with waiting time before consultations were 35% for Cordaid P4P health facilities and 28% for non-P4P health facilities (government health facilities). When it comes to the motivation of health workers, the evaluation results did not show any significant difference with all health facilities (P4P and non-P4P), registering less than 50% score on all motivational factors such as salary, working hours and working conditions. However, P4P diocesan health facilities scores highly on team work and staff empowerment. In general, P4P health facilities scored consistently much better than non-P4P facilities on intrinsic factors such as team work and responsibilities entrusted to individual workers (Canavan & Swai, 2008).

Canavan and Swai also noted that the rewarding of P4P bonuses at Cordaid supported health facilities was erratic, with some health facilities having received the six month bonus only three times in 3 years. However, despite the erratic nature and the low amount of the bonuses (each staff member received an average of approximately \$2 per month), most workers agreed that the existence of P4P had enabled them to communicate better and make decision by being allowed to decide on how to distribute the P4P bonuses. Nevertheless, many workers considered P4P bonuses more as ‘top-ups’ of their salaries than anything else (Canavan & Swai, 2008).

Based on the experiences in different P4P programmes, it is noteworthy that the amounts given to health workers as rewards seem to be a factor on determining whether P4P is considered effective or not. In Rwanda, P4P is well financed with major donors being the World Bank, the Global Fund Against Aids, Tuberculosis and Malaria (GFATM), as well as bilateral cooperation. As opposed to workers in Tanzania’s Cordaid P4P funded facilities whose salaries increased only by approximately \$2 per month, health workers in the P4P programme in Rwanda had a major increase. Depending on the position of an individual worker, the amounts can vary from \$75-750 per month and this amount is more or less their basic salary (Kalk, Paul, & Grabosch, 2010).

What is important to note is that despite the low rewards, the evaluation by Canavan and Swai concluded that health workers in the catholic diocesan health facilities in Tanzania supported by Cordaid showed more intrinsic motivation than their counterparts in government facilities

where P4P was non-existent although these intrinsic factors were not enough in increasing service utilisation and the quality of care which are cornerstone assumptions to pay for performance.

Contribution of the study

With the exception of studies in Rwanda, there are few studies on P4P in sub-Saharan Africa. This is mainly because many P4P programmes are still in their early stages of implementation including pay for performance in Tanzania. Studies of programmes in early implementation stages are crucial in that they inform policy-makers and donor agencies of possible pitfalls, challenges and gains when there is still an opportunity to modify the nature or scope of the programme. In addition, most studies of health intervention programmes are mainly quantitative in nature and or large scale country or regional surveys. While these large scale surveys and quantitative studies are significant, they do not capture small-scale subjective meanings and views of targeted populations.

The subjective meanings are crucial in early stages of programme implementation and findings from studies like this can assist to establish the direction and need for further quantitative studies or large scale surveys. This study captures the experiences, perceptions and expectations of community members and low-level health workers which are rarely captured when programmes of this magnitude are designed. My informants expressed their views in a setting close to natural to them, and in this way it minimises the social desirability effect. The views of low level health workers may not otherwise be heard since they often do not take part in sensitization seminars or if invited may be afraid to express themselves in the presence of their superiors.

Chapter 4

Conceptual Framework

The study uses the AAAQ (availability, accessibility, acceptability and quality care) framework a rights based approach and the theory of motivation as major tools in the analysis and interpretation of the study findings. Before introducing the AAAQ framework in detail, there is an attempt to locate the AAAQ framework within the various discourses that has shaped approaches to maternal health. These include the basic needs approach (BNA), the capabilities approach (CA) and finally the rights based approach (RBA).

From Basic Needs Approach to Rights Based Approach

Mahler's statement introducing chapter 2 (see page 6) marks a paradigm shift from a traditional view of maternal health as simply a health disadvantage to a rights oriented view. In this new paradigm maternal health is viewed as a basic element of women's human rights. The paradigm shift can be seen as part of a broader discourse on development, inequalities and poverty.

In the mid-1980s the basic needs approach (BNA) which had been basic in defining poverty alleviation and development aid was losing its dominance (Clark, 2006). The basic needs approach was pioneered by Streeten and colleagues, and Stewart among others and it originates from the work of Abraham Maslow, who in 1943 published an article entitled 'A theory of human motivation' (Maslow, 1943) which proposed a hierarchy of needs for human beings. Later in the 1950s, Pitambar Pant of the Indian Planning Commission developed the concept of 'minimum needs'. However, it was not until the ILO's World Employment Conference in 1976 that the basic needs were defined and prioritised in terms of development policy (Jolly, 1976). The rationale behind the basic needs approach is to provide for the basic needs of all humans particularly the poor and deprived (Kirkemann & Martin, 2007). As such the basic needs approach takes a 'welfarist' perspective to the issue of poverty and development assistance.

The major criticism of the BNA is that it does not encourage investments or ownership of commodities but instead encourages a subsistence way of life (Clark, 2006). The perspective views the poor as in need of assistance and as beneficiaries to such assistance and as a result does not take into consideration the ‘agency’ of the perceived ‘beneficiaries’ (Kirkemann & Martin, 2007). These shortfalls in the basic needs approach led to the rise of competing paradigms on how to explain poverty and development. Among these perspectives, the capabilities approach (CA) and the rights based approach (RBA) have dominated development discourse in recent years.

Amartya Sen and Martha Nussbaum are the leading proponents of the capability approach. The capability approach is mainly concerned with functional capabilities which Sen referred to as substantive freedoms which people should have reason to value (Sen, 1999). The approach moves away from the ‘welfarist’ view of the poor as passive recipients of aid to active agents of change (Sen, 1999). The approach has been dominant to the extent of inspiring the creation of the UN’s Human Development Index (HDI) by the Pakistani Economist Mahbub ul Haq. However, there is a major point of divergence on how Sen and Nussbaum conceptualise the capabilities approach and this difference has led the approaches to rival each other. The criticism of Sen’s version of the capability approach is that it is considered as an elaboration of the basic needs approach, and emphasise the previously implicit assumptions about the ‘value of choice’ in the basic needs approach (Clark, 2006). Unlike Sen who focuses on substantive freedom, Nussbaum emphasises on ‘basic human entitlements’ and this is arguably closer to human rights than Sen’s concept (Nussbaum, 2002). Hence Nussbaum’s conceptualisation is closer to the AAAQ framework.

Nussbaum’s conceptualisation of the CA makes an explicit attempt to link human capabilities and human rights. She developed a list of capabilities perceived central to human beings and these are: *Life; Bodily health; Bodily integrity; Senses, Imagination and thought; Emotions; Practical reason; Affiliation; Other Species; Play; Political and material control over one’s environment* (Nussbaum, 2000). She separated the capabilities into 3 categories, that is, basic, internal and combined capabilities. Basic capabilities are the innate potential in individuals which have to be further developed. Internal capabilities are sufficient conditions in the external environment to trigger or develop basic capabilities, while combined capabilities is the summation of basic and internal capabilities (Garrett, 2008).

Nation-states and the international community's major obligations in public policy are therefore to promote the combined capabilities (basic and internal capabilities). This can be made possible if education and training and external institutional and material conditions are made available for human beings to exercise their capabilities (Garrett, 2008). Women's reproductive health can be seen in terms of Nussbaum's concept of human entitlements especially the first three, life, bodily health and bodily integrity. The Cairo Consensus at the International Conference on Population and Development (ICPD) emphasised the importance of the rights approach if reproductive health and gender equality is to be addressed (UNFPA, 2011). It is from this background and perspective that many theoretical frameworks in maternal health are emerging including the AAAQ framework.

AAAQ (availability, accessibility, acceptability and quality care)

The proponents of the framework are Hunt and De Mesquita, and Yamin (Hunt & De Mesquita, 2008; Yamin, 2009). The framework is useful in understanding factors that act as barriers to maternal health care. In an ideal world, health care should be available (1st A), accessible (2nd A), acceptable (3rd A), and this health care should be of adequate quality (the Q). Is the health care available? Is it accessible? Is it acceptable? And is it of good quality? The answers to these questions may help us explain and understand the barriers to maternal health care.

In 2009, the Human Rights Council issued a declaration on Maternal Mortality and Human Rights. The declaration recognises the Human Rights aspects of maternal health such as the right to life; the right to health; and the right to bodily integrity (Yamin, 2009). Under ICESCR¹⁰, CEDAW¹¹ and other international treaties, guaranteeing the right to health, states have three major primary obligations which are: to respect the right to health, to protect their citizens from any infringement to the right to health and to fulfil the right to health. The implementation of P4P by the government of Tanzania can be seen as an attempt to fulfil the right to health which demands that States: "*take positive steps to realise the right to health, such as policy, legislative, budgetary and administrative measures*" (Hunt & De Mesquita, 2008, p. 9).

¹⁰ The International Covenant on Economic, Social and Cultural Rights

¹¹ The Convention on the Elimination of All Forms of Discrimination Against Women

CEDAW requires States parties to: “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation” (article 12.2). In addition, the UN Committee on Economic, Social and Cultural Rights, which is responsible for the monitoring of the ICESCR , stated that the treaty’s obligation must be “understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information” (General Comment 14, para.14 in Hunt & De Mesquita, 2008, p. 5).

Under international law, states are supposed to take and use “appropriate” action towards the progressive realisation of the right to health. The “appropriate” means and action include providing health facilities, goods, and services that are available, accessible, acceptable, and of adequate quality (AAAQ). The health services have to be accessible both in physical and economic terms on the basis of non-discrimination, acceptable both medically and ethically and of good quality (Yamin 2009; Hunt & De Mesquita 2008). The table below shows the link between AAAQ framework and the right to health.

Table 3.0: Link between AAAQ Framework and Human Rights

Criteria	Right to Health Requirement
<i>Available</i>	An adequate number of goods, services and facilities necessary for maternal health, as well as sufficient number of qualified personnel to staff the services.
<i>Accessible</i> (physically and economically)	Maternal health, sexual and reproductive health services which are both physically and financially accessible
<i>Accessible</i> (non-discrimination)	Health services must be accessible on the basis of non-discrimination.
<i>Acceptable</i>	All health facilities, goods and services must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements.
<i>Good quality</i>	Maternal health care services must be medically appropriate and be of good quality.

Source: adapted from (Hunt & De Mesquita, 2008)

The obligation by states to fulfil their citizen’s right to health entails coming up with new and innovative ways in health systems. The major challenges to health care delivery in Tanzania

and many other developing countries as mentioned elsewhere, are partly related to lack of adequate health staff and this problem is further compounded by the fact that the few health staff available is largely de-motivated to carry their duties expeditiously due to poor work condition and remunerations among other factors. Hence P4P in Tanzania intends to *“influence the performance standards and behaviour of health workers in service provision at primary health level, particularly maternal, newborn, and child health”* (MOHSW, 2008c, p. iv). Evidence suggests that result- based financing improves the productivity and motivation of health worker by offering extra incentive (Loevinsohn & Harding 2005; Soeters et al. 2006; Kalk et al. 2010). In theory, improved productivity and motivation of health workers impacts positively on the availability, acceptability, accessibility and quality of care and this ties the AAAQ framework closely with the motivation of health workers.

Health initiatives such as P4Ps aim to improve the care giving industry by rewarding both the patients and care-providers in general. The main beneficiaries of P4Ps in MCH are supposed to be women the end-users. Result-based initiatives borrow heavily from psychology and economic theories of motivation. The concept of motivation, although it can be argued to be cultural specific, in the case of P4P it is so much linked to health system factors and as such gender complexities cannot be completely captured. Motivation theory however suffices to analyse and discuss my research findings in the last two empirical chapters.

Motivation

Motivation can be broadly defined as intrinsic or extrinsic. According to Nancy Folbre (2004) care-giving is labour intensive and such a large proportion of it is as a result of intrinsic motivation as opposed to extrinsic rewards associated with the work.

Intrinsic motivation

According to Edward L. Deci and Richard M. Ryan (1985) *“one is said to be intrinsically motivated to perform an activity when one receives no apparent reward except the activity itself”*. In the same regard, one is said to be intrinsically motivated when one is moved to perform an act for the fun of it or the challenge entailed rather than because of external pressure or rewards (Deci & Ryan, 2000). Intrinsic motivation was first acknowledged in animal behaviour studies. White (1959) discovered that many organisms engage in exploratory and curious-driven behaviours even in the absence of reinforcements or reward.

Deci and Ryan (2000) argues that in human beings, intrinsic motivation is not only a form of motivation, or even of volitional activity, but it is a pervasive and important one. Intrinsic motivation is a significant feature of human nature that affects performance, persistence, and the well-being across life's epochs (Deci & Ryan, 2000).

People are intrinsically motivated differently for different activities. It is therefore important to note that intrinsic motivation is situational and at times task specific (Deci & Ryan, 2000). However, Deci and Ryan admitted that their approach to intrinsic motivation is primarily psychological, meaning that they were interested in innate needs for competence and autonomy within the human conscious self. Serra and colleagues argue that in many countries, especially developing countries, social service industry particularly healthcare and teaching relies heavily on intrinsic motivation (2010a). In the same regard, Delfgauuw and Dur (2008), Prendergast (2007) and Fancois (2000) have shown that public service is mainly intrinsically motivated meaning that service providers in the public service exert more effort in their work and require fewer extrinsic incentives than profit-oriented service providers.

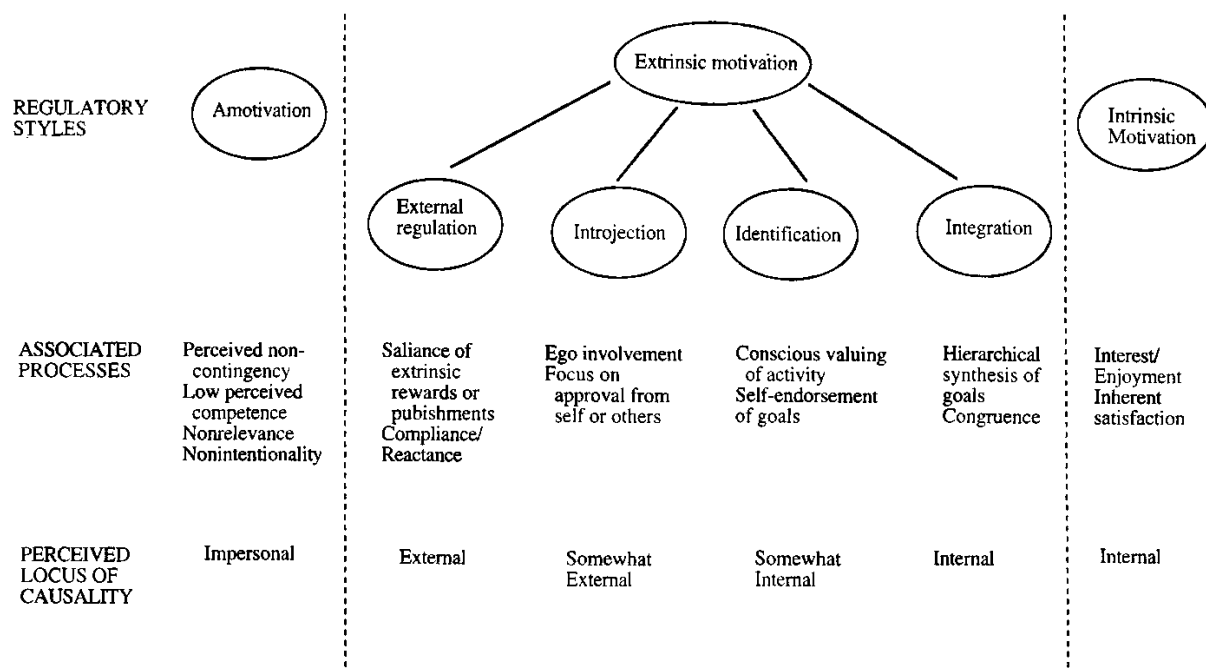
Extrinsic motivation

Extrinsic motivation is defined as *“doing an activity in order to attain some separable outcomes other than the enjoyment of the activity itself”* (Deci & Ryan, 2000). Thus the major difference between intrinsic and extrinsic motivation is the instrumental value carried by the latter. Although intrinsic motivation is arguably an important type of motivation guiding human behaviour, Deci and Ryan (2000), argued that in the adult world, the freedom to be intrinsically motivated becomes increasingly curtailed by social demands and roles we assume in society. The school system and duties we carry in the society makes it increasingly impossible not to be extrinsically motivated. Thus Deci and Ryan argue that it is better to see motivation as a continuum from amotivation to active personal commitment. The continuum is made possible by the process of internalization and integration of values.

Deci and Ryan (1985) defined internalisation as *“the process of taking in a value or regulation”*, and integration as *“the process by which individuals fully transform the regulation into their own so that it will emanate from their sense of self”*. Through this process of internalization and integration, one's motivation for behaviour can range from amotivation or unwillingness, to passive compliance, to active personal commitment. Figure 1

below shows the continuum of human motivation. The continuum represents the level of individual willingness when performing tasks. The left side represents the most unwillingness to perform a task, while external regulation is the most controlled type of external motivation by external rewards. Integration represents the least controlled extrinsic motivation by external regulation and can be classified as caused by internalization of values as much as intrinsic motivation. Individual behaviour however, can never be truly reliant on amotivation nor is it purely on intrinsic motivation. Hence the continuum by Deci and Ryan (2000) is very useful in understanding human motivation in choosing the careers, friends as well as routines in everyday life.

Figure 2.0: A taxonomy of human motivation



Source: (Deci & Ryan, 2000)

Usefulness of theoretical Frameworks

The underlying assumption of P4P in maternal health in Tanzania and in general is that it stimulates behavioural change by motivating health workers at individual and at facility level. Motivated health workers are perceived to perform better which is crucial in making maternal health services accessible, acceptable and of good quality. The theories are useful in analysing the experiences of nurses in nursing as a profession, the barriers to maternal health services as well as experiences, perceptions and expectations to P4P.

Chapter 5

Study Methodology

P4P being a new strategy in mother and child health, little is known in this area and its contribution to improved motivation of health workers which is presumably a precursor to improved quality of care. Given this background to the topic under study, I found qualitative research approach more appropriate in achieving my study objectives. The topic is explorative in nature and dealing with expectations and perceptions phenomena that are not easily quantifiable.

Qualitative methods are interactive and humanistic in nature (Creswell, 2002), and as such allowed me to interact with my informants, a key factor in getting informants' subjective meaning and interpretations to the study topic. Thus during fieldwork, I used qualitative tools for my data collection. The tools employed are in-depth interviews (IDIs) and focus group discussions (FGDs). In addition, I also made some informal observations and conversations that I found to be of significance to the study and more importantly, useful in data triangulation.

Study Area

Mvomero is one of the six districts in Morogoro region of Tanzania. It is bordered by two regions, Pwani Region to the east, and Tanga Region to the north. To the southeast it is bordered by Morogoro Rural District and to the west by Kilosa District. Administratively, Mvomero is divided in 17 wards and has 101 villages. Mvomero district's population is 260 535 (Mboera et al., 2007). It became an independent district in 2005 and previously it was under Morogoro Rural district.

Mvomero district's economy depends heavily on agriculture, mainly from crop production. Main crops in the district are rice, maize, cassava, fruits, and vegetables, as well as large scale sugar plantations and sisal plantations (Randell, 2008). In Mvomero district there is a sizeable population of the Masaai people who practice pastoralism. There are 56 health facilities in the

district including 3 hospitals, 7 mission hospitals, 4 health centres, and 42 dispensaries¹². The road network linking Mvomero and Morogoro is in good condition compared to many rural roads in developing countries and currently the road is under construction. The road is busy with local commuter buses which go as far as Dar es Salaam. However the main forms of transport linking villages and health facilities in the study area are bicycles and motor-cycles (Piki-Piki).

The health facilities in Mvomero district are strategically located and this is characteristic of the Tanzanian health system as also noted in other studies in rural Tanzania (Mrisho et al., 2008);(Mosha, Winani, Wood, Changulacha, & Ngasala, 2005). Health infrastructure coverage is high in Tanzania; however, the coverage varies between urban and rural areas with an estimated 90% of the population within 5km of the nearest facility (MOHSW, 2009).

The research was carried out at 5 health facilities. The health facilities are Mvomero, Makuyu, Hembeti, Dakawa and Milama. Four of these health facilities are public dispensaries with the exception of Milama which is a mission health centre run by the Roman Catholic Church (RCC). Dispensaries provide health care for the village level with the average number of 3-6 villages. The average population served by dispensaries varies between 3000-5000. Health centres provide health care at ward level (grouping of villages) and covers an estimated population of 50 000 (Canavan & Swai, 2008). According to MOHSW's stipulation, a dispensary is supposed to have 5 health workers, while a health centre is supposed to have at least 15 workers (Smithson et al., 2008). However, in practice Mvomero dispensary has 15 health workers, Makuyu dispensary has 4 workers, Dakawa dispensary has 7 workers, and Hembeti dispensary has 4 workers active by the time of the fieldwork.

Gaining access to health facilities, informants and participants

The study relied mainly on purposive selection of informants and participants. My informants were 12 for in-depth interviews, and 17 participants for focus group discussions (FGDs), which were divided into 3 groups. In choosing health facilities I selected facilities that were closer to Mvomero shopping centre where I was staying. Participants in women's focus group discussions were accessed at health facilities on a clinic day (a day for antenatal and postnatal care). Self-recruitment of participants was used for the five participants in each of the two

¹² List of Health Facilities acquired at the New District Offices of Mvomero near Dakawa

female groups. Purposive sampling was a suitable strategy for my research for both scientific and practical reasons; it gave me access to informants with the knowledge and information on the area I was researching on while on the other hand it enabled me to reduce cost.

Snow balling technique was used to access participants in men's FGD, this was suitable as it was difficult to access men at health facilities, and I had to use a friend¹³ to recruit participants in the focus group discussion. The basic criterion for being a participant in the FGDs was for one to be a parent. This was because the broad study topic under discussion was on maternal health care and as such being a parent was seen as a relevant impetus to the discussions. In addition, snow-balling was used for the access of the first 6 interview informants; this was mainly because I was still waiting for my research certificate from the National Institute for Medical Research (NIMR) in Tanzania although at this point I already had an Ethical Institutional Clearance from Ifakara Health Institute's review board (IHI-IRB). However, this influenced my access to informants as I did not have all supportive documents if needed. Due to this constrain, snow-balling technique became an efficient tool as I was relying on being referred to informants by other informants.

Data collection methods

In-depth Interviews (IDIs)

Twelve in-depth interviews were conducted with health workers to explore their perceptions, experiences and expectations with the P4P programme. The basic biographical information of my informants is summarized in table below. Interview guides were used in IDIs and the guides are attached as appendix A for the English version and A1 for the Swahili version. This type of face to face interview accorded me the opportunity to have a vivid picture of the informant's perspective and perceptions on the research topic while allowing me to maintain a minimal presence (Silverman, 2001). Eleven interviews were conducted in Swahili and only one in English. Although the interview guide was already translated to Swahili I still had to rely on the interpreter for probing and this sometimes breaks the flow of the discussion.

¹³ A man called Osama came to be my friend in Mvomero, he is a Piki-Piki (motorbike) rider and he used to take me around for my interviews. He also helped me in arranging and recruiting participants for FGD for men.

Table 4.0 Informants' Basic Information

<i>Pseudo-names</i>	<i>sex</i>	<i>education</i>	<i>Qualification</i>	<i>Job title</i>	<i>age</i>	<i>Years</i>
Memory	F	Form 4	Certificate in Nursing (3yrs)	Enrolled Nurse	40	15
Furuwa	F	Form 4	Certificate in Nursing (3yrs)	Enrolled Nurse	37	2,5
Mama Joyce	F	STD 7	Certificate in Nursing (1 yr)	MCHA ¹⁴	40	20
Rose	F	STD 7	Course in midwifery (1 year)	MCHA	47	6
Maidei	F	Form 4	Certificate in Nursing (1 year)	MCHA	37	2,5
Lydia	F	STD 7		Lab Assistant	35	10
Kudzai	M	Form 4	Diploma in Nursing (4yrs+ more training)	Clinical Officer	45	17
Nema	F	Form 4	Diploma in Nursing (4yrs)	Registered nurse	24	2
Mama Kuzini	F	Form 4	(1yrs training)	Medical Attendant	42	
Mama Pesa	F	STD 7	Certificate in Nursing (3yrs)	Public Health Nurse	53	32
Rumbi	F	STD 7	Certificate in Nursing (3yrs)	Enrolled Nurse	42	13
Rudo	F	Form 4	Diploma in Nursing (4yrs)	Registered nurse	28	5

Source: data collected from the field July-September 2010

The use of in-depth interviews was helpful despite the interruptions in that it elicited individual experiences, opinions and feelings in an unstructured talk (Kvale, 2007), to the extent that during one interview the informant had to talk uninterrupted for 20 minutes while answering this question: *What do those close to you say about your job?, i.e., your relatives, friends and colleagues.* In response to this question, the informant talked about how at one point there was an accident at work, and how she suffered, how she was not compensated, how she left the job and finally why her relatives want her to leave her current job. All this information she provided was however relevant to the topic. What intrigued me most as a researcher was how the interview method was able to establish a rapport between my informant and I and more importantly how this technique had managed to elicit such deep seated feelings from my informant.

¹⁴ Maternal & Child health aide – this cadre has been removed currently and replaced by Assistant Nurse

Mostly the interviews were conducted at a health facility except for two interviews. One was conducted in a local restaurant and another one at the informant's home. It was the informants given the nature of their job who could suggest the site of the interviews. I had to be always ready and patient.

Focus Group Discussions (FGDs)



(Source: fieldwork photo- men's focus group discussion, July 2010-Sept 2010)

Three focus group discussions were conducted during the course of the fieldwork. Topic guides were used in FGDs and are attached as appendix B for the English version and B1 for the Swahili version. Two FGDs were conducted with women participants and one with men. The groups for women were conducted at two health facilities which are Mvomero, a public dispensary and Milama, a Roman Catholic health centre. The groups were conducted in order to have the perceptions and experiences of the community with existing maternal care offered in the research area. The reason behind this selection was to find the differences in care-giving perceptions, if any, between public run health institutions and faith-based health facilities. The tables below present the basic information of my participants in FGDs.

Table 5.0: FDG 1 Participants' basic information (women's group 1)

Pseudo- names	Age	Number of Children
Dada	28	2
Fatima	25	4
Mama Irene	40	5
Mama Mkubwa	50	9
Mama Mdogo	38	4

(Source: data collected from the field July-September 2010)

Table 6.0: FDG 2 Participants' basic information (women's group)

<i>Pseudo-names</i>	<i>Age</i>	<i>Number of Children</i>
<i>Viola</i>	<i>32</i>	<i>5</i>
<i>Mai Two</i>	<i>40</i>	<i>6</i>
<i>Fadzi</i>	<i>20</i>	<i>2</i>
<i>Pendo</i>	<i>25</i>	<i>4</i>
<i>Tsitsi</i>	<i>30</i>	<i>2</i>

(Source: data collected from the field July-September 2010)

The number of participants in each of the women's groups was 5. This small number accorded every participant the opportunity to share their insights on the study topic (Krueger & Casey, 2009). The small groups in this context was suitable considering that I was conducting two separate women's groups which in a way was going to increase the range of my informants' experiences and perceptions on maternal care services (Krueger & Casey, 2009). The men's group was one and it had 7 participants. I increased the number of participants in this group in order to increase the range of perceptions and perspectives on maternal care services.

Table 7.0: FDG 3 Participants' basic information (men's group)

<i>Pseudo-names</i>	<i>Age</i>	<i>Number of children</i>
<i>Baba Mkubwa</i>	<i>55</i>	<i>8</i>
<i>Rafiki</i>	<i>34</i>	<i>3</i>
<i>Bwana</i>	<i>35</i>	<i>4</i>
<i>Mzee</i>	<i>60</i>	<i>7</i>
<i>Mushuwa</i>	<i>42</i>	<i>5</i>
<i>Munya</i>	<i>28</i>	<i>4</i>
<i>Mugo</i>	<i>22</i>	<i>1</i>

(Source: data collected from the field July-September 2010)

The idea of a male student researching on maternal care and moreover studying gender also intrigued my participants mostly in the male group. In reflection, I felt that conducting women

focus group discussions on maternal care was much easier for me than discussing with men on the same issue and this was beyond my assumptions. I remember asking one question:

Me: Do you accompany your wives to hospitals for check-up or for delivery?

Mzee: Yes we do but we just leave them there and come back ...

Me: Come back where? Don't you stay in the delivery room? Are you allowed...?

Mzee: Haha-h (laughing)...young man we don't do that, we don't break our culture and in fact you are not allowed to look at your wedded wife when she is not dressed...you embarrass her. Even our religion does not allow that...! And you said you have a baby where you there when she was born...I mean in the labour room?

Me: Yes I was there... (Hahaa...laughs from several men)...

Rafiki: So tell us what will women be wearing when they give birth?

Me: You mean you have not even asked your wife that...and how many children did you say you have once again?

Rafiki: Three...we don't talk such things!

Although during the analysis of my data this conversation did not even constitute a major theme, at the time the topic broke the momentum of the discussions in the group and nearly turned the FGD into a group interview with these two men.

Informal Conversations and Observations

During the course of my fieldwork I made observations that were useful in data triangulation. The access I gained into labour rooms at health facilities and the day I spent at Milama health centre antenatal clinic day enabled me to see the interactions between health workers and patients. In addition, I had informal conversations with community members and health workers during my stay in Mvomero concerning health issues in general and the relationship between health workers and community members.

In addition, I had informal conversations and e-mail answered questions by some officials working at the district offices in Mvomero, who wanted to remain anonymous. These observations and informal conversations augmented data acquired through interviews and in focus group discussions.

Documented Data

Many secondary sources were used in this study. These secondary sources were vital in the writing process of the thesis and in the triangulation of my data.

Language Barrier and the Interpreter Effect

This was my first research I had to conduct with the help of an interpreter. As such I had to prepare myself for the challenge by reading literature around the area prior in order to avoid pitfalls associated with the use of an interpreter in social research especially in cross-cultural studies (Freed, 1988).

In Tanzania Swahili is the official language as such it is the formal language of communication in the country. Although English is also recognized as an official language few people especially in rural areas are conversant in it. However, Swahili and Shona (my mother language) are both in the Bantu languages family and as such the vocabulary, meanings and sounds in Swahili were not completely foreign to me. To the extent that by the time I had my last interviews and FGDs I was in a position to interrupt if I needed to probe before my interpreter's help as I was getting the general meaning in responses and arguments.

Using an interpreter is exhausting and gives extra responsibilities (Jentsch, 1998). The interviews did take longer time than usual but my interpreter, Rogers.M.D. Kabesa¹⁵ is fluent in Swahili, English and we got along easily. As a researcher the experience was rewarding to see how I was able to handle my first fieldwork that needed an interpreter. All the interviews except one were conducted with the interpreter's help. However, I was happy that I had one interview in English and I had to use this interview as the yardstick during the transcribing and editing process to see the similarities and differences and what could have been possibly gained or lost with the use of an interpreter.

Ethical Dilemmas and Considerations

The research proposal was approved by the Norwegian Social Science Data Services (NSD) in Norway and by the National Institute for Medical Research in Tanzania (NIMR). In Tanzania

¹⁵ Rogers. M.D. Kabesa is an Advance level (A Level) graduate who plans to join a local University in Tanzania.

I was hosted by Ifakara Health Institute, as such the Ifakara-Institutional Review Board (IHI-IRB) approved my research proposal first before it was forwarded to NIMR.

Participants and informants in this study were informed about the research and its objectives. Participation in the research was voluntary and informed consent forms were used but not everybody returned them. However, as according to Davies (1999) it is the acceptance of the informant to take part in the research that matters most. Permission was asked to use an MP3 voice recorder mostly because of the language barrier

Reflexivity and Positionality

Getting access to my research area was more difficult than I thought. Due to my immigrant status in Norway I was suppose to apply for a referred visa whose processing period could take up to four months . As I was still waiting for my research certificate, it was impossible for Ifakara Health Institute to write an invitation for me which could have made the process much easier. I therefore had to travel through Uganda where I got Tanzanian visa after two weeks of stay.

The ordeal helped me to focus on my research topic and redefine my position. The challenges I faced in Tanzania, like the language barriers and delays in the research clearance process were to me far less difficult to deal with as compared to how I got the travel visa. In other words, I was not so much worried about the differences I had with the people of Tanzania but I was trying to concentrate on the aspects we had in common. The language barrier was not so huge considering that Shona and Swahili are all Bantu languages, the dressing, culture and food was not so foreign to me. I felt like an insider-outsider throughout my stay in Mvomero.

However, my identity as a male student studying gender was one thing that at times intrigued my informants especially male informants. At times they could ask why I was studying a programme considered to be for 'women' and moreso researching on women's health issues. Trying to explain my positions and research interest was one thing that was so difficult than I thought. All in all this made me to realize how vulnerable I am sometimes as a researcher when researching on 'non-traditional male issues'.

Chapter 6

Utilization of birth care services: the experiences of providers and users

The overarching goal of pay for performance in Tanzania is to increase and improve the availability, accessibility, acceptability and quality of care in maternal and child health in particular and health delivery in general. This chapter will discuss factors in the study area that affect availability, accessibility and acceptability of maternal health services.

The chapter will be divided into two major sections. The first section will look at the provider side factors that have an impact on the utilization of maternal health care. It will consider supply shortages, understaffing, unqualified staff, staff attitude as well as the role of informal payments. The second section will look at user side factors that affect the utilization of maternal services, which are economic, social and cultural. The chapter is based on data collected through interviews with health workers and focus group discussions with community members.

Provider side factors

Supply shortages

In all three focus group discussions with community members and in interviews with health workers, shortage in equipments and medication emerged as a major issue. The shortage of proper equipments and medication in many cases did not encourage mothers to seek maternal health services at primary health care units (dispensaries and health centers). Under such circumstances mothers are normally left with two options, either to deliver at home or to visit either secondary or tertiary health facilities. The following quotation from Dada exemplifies this:

“Like myself I went to give birth in Moshi (a district in another region) [...] because here there are no instruments and I was supposed to buy everything.”

By-passing of a primary health care unit tended to be a common problem in the study area. This tendency is linked to a number of factors including supply shortages. Mothers are

expected to contribute to the delivery kit in order to get services. They tend to prefer secondary and tertiary health facilities which are better equipped and better prepared to handle any complications that might arise as shown in Fatima's decision:

"[...] well I had my first child here (Mvomero Dispensary) [...] but the other one was not here because I didn't feel that it went well here with the first one so I decided to do it in another place. I was afraid since the instruments are not good they might refer me to Bwagala¹⁶ so I decided that it is better I go there to Bwagala myself, it's a mission hospital aah...."

In this case the decision by Fatima to by-pass the PHC unit and go Turiani Mission Hospital was influenced by her previous experience.

Old and broken equipments

The lack of testing equipment at health facility in the study area was cited in FGDs as a reason that affects nurses' ability to provide good services and this lead to either treatment without conducting proper tests, late or undue referrals in maternal cases. Baba Mkubwa in the following quotation shows that:

"That's why I'm saying these nurses they don't have instruments like to see if its time or not (delivery time) so that's why I say instruments also contribute a lot because those instruments can tell her the patient's condition, like if the baby is big or if there is a condition that needs a big hospital for an operation so that the baby can come out [...]."

Lack of basic EmONC affects the nurses/midwives' performance in carrying out their duties. At Hembeti dispensary, the facility did not have a baby weighing scale, instead, the health workers had to weigh the baby held by her mother and then less the mother's weight. This procedure is not as reliable as using a proper baby weighing scale. At other health facilities in the study area, equipments were not available, old or broken. At Milama health centre during their ANC day, the midwife's stethoscope was broken and she could not take the blood pressure of pregnant mothers. The midwife had to wait for the doctor to borrow his stethoscope. Dakawa dispensary did have a birth scale but was not in working order. This lack of proper functioning equipments negatively impacted on the performance of health workers.

¹⁶ Bwagala is also known as Turiani Mission Hospital it offers Comprehensive Obstetric Care and is used as a referral centre by Health Facilities in this study.

Electricity

Shortage in electricity supply was mentioned as a major challenge in the study area. The electricity meters that are being currently installed by TANESCO¹⁷ at health facilities in the study area are pre-paid which means the units had to be bought before use. Nema in the following quotation shows the dilemma this can cause:

“We don’t have a sterilizer, they had it before but now it’s broken we have to boil and gasoline is a problem. They (DMO’s office) used to bring it but now it can pass almost 2 or 3 months without it so it’s a bit difficult, if you get a mother after you have attended her you have to go and buy gasoline with your own money to boil the instruments so that they can be used to another mother [...] we had electricity meter here but they cut it because they didn’t pay the bills and now they have put pre-paid meter and if we run out of units I don’t know who will refill, like now it’s out! Imagine if a mother comes here in the night and there is no electricity. How can you help her, it is a problem if she comes here and it is dark. Of course she will turn and go back.”

The use of pre-paid meter at a health facility does not auger well for the utilization of maternal health services. The situation is worsened by the fact that the supply of gasoline which is the substitute of electricity to the dispensaries, seem to be erratic. A dark health facility at night obviously discourages mothers to come for deliveries. To keep the health facility open, health workers at times use their own money to buy gasoline. In addition, the unavailability of basic equipments such as sterilizer offers great risk to health workers against infections and HIV was the most mentioned by informants.

Understaffing

The issue of understaffing was raised as a major concern. FGD participants thought this was associated with increased risk of complications during pregnancy and birth:

“[...] so they must add more nurses [...] and one doctor for helping us [...] because most pregnant women are susceptible to many kinds of diseases that can cause many deaths.”
(Mama Irene in women FGD1).

¹⁷ Tanzania Electricity Supply Company Limited

Health workers in the study area generally tended to agree that there is shortage of health personnel at their health facilities. Understaffing was identified by health workers as a factor that contributes to work pressure, working long hours and to the general dissatisfaction with work. Work pressure contributes to poor staff attitudes and also impacted on the quality of services offered. Here is what Rumbi had to say about understaffing:

“Like in this village, like here we are few here, you know, so we don’t have that time table and no shifts like now you can see we are 3 nurses and 2 doctors and this area is very big. Our service area starts here up to Ranchi, Sokoine all they come here so you may find that you don’t have time to rest, I can work here until 4pm and when you go home then you may find they come to call you and you are back again at work and in the night you may find yourself still at work and in the morning you have to prepare again to go to work because we are so few. If we were many then there was going to be a schedule. So sometimes you may find yourself thinking or saying you wish you can work with something different.”

When a health facility is understaffed, workers end up work for long hours. Working long hours affects the morale and work attitude of health workers. Nema, a nurse, questions the deployment policy at health facilities:

“Here we are only 2 nurse/midwives so if one goes on vacation then its only one remaining. This can be a little bit demanding, but they say in dispensaries it has to be only 2 nurses, well I don’t know because in other centres there are more than 2.”

Inconsistency in deployment policy is also another issue that can demotivate health workers. Health facilities that are classified in the same group at times have different numbers of health workers regardless of the fact that these health facilities’ catchment areas are relatively similar. For example, Hembeti dispensary had a total of 4 health workers and it serves 3 villages, while Makuyu dispensary had the same number of workers but serves 6 villages.

Maidei also reported the lack of adequate staff. When I asked her to describe to me her previous day’s work here is what she had to say:

“[...] like yesterday I didn’t sleep, like even the day before I was here until 6pm when I went home I came back at 8pm and I left 11pm so when I was home around 1am they woke me up.

So we work in all departments and help each other like here we are very few so team work is important. [...] so if those in laboratory clinic they don't come to work I have to go there and attend patients, I can give injections, doing testing and after that maybe there is need to put the drip on other patient or giving medicine or take in payments, so you know it's like doing everything.”

Maidei is a nurse/midwife but does almost everything including being a cashier at times. This highlights the pressure of work when health workers are few at a facility. The pressure of work when workers are few at a facility was experienced as a major challenge by health workers.

Unqualified staff

While understaffing emerged as a major talking point of health workers, the community members also raised concern over the qualifications of health workers who are posted at dispensaries. Mzee, a participant in men's focus group discussion, questions the competence of health workers at his local dispensary:

“[...] so we don't know because it is a dispensary maybe and not health centre so that's why they bring unqualified personnel because if they were qualified for the dispensary they were supposed to be able to write.”

Rural health facilities normally have a challenge in attracting highly qualified health personnel. Highly qualified health workers prefer to work in urban centres where they have more opportunities in career growth. In addition, urban health workers in urban centres have chances to find other sources of income and as such do not only have to rely on their salaries. Of all my informants, only three out of twelve had diplomas in nursing (which is the highest qualification in nursing in Tanzania), the rest had certificates or were enrolled nurses. This point to the same factor that rural health facilities have challenges in attracting qualified staff.

Poor responsiveness

Positive staff attitude was noted in all FGDs with community members and some in-depth interviews with health workers as an important factor decisive to the utilization of available maternal health services. The nurses/midwives were accused of using abusive language, lack

of compassion, lack of communication and sometimes making undue referrals. The following statement illustrates the poor attitude towards patients:

“Well sometimes you go there and the nurse may say oh wait I want to eat and you are in pain so with that experience at a clinic next time you will make a decision yourself to go to the hospital or do it at home because of that thing you encounter at clinic aah.”(Viola in women FGD 2).

Poor responsiveness to patients affect acceptability of maternal services and this sometimes lead to mothers by-passing the primary health facility for a higher level facility or to prefer a same level facility that may be far from where they live. Previous experiences at a health facility are crucial in shaping the choice of the place of delivery as highlighted in Viola’s quotation.

Abusive language

Some health workers admitted the use of abusive language to patients at times. This could be seen as an implication on the frustrations caused by the workers’ environment, as the following quotation from Furuwa, a nurse/midwife demonstrates:

“For me what I don’t like is the attitude and bad behaviour for some of us nurses towards patients, so that’s the thing I don’t like for example to a pregnant mother who sometimes come here to give birth and she is in labour which means she is not in good mental status already so she gets here and complaining much about pains then we start saying bad words or cursing her, so those things I don’t like it at all [...] and even me I strongly condemn that and I usually try tell the nurse no that’s not right.”

The use of abusive language affects the utilization of maternal health services. Although health services might be available, their acceptability mainly depends on the attitudes of health providers towards patients. Mama Pesa, a nurse/midwife, claims that poor staff attitude is more detrimental to the acceptability of maternal services than shortages in supplies or working conditions:

I will tell you something the biggest thing is this (pointing the mouth) forget the equipments forget whatever or anything else even a donor or aid may come and they bring everything here and build even houses but here (pointing her mouth) if you can't fix it then there is nothing, so the biggest and most important change is suppose to be our language, to us nurses the language we use is bad sometimes truthfully speaking. I might be one of them too because I'm a nurse [...] yeah because we are all nurses who else then so there's a bad attitude towards patients that why some of them are running away and give birth in bushes and some are dying because of our attitudes, the language we use to them, so language and attitudes are the biggest change we need [...]."

Informal payments

Informants in focus group discussions reported that at times people had to informally pay money to get services at local dispensaries. Cases of bribes and favouritism were raised in the discussions. Many reasons were offered for these informal payments. They varied from low salaries given to health workers to shortages in supplies as the following quotes exemplify:

"Yes if you get a service because you paid well that is your secret you can't say it to anybody. Do you think if you have money you can't get all those services and things they say they don't have? The most important thing is money [...] do you think if you go there with 10 000 (T.Shs)¹⁸ well it's faster but if you don't have even a T.Shs 10 do you think somebody will care about you and this is not only here (Mvomero Dispensary) but even in other government hospitals like Mwananyamla, Amana, Muhimbili." (Mama Irene in women FGD1).

Informal payments are triggered by shortages hence service users have to seek favours from providers by providing extra incentives in cash or kind. In certain instances, services providers end up asking for informal payments as a precondition for service provision. In this case, access to services becomes a privilege to those who can afford extra payments and not a right to everybody. There can be several reasons for the demand for informal payments, in the following citation, Mama Mkubwa highlights at one of them:

"There are those who are up and those who are down (meaning the rich and poor). Those who are down (the poor) they are not allowed to give birth (because they cannot afford to pay

¹⁸ Ten thousand T.Shs is slightly less than USD 7

bribes). *It's like give me something [...] do you think someone can stay until the end of month with no allowances, no, and now bribery is everywhere...*”

Low salaries and lack of attractive allowances can also support the culture of informal payments. In the Tanzanian context, principally maternal health is free of charge, but due to shortages mothers are expected to contribute to the delivery kit and this at times might also be misinterpreted by patients as an act of corruption by health workers as highlighted:

“Some they behave in a good way [...] but others when you bring a mother it becomes an issue oh go get gasoline, go get gloves and when she delivers you give them money those kickbacks. They are getting paid by the government but you have to give them money [...] so that thing is disturbing.” (Bwana in men's FGD).

Although Bwana is accusing the health workers of the so called ‘kickbacks’, this citation highlights more on the policy of cost sharing in Tanzania which demands women to contribute in form of delivery kits. This principle requires mothers to contribute with things like gloves and razors to the delivery kit. The principle of cost sharing though seems to contradict the fact that maternal services are supposed to be free of charge. It is difficult for service users to reconcile these two principles in health services in Tanzania.

Health workers in interviews did not totally disregard claims of bribes by the community members. When I asked Mama Pesa if they take any bribes from patients here is what she had to say:

“We have learned from the past that if somebody comes here with money and you attend to him first, then you become a slave. He may just request a stupid thing or tell you to come to his home to attend him there and because you have already taken his money then you must go, and if you go there what about the other patients that need you here. I also see that as degrading yourself why don't you be proud at your work place.”

Mama Pesa is not declining the existence of some kind of informal payments. Whether the payments are ‘asante’, money given as a token of appreciation or ‘chai’, money that can be considered as a bribe for services, it is not explicit. What is clear though is that the payments seem to be client oriented according to nurses although Bwana argued otherwise above.

Health workers claimed that informal payments are degrading as they provide platforms for clients to ask for unreasonable favours from health workers.

User side factors

This section presents user side factors that affect the accessibility of maternal health services in the study area. The section will look at the lack of transport, lack of money, the role of TBAs and beliefs. These factors together with the provider side factors presented above have an impact on the acceptability and accessibility of maternal health services.

Lack of Transport

Lack of transport was noted as one major challenge for health facility delivery. In case of emergencies, mothers and their families had to figure out how to get to the health facility. The easiest and cheapest means of transport for people in the study area are bicycles and Piki-Piki¹⁹. These types of transport are not proper for a woman who is in labour or pregnant. In addition, not all households had ownership to a bicycle or a Piki-Piki. Those villagers who do not own a bicycle have to hire or borrow from their neighbors or relatives. Here is what Tsitsi had to say:

“[...] your relatives or your husband must try to find transport and imagine if it is an emergency and in the night”.

In the interviews and focus group discussions, husbands and relatives were mentioned regularly as very important in the organizing of transport. In addition, the decision on which type of transport to use was mainly based on the husband’s ability to pay for the means.

Transport is a major challenge especially to communities that live far from health facility. Mama Two, a participant in women focus group 2, live in one such a village that is far from health services:

“You know some live far away like Makuture and its very far...and the hospital do not have ambulance...sometimes you can use a boda boda²⁰ but sometimes aah you can’t [...] and some give birth on the way”.

¹⁹ Piki-Piki is a local Swahili name for motor-cycles that are used for hiring.

²⁰ Boda Boda is used interchangeably with Piki-Piki. This is a motorbike that is used as a taxi.

All these statements point to the fact that transport is a very big problem in the study area. The area has relatively good roads for a rural area in Tanzania but it's the means that is not available. Tsitsi's quotation also reveals men's role when it comes to maternal issues, in many instances there were nuances that suggest that men's major role in the pre-delivery phase is the sourcing and organizing of transport means to the health facility.

Lack of Money

In all focus group discussions, affordability of maternal services was also mentioned as a factor that limits the accessibility of these services in the study area. Maternal health services are principally free in Tanzania but as mentioned above, mothers are normally requested to contribute to the delivery kit through the policy of cost sharing. The study area's main economic activity is agricultural, which is seasonal and affected by many uncertainties like droughts. Milama a Roman Catholic mission health centre, charges 5000 T.Shs per delivery (which is equivalent to US\$3.50) but more often the amount becomes more including other costs on medication and other hidden costs. The following quotation from Fadzi, a mother of one in women FGD 2 clearly reveals this dilemma:

"[...] and that's 5.000 T.Shs (delivery fee) without anything else and if they put you on drip that means more than that. So if they put drip it could reach up to 15.000 or 20.000 T.Shs so either you sell something in order to pay."

Selling of one's possessions is one way used to source for cash to settle hospital bills. In this group I also asked my participants why it was difficult for them to pay for the charges considering that they are farmers. To this, Pendo, a mother of three, offered an explanation:

"We do farming yes but it depends on the season. Sometimes there could be shortages in the rain or the season is not good like you may go to the farm and you come back with only 1 packet of 60 kgs and in the family you are 5 or 6 people and that is not enough even to supply things in the family."

Erratic droughts in Tanzania affect many rural families' sources of income. Many rural families in rural Tanzania rely on subsistence farming and as such less rain means less income

and food. This makes maternal services more inaccessible to many families as Pendo points out.

Decision Making

Decision making on whether to deliver at a health facility for a woman is mainly influenced by those around her especially her spouse. The economic status of the husband mainly influences the choice of place of delivery. The husbands' main role in maternal health is in the decision making and sourcing of money for payments at the facility and for transport to the health facility. In the FGDs, both in men and women's groups, it was noted that the husband's major household role is to make important decisions for the family. In the case of Fatima, her husband made the decision to go to Turiani mission hospital:

“As for me my husband told me to go to the hospital. When I went for ANC at the dispensary, they told me that I might have complications and advised me to go further and he said Ok and the nurses referred me to a bigger hospital.”

Husbands made the final decisions in most families in the study area and this seem to reinforce the traditional perspective on gender and household roles in Tanzania. In addition, Bwana, a father of four, confirmed that it is the husband's duty to make the decision for the place of delivery because:

“The mother at that time is in pain and can't make decisions so it's me who must decide [...] and in our case we went to the hospital.”

For Bwana to say that he made the decision since his wife was in pain may be seen as a way to justify his decision making role in the household.

The role of Traditional Birth Attendants (TBAs)

Health workers had a divided opinion over the role played by TBAs in maternal care, to others the availability of TBAs was viewed as a barrier for facility delivery. Their point of departure was that TBAs discourage women to go for facility delivery so that they can get 'clients'. Others felt that the availability of TBAs meant it was easier for mothers who then do not have to walk long distances or worry about transport to go for a facility delivery. The other opinion

was that TBAs assist health facilities in mobilizing for facility delivery. The health workers in general wanted TBAs to assist in mobilization for facility delivery while not performing deliveries. In the following quotation Mama Pesa sees TBAs as taking advantage of the people's beliefs to make a living:

“They are told that if there's patient from your area you just take the patient to the hospital but you just carry with you the delivery kit maybe by accident if the mother gives birth along the way then you can help her but now they say thanks, and they see that as a form of employment they get a little bit of soap, some money to buy food.”

In Mvomero TBAs were given delivery kits to use in emergency situations. Instead, some TBAs are now taking advantage of that to make a living by the 'asante' they get from the clients they assist.

However, health workers also noted a positive role played by TBAs in assisting 'safe motherhood'. Some TBAs are professional in doing their duties, they only assist deliveries in cases of emergencies and when they do so they send reports to the health facility. Some TBAs know that their basic work is to assist in the mobilization for facility delivery. Mama Pesa knows one TBA who is like that:

“We have one Masaai mother who is a qualified TBA. If she has a case which she knows something and she knows that this one I cannot help or this I can help so she knows and she brings them to the hospital and when she gives us a report she will tell you how many referrals she made [...] if you give a motivation to somebody like that what do you think? She will work more and assist people.”

Local Knowledge Systems

Intricately linked to the preference of home delivery and TBAs, are issues that deal with community beliefs and their knowledge systems. In interviews, health workers acknowledged that there are practices at health facilities that go against the beliefs and ideals of health services users. Elements that were cited to be in conflict with health facility requirements were: preference for traditional medicine and difference in birthing position. Furuwa, a nurse midwife commented on the use of traditional medicine:

“They come here when they are pregnant, almost all of them they do attend clinic but when it’s time for giving birth they don’t. Many tend to do it in their homes with a traditional birth attendant. This is a village, well I think many tend to do that in their home because sometimes they don’t want to be in labour for long so they usually want to take the traditional medicines which they believe would reduce the pains and that we don’t allow here so that is another reason too.”

These beliefs to a lesser extent show why some community members do not use health facilities for delivery even if they live so close to the facility. In addition, some women do not find the services offered by health facilities as culturally appropriate especially on birthing position. Nema a nurse/midwife experienced this challenge before:

“Our services are culturally appropriate but others, maybe a Sukuma mother is her 14th or 13th, 9th or 5rd pregnancy will come with all these having been delivered at home, so when she comes and she is in labour then she will say I have delivered all my children on ground or just bending which is not good. So you will tell her that you are in hospital now so you must do as we tell you. If she says she doesn’t want then you can ask her why did she come to the hospital then? [...].”

TBAs are members of the communities they serve and as such share similar cultural norms, values and belief systems with their ‘clients’ and this make them attractive to certain community members who want to preserve their identity and belief systems.

Discussion

This chapter demonstrates that provider side factors play a major role as barriers to the access of maternal health. The same conclusion was reached by Mæstad’s study in Tanzania in 2007. The study points at low utilization of maternal health services as caused mainly by provider side factors. Shortages in medical supplies and human resources at health facilities impacts negatively to the accessibility, acceptability and quality of care. These shortages lead to practices that are not beneficial to health care provision. We have heard Mama Mkubwa and Bwana (*see page 50*) complaining about perceived corrupt activities by health workers. Mama Mkubwa had a strong belief that economically better off patients get better services because they are able to bribe health workers than poor patients. In their study in Rwanda, Serneels

and Lievens (2008) found out that there was a lot of embezzlement of drugs and favouritism in public health facilities. They attributed these malpractices to shortages in supplies, poor working conditions and poor rewarding mechanisms.

Mæstad and Mwisongo's study in Tanzania in 2011 found that informal payments lead to 'rent-seeking' behaviours, a situation where health workers create artificial shortages to solicit extra payments from patients. In their analysis, they found that informal payments had some positive and negative consequences to the quality of care and retention of health workers. Positive in that informal payments encourages retention and negative in the sense that health workers might deliberately lower the quality of service to get payments (Mæstad & Mwisongo, 2011). Stringhini and colleagues (2009) had almost similar findings in their work in Tanzania, however, contrary to the traditional belief that bribes are initiated by health workers, they found that informal payments in the context of Tanzania are mostly client-initiated. In addition, health workers reported that the bribes lead to them losing self-esteem. In this study, Mama Pesa (*see page 50*) also mentioned the loss of self-esteem and enslavement as negative effects of bribes. Under normal circumstances, health workers in Tanzania seem not to prefer bribes. However, the fact that informal payments are mostly client oriented does not exonerate health workers from wrong doing, due to 'rent seeking' behaviours, health workers induces patients to offer bribes.

The most important aspect in health care provision is trust between service providers and clients/patients. Trust between a health worker and patient is vital in defining the perceptions each carries for the other and ultimately to the quality of care. The study indicated that the relationship between the provider and client in the study area was characterized by some degree of mistrust. The community members in FGD felt that the nurses were neglecting them. On the other hand the nurses lacked basic EmONC to perform their duties expeditiously. The study by Mrisho and colleagues (2008), in rural Tanzania found that community members accused nurses of lacking compassion.

As in this study, the use of bad, demeaning and provocative language was noted. Mrisho's study was mainly focusing on the community members' perceived views on the choice of a place of delivery hence the nurses did not have an opportunity to answer to some of the factors that were raised by the community members. In this study, the nurses did not deny the use of abusive language at times but argue that this negative attitude towards work is mainly

caused by the frustrations around them in terms of shortages in supplies and unfavorable working conditions which are the subject of Chapter 7.

Amooti-Kaguna & Nuwaha (2000) in Uganda and Brieger and colleagues (1994) in Nigeria, found negative staff attitude as a major barrier to the use of maternal health services. Due to the negative attitudes towards work and patients, the nurses are at times accused of poor responsiveness and making undue referrals. This was repeatedly mentioned in FGDs with community members, an accusation that health workers denied. However, as this study and Mrisho and colleagues' study reveals, the accusations and counter-accusations are symptomatic to the lack of a clear communication process between nurses and patients.

In general terms, health workers in the study area are highly demotivated to perform their duties. As mentioned earlier, the nurses are frustrated since they are the easy targets for blame when health services are of poor quality. Indications are that facilities in the study area are understaffed and poorly equipped. Mæstad (2007) found the acute shortage of and lack of essential equipment and supplies for emergency obstetric care. He found that 52% of health centres and 70% of dispensaries experiences these acute shortages (Mæstad, 2007).

The supply shortages are compounded by understaffing which means that the few available health workers are over-stretched, under pressure and under great strain to try to provide the best services they can in the circumstances. The acute shortages in BEmONC coupled with accusations of under-performance seriously damage the morale of health workers in the study area. There are elements of care provision beyond the power of nurses; a good example in this study is the lack of electricity at public health facilities in the study area. TANESCO, a public utility for electricity in Tanzania, during the time of the fieldwork was in the process of installing pre-paid meters at dispensaries in the study area. Pre-paid meters mean that without paying first, health facilities do not have electricity and consequently patients cannot come to seek care at 'dark' facilities.

Although health system factors are seen as crucial in this study, user side factors also play a role in the accessibility and acceptability of quality maternal services. User side factors such as lack of transport and money to pay for transport or to buy unavailable provisions at the health facilities were mentioned as barriers to the accessibility of health services in general and maternal services in particular. This highlight gender role in maternal health in the study

area, in the study area, it is considered a man's duty to provide for health bills. In a way it shows men's privileged economic position.

Decision making which is important in deciding the place of birth to avoid delays in maternal health is a male preserve. According to Connell (2002) man still maintains a dominant position despite in many societies despite the fact that liberal theorist propose otherwise. Mrisho (2007) also found that decision making on the place of delivery is still much considered a male preserve in rural Tanzania. In addition, social and cultural factors seem to play a cameo role in the accessibility and acceptability of maternal services. Despite the availability of health services, the utilization of such services in Tanzania is low. This can be illustrated by the great difference between antenatal care (ANC) and deliveries at health facilities.

According to the demographic health survey in Tanzania 2004-05, 94% of pregnant women receive ANC but of this number only 47% deliveries take place at health facilities in Tanzania (DHS, 2005). The reasons for this low utilization of delivery services can be found both on the provider and user side. Some service users would prefer to give birth with the assistance of TBAs. These preferences highlights on the unacceptability of some services offered at health facilities. The birthing position is one example that was mentioned in this study. Brieger and colleagues (1994) in their study in Nigeria concluded that the provision of relatively accessible maternal services does not guarantee their use if social and cultural factors are not taken into consideration.

Conclusion

The chapter has shown the importance of provider side and user side factors to the accessibility of maternal health services. The first part presented provider side factors while the second part presented the user side factors. By and large, provider side factors seem to play a major role in determining the utilization of maternal health services.

The following chapter presents the perceptions and experiences of nurses/midwives with their work. These perceptions and experiences seem to be shaped by factors discussed in this chapter. The level of accessibility, acceptability and quality of care of maternal health services has a bearing on health workers' motivation and performance.

Chapter 7

To be a Nurse: Perceptions, experiences, motivation

Chapter 6 looked into factors perceived as barriers to the accessibility and acceptability of maternal health services. Through the dialogue between the provider side and the user side, we explored the relationship between health workers and patients, their aspirations and challenges in giving and receiving care.

This chapter is looking into perceptions and experiences of nursing and midwifery as work. These perceptions and experiences inform us of the nurses/midwives' values, and needs which are important when it comes to their motivation, which P4P strives to support. It is divided into two major sections. The first section will present the general perceptions of nursing from health workers' perspective and the second is on the working condition and environment.

Nursing/Midwifery in perspective

This section will have four major sub-headings. It will look at nursing as a demanding profession, nursing as a profession that requires dedication and commitment, the balance between encouragement and force and lastly community and family role in nursing. In short the section brings out nurses' reflections about their profession, what they like and what they do not like.

Maternal health as a priority area

Most health workers interviewed described nursing as a challenging and demanding profession. They singled out MNCH as the most demanding part in their job. MNCH requires more time and attention. MNCH was described as a 'delicate' section that requires knowledge and right skills. In MNCH the pressure is added because the nurse/midwife will be "trying to save two lives." Most of my informants as Rose described their job as tough:

"Well the place where they need me most is mother and child section (MCH). You can go there thinking you will work for a short time and then more mothers may come and suddenly you are stuck there than you thought."

MNCH is one of the busiest departments especially at primary health facilities. Health workers indicated that team work and right skills are important in a maternal case. Kudzai emphasized on the need to offer quality services in MNCH:

“I like to deliver a high quality service [...] in general but my concentration is pediatric and reproductive services because those areas are very sensitive, if you are not serious you lose a lot of children and mothers and that’s why even though I might be in another department when a maternal case comes in, I will make sure to offer my knowledge and assist the nurse or nurse/midwife to make sure we deliver a quality service so that we won’t lose the mother or the baby.”

Maternal cases needed urgency and health workers were quite aware of the fact. Reducing delays at a health facility when a maternal case shows up is critical in reducing maternal mortality. Maidei prioritizes maternal cases than other patients which she refers to as ‘normal patients’, especially in the study area where transport used by the expectant mothers is at times risky or not easily available:

“When you are called you ask if it’s a mother or normal patient. If they say it’s a normal patient then you can continue to eat quickly and then you go and attend but if it is a mother you will stop eating because a mother is in more danger. A mother can come with a broken womb because of the transport they use and at times the head of the infant is already out so if you are late she can deliver here (Where we were having this interview) or die, then words will go out quickly that there is lack of professionalism at the clinic.”

For optimal utilization of the services offered, a health facility depends on a good image. Loss of life at a health facility is not considered a random occurrence but connected to lack of professionalism by community members and as such members in the community can avoid services offered by the health facility. These types of pressure health workers are subjected to, lead Lydia to describe the profession as demanding:

“[...] well maybe I could be a kindergarten teacher you know for us we don’t have leave or anything and we work from early morning to evening, from January to December and from Jumatatu hadi Jumapili²¹.”

²¹ Jumatatu hadi Jumapili is Swahili meaning Monday to Sunday

Understaffing that had been raised in Chapter 6 is mainly responsible for the work pressure workers in the study area are subjected to.

Dedication and Commitment

Nursing was described as a profession that requires dedication and commitment. Most of my informants liked their job despite admitting that the work environment is not conducive. To them nursing is a job they will do until they retire. They do not want to change professions but need improvements in their work conditions. If conditions at work improved the health workers would be more motivated to do their job. Nema in the quotation below shows how she is committed to her job:

“If I had another chance to choose a new profession, I could choose nursing, I like it. When I finished secondary school I talked to my father that I like to be a nurse and he enrolled me to nursing college. If I will stop doing this, hospital work, well I don’t know what I will do as I have it in my blood and heart. This means even if I stop I will still have it”.

When describing nursing, most of my informants used words like ‘blood and heart’, in trying to show how emotionally were they connected to their work. Some mentioned names like Florence Nightingale and Mother Theresa as role models and people who inspired them in their work. There was a connection between nursing and ‘volunteerism’, a connection that can typify low salaries associated with the profession but more importantly a good ‘heart’ as Maidei stated:

“Like what I could do, I could do business [...] well because in nursing first and foremost you have to be very dedicated and have a good heart, it’s like volunteering, and secondly you meet people with different knowledge and levels of understanding and your heart is tested every time.”

Due to the conditions nurses are associated with such as low salaries, lack of allowances, pressure at work, poor working environment in general, leaving nursing for other professions is one option available to nurses in my study area. The option considering the time they invested in training is not so easy hence the more qualified will opt to move to urban areas or overseas for better working conditions and remunerations.

Role dilemmas

Informants in the study reported that they commonly struggled with the balance of encouraging their patients and what might be interpreted as the use of force. The nurses explained that their major concern was to provide the best possible care and at the same time maintaining a good relationship with their patients which to them seemed to be a delicate balance. The nurses reported that their ultimate goal is to save a patient's life while at times the patient might not be cooperative. In cases like this, nurses had to raise their voices, in need of offering best possible care available. Furuwa had this to say:

“You know that what they believe is that nurses are a problem and not sensitive, you know sometime when somebody is in the delivery room and you are telling the patient maybe to lie the proper way to be able to deliver without a complication and the patient could resist so maybe you have to raise your voice just by helping so I don't know if it's that or what [...] but you might be helping and they will say aah that nurse is very strict something like that. Sometime we do have a relative in the delivery room and that relative could be shouting more than the nurse [...]. Complains don't come from the patient mostly, but from the relatives in the delivery room. The patient say thanks at the end but not the relatives' and it's those who say some bad things about nurse.”

Poor attitude and helping behaviour to patient is difficult to discern sometimes. In cases where a patient and a nurse do not share the same beliefs especially in the birthing position, nurses end up forcing their orders on a patient. At the health facility, a nurse has more power over a patient due to his/her work position and institutional support, however, the nurse loses this power as soon as the patient is out of the health facility. As such the differences can lead to patients not visiting health facilities if they feel that their cultural beliefs are not being respected at health facilities. The acceptability of health services to patients is one critical element in their utilization. My informants tended to agree that in general it is the nurse who is right and the patient wrong in most conflicts as reflected in Rose's words:

“Well it can happen [...] you know patients are so different and difficult. A mother may come in the labour room at the stage of contractions and some of them they get confused so when you try to tell her something and she doesn't understand or refuse [...] sometime you have to be a little bit hard on her. This is to avoid infections and to help her deliver the baby safely. In

the end everything will be fine and some mothers may apologies for their behaviour in the labour room.”

Bad attitude can be reflected as the fear of infections by health workers from the patients. The fear of contamination from infectious diseases is one theme that will be discussed in this section. It is this dilemma between poor attitude, help and poor working conditions that at times guide the behaviour of health workers towards patients.

‘Christ’s work’

Nursing is seen as a role that brings the care givers close to the community. Many informants besides financial benefits the profession brings, mostly they viewed nursing as a profession that gives them a chance to contribute to the society in a meaningful way. In this way, the complements and acknowledgements they receive from their patients and families give them extrinsic motivation to continue to work. This is exemplified by Furuwa here:

“Like I have said I like children. You know I can see them here playing around but at the clinic I have more chance of being so close to them and sometimes a lot of them at once [...] well and giving them care and educate their mothers. You know here I have more chance and the opportunity to reach and educate the society more than I could at home.”

Being close and appreciated by the community is one of the motivations for health workers in continuing to give care. The appreciation from society members brings satisfaction to health workers despite poor working conditions. As mentioned before, nurses see their profession as ‘volunteerism’ which needs a good ‘heart’, likewise, Rose described the work as Christ’s work. Making a subtle connection on the role of religion in care-giving, she said:

“Yes I will let them [her children] be maybe a nurse or midwife or doctor because this is the job which puts you so close to the community by giving all your heart to the work so we say this is Christ’s work. So when my children are in this profession well I think it’s good and as I know well he or she is helping others.”

Health workers seem to perceive their work as ‘helping’ others. Despite the fact that they also get a living and remuneration from their job, they seem not to view the benefits as

compensation to their skills, effort and time. When they are performing a duty they see it as a helping behaviour. Besides being useful to the community, Mama Pesa revealed how nurses can be useful in their families as well:

“[...] I did go for nursing and I like it later on and I was so passionate to treat patients. My mother got sick so I’m the one who was taking care of her and treating her until she passed away. Although she was sick, she was happy with the care I gave her home- as you might know that nurses were really bad during those days.”

Maidei also explains why a health worker is important in a family:

“Some patient can take 9 injections but at the end when the patient tests for Malaria it will still be there [...]. How can this be possible? But if you have a relative who is a nurse, she can help by putting a drip at home and look after the patient.”

Health workers like Maidei and Mama Pesa are conscious to the fact that their profession can lead to extra responsibilities in families and they are quite prepared for that. In other words, nursing is not only a job to earn a living but a way to help the family and community for Maidei, Mama Pesa, Furuwa and Rose.

Working Conditions

This section will present the work environment related factor from the perspective of health workers and is sub-divided into five categories. It will look at the issue of allowances and benefits, nurses’ salaries and the fear of HIV by health workers. Work environment and condition of health workers in the study area impacted on the quality of services offered to community. Likewise, the health workers’ work environment had an impact on their motivation and view of P4P.

Poor Salaries

Poor salaries were mentioned in interviews as one factor that leads to the informants’ demotivation. The salaries health workers get is not enough to cater for their needs. Most resorted to farming as a way of supplementing their meager salaries. In the following quotation, Rumbi highlights the elements she does not like about her job:

“The salary is not good, the environment is not good. The life we live here is very difficult. We are doing our work in a difficult situation. We can be happy if our salaries are increased a bit and also if we can get accommodation here at the clinic. When we are not happy how can we give good services to the community?”

In general, if workers are happy they perform their duties well. When conditions at work are not conducive for health workers, the services they offer are negatively affected. Perceived low salaries were mentioned in almost all my interviews with health workers. Salaries seem to be a major concern for workers in the study areas as Memory’s quotation illustrates:

“Our salaries are very low considering the work we do and considering that we don’t even get paid in night shifts. I just depend on my monthly salary. Sometime when you are on night shift and there’s an emergency you have to accompany the patients to the referral centre but to get paid for that emergency situation is a problem.”

Fairness is cornerstone when it comes to rewarding workers. In the study area, there is a general feeling from nurses that they are doing more than they are paid for. This has negative implications on the quality of services they offer to patients. Given this scenario, a few nurses admitted to have thought of or being pressured to leave their jobs by friends and family as Maidei:

“Some say aah sister what kind of job is this, sister you should stop it, it’s like you are just volunteering. You work day and night and the pay you get is very low, just stop come home and do farming or else get another job somewhere or in another country. Especially considering that you are a qualified nurse/midwife”

As mentioned somewhere, farming is one strategy nurses use to supplement their salaries. However, some health workers were appreciative of their salaries. Mainly older or less qualified informants such as Mama Joyce who was only left with 4 years to retire showed this appreciation:

“I have no regrets with this job, I like it; of course many will say the salary is low but its ok. This job is what makes me eat with my family so I am satisfied. I have been able to send my children to school through this job.”

Unlike Mama Joyce, Rumbi on the other hand had some regrets and will miss the nursing salary but only if she finds herself in a situation where she is unemployed. When I asked her about what she will miss in nursing, here is what she said:

“As for me I don’t have many options around, but well what else I need I am working, and I am getting a salary. This salary is helping me and my family but if I could get another job maybe I will leave but not when I will be unemployed”

Rumbi has seven years of primary education and is an enrolled-nurse and as such the options available to Maidei who has four years of secondary education and a qualified nurse/midwife might not be available for Rumbi. In a situation like this, nursing is the only career option for her.

Allowances and Benefits

In all interviews, the issue of lack of allowances and benefits was mentioned. Informants identified this element as contributory to their low work morale. Informants expressed frustration when they do not get allowances and benefits they know they are entitled to. Health workers in the study area feel entitled to allowances, among them, risk allowances, night shift allowances and caller allowances. In the interviews the health workers claimed that the allowances were not paid in time or not paid at all. In certain cases, they claimed that the allowances are misused or abused along the way. The following quotation from Rose supports this claim:

“There are some allowances which we are supposed to get but we don’t. They have to consider us and give us our allowances in time in order to motivate us. There are cases where you can be certain that your allowance was misappropriated. Sometimes it takes a long time before you can get your allowance or in certain cases, the money that will come will be far much less than the amount you will be expecting. These kinds of things do not motivate us in our work.”

Health workers expressed frustration over delayed allowances. The district office responsible for the disbursement of the allowances admitted that at times the allowances take long before they are settled. Nema expressed her anger in the following quotation:

“The thing that I hate most is not getting my rights which I am entitled to, that’s what I hate most I just hate that [...]. We are supposed to get allowances with so many names but we don’t, I hate this.”

In Chapter 6, poor staff attitudes had been mentioned as one reason that affects the acceptability of maternal health services in the study area. When health workers are angry due to their working environment or conditions they might transfer their frustrations and anger to their patients. Health workers are subjected to many risks from infections and they should be compensated for the risks as Rumbi says:

“You know when you are in the labour room there is a great risk of infections. We are supposed to get a risk allowance but we don’t get that. We are told that we are supposed to get that risk allowance but since I started doing my job, I have never got that allowance. What I get every month is my salary, only my salary.”

Experiences of health workers in the study area as demonstrated in the succeeding chapter shape their perceptions and expectations on P4P. Not getting allowances they are entitled to, is highly demoralizing to the informants. Lydia singled out night allowances in particular when she said, *“for us if we do night shifts but we don’t get paid, here we don’t get paid.”*

HIV Fear

My informants showed a great deal of fear of infection particularly HIV. They felt so prone to infection in case of anything going wrong. This fear affects the way the health workers interact with their patients in the labour room. Due to shortages in equipments, the nurse/midwives are mostly driven by fear in the labour room from HIV infection. In some cases, they perform deliveries without gloves and aprons, basic provisions in the labour room as illustrated by Rumbi:

“This job is very difficult, especially the risk of infections. Sometimes we protect ourselves but it is difficult, like now delivery kits are not enough, and equipment in the delivery room are not adequate as well. In the labour room it is mandatory to have simple things as apron, mask, boots but all these we don’t have.”

Supply shortages discussed in Chapter 6 was a recurrent theme in all interviews and focus group discussions, the shortages especially in the delivery room caused fear in nurses and this inevitably affects the way they perform their duties as well as their interaction with expectant mothers. The fear is mainly due to the fact that the basic equipments and protective clothing needed in the labour room are not there sometimes. This lack of protection makes the nurse/midwives vulnerable and as a result prevents them to do their duties wholeheartedly. Furuwa labels the fear of HIV as the ‘dark side’ of nursing, she noted the issue of accidental needle pricks as something that makes her to regret to be a nurse sometimes:

“You know every job has its dark side [...]. In our line of business there is a risk of infections, you might prick yourself with a needle that you used for an HIV positive patient unknowingly and if this happens sometimes you can wish if you were a teacher.”

Some nurses tended to see all patients as a potential risk of transmitting HIV and treated all patients with skepticism and fear as illustrated in Maidei’s quotation:

“I could be a teacher aah but no I’m allergic to chalk, well if I could have means I can change my career because you know many mothers they are HIV positive, so if you are not careful you can be infected [...].”

Rose comments that infections can also be transmitted from patient to patient. In this case it is nurses’ duty to try and reduce this risk at health facilities.

“We ask the mothers to bring a bucket and a basin with them. You know they can have urine at anytime during labour. Here we only have one bucket and because of this PMTCT, patients’ conditions are different. We want to prevent those infections so we request them and explain why.”

Body fluids are considered a risk both to the nurses and to other patients. In an environment where the opportunities to secure a good hygienic standard are limited, the precautions taken by the nurses to reduce risk may be understandable, even if they from a medical point of view may seem to be exaggerated.

Discussion

The chapter explored nurses' evaluation of their work and nursing as a profession. Nurses revealed the '*dark side*' of their profession related to risk and contagion but also marveled in the joys experienced in providing nursing care to the patients and the community. In this study, the challenges in nursing in Tanzania seem to out-weigh the perceived benefits. In this context it is of interest to dwell on the issue of motivation; why do nurses despite numerous challenges keep on going with their job? We have seen Rose describing nursing as 'Christ's work' and Nema saying that nursing is in her 'heart and blood'.

Despite these perceived positive perceptions on nursing, health workers complained mainly of the poor working conditions and remuneration system. Health workers in the study area felt unfairly treated by their employer. Other studies in Tanzania have also come up with almost similar findings. In a study by Songstad and colleagues, health workers in Mbulu district of Tanzania reported unfairness in areas of remuneration, training, promotion as well as human resources management (Songstad, Rekdal, Massay, & Blystad, 2011)

Nurses described nursing as a profession that requires a lot of commitment, a good heart and dedication. There is some indication in this study that nursing is perceived more as helping behaviour than a profession. In economics there have been some studies investigating if nurses are more altruistic than other professionals. The aim of most of these studies is to see what really matters to nurses when picking up their career option. Literature seems to indicate that more cooperative individuals may select certain professions to acquire internal satisfaction (Brekke and Nyborg 2010; Serra et al. 2010b). In many cases, nursing is used as one such profession where intrinsic motivation is more valued than extrinsic motivation (Prendergast 2007; Delfgaauw and Dur 2008; Brekke and Nyborg 2010).

Brekke and Nyborg (2010) argued that a combination of low salaries and allowances and intrinsically rewarding work only attracts those who are already intrinsically motivated. In an economic experiment using the dictator game, Jacobsen and colleagues (2011) found nursing students to be more generous in their donations to Amnesty International than real estate broker students. Jacobsen and colleagues' dictator game results seem to support that nurses are willing to help and donate to charity and as such can be argued to be more altruistic. Serneels and colleagues (2010) in Rwanda and Ethiopia found out that health workers who

had higher intrinsic motivation, measured by the workers' willingness to help the poor, were more likely to pick rural jobs where working conditions are not as good as in an urban setting.

In another study in Ethiopia by Serra and colleagues (2010b), it was found that philanthropically- and pro-social oriented health professionals preferred to work for the non-profit sector and, more interestingly, it was found that non-profit employers pay philanthropically motivated health professionals less than those who are not. These findings seem to support the findings in this study that despite the harsh conditions the workers reported, many did not wish to change work location to urban areas where better opportunities are available to make extra money to supplement their salaries. However, we should not overlook other reasons that might influence health workers' choice of work station, such as family reasons, personal background, and education among others.

Another school of thought argues that, choosing nursing as a profession does not necessarily point to a conscious self-selection process where individuals are driven by their altruism. Freidson (2001) argues that rather than presumed internal generosity, occupational differences among professionals are socialized within a specific occupation. Hence Jacobsen and colleagues (2011) argue that the fact that nursing students donated more money than real estate broker students to Amnesty International could be due to the fact that nursing students experience a stronger sense of duty due to their professional demands.

However, there are other behaviours in nurses such as preference for a place of work which seem not to be explained adequately by intrinsic motivation. Serneels and Lievens (2008) in their study in Rwanda found that highly educated health workers were scarce and as such took up urban job opportunities. The same was also found in the study of Manongi and colleagues (2006) in Tanzania.

In this study, of the 12 health workers interviewed, only three had a diploma in nursing while seven including these three had 4 years of secondary education (Ordinary Level). This demographic information confirms what Manongi and colleagues (2006) and Serneels and Lievens (2008) found in Tanzania and Rwanda respectively. Except for the three health workers who had a diploma in nursing, my informants had little prospects of finding a job posting in an urban area where there are perceived better opportunities for career development and means to supplement low salaries.

While generally, authorities seem to agree that the motivation in care-giving is mostly internally driven, this study found that external regulation, which Ryan and Deci (2000), defined as “*the most controlled type of external motivation*” might have a significant effect on health worker’s morale at work. Serneels and Lievens (2008) found that monetary rewards attached to the job matters and can be a motivational force for performance. However, as I have argued, monetary rewards as salaries, allowances and benefits (which constitute external regulation) are crucial to health workers but as a way of maintaining the internalized drive in individuals in providing care. As argued by Deci and Ryan (2000), all adult individuals in our society have obligations to meet which needs money, and getting an external reward for work (salaries and bonuses in most cases) is one way of meeting these obligation which should not be seen as compromising intrinsic motivation. This is why financial rewards seem to carry more value in circumstances where individuals get relatively low salaries.

Lehmann and colleagues (2008) in their study on staffing in low income to middle income countries concluded that financial factors are important in staff retention although evidence is inconclusive in rich countries. In developed countries, other factors such as organizational and professional support were seen to be more important for staff retention than financial factors (Lynn and Redman (2005). This can be explained by the fact that workers in developed countries are better salaried than their counterparts in developing countries hence do not worry about basic needs as these can be relatively well covered by their salaries. In contrast, in my study workers are worried about money to buy food, pay accommodation, pay school fees and basically to cover ordinary living expenses.

Besides financial concerns, health workers in the study area are also worried by the perceived lack of organizational support, a kind of regulation by their employers that can enable them to perform their duties in a safe working environment. Acute shortages of equipments discussed in chapter 6 exposes workers to risk of infections. Furuwa (*see page 68*) aptly summed the risk particularly from HIV as ‘*the dark side of nursing*’. Rumbi on the same page showed how exposed to the risk of infections health workers are in the labour room. Workers perform their duties at times without basic equipments in the labour room such as aprons and gloves and this is in a country where between 5.3 to 6.1%²² of the adult population is HIV positive.

²² <http://www.unaids.org/en/regionscountries/countries/unitedrepublicoftanzania/>

Studies have shown that lack of protective clothing material for health worker lead to the discrimination of HIV positive patients. Dieleman and Harnmeijer (2006) singled-out sub-Saharan Africa as a common place for these discrimination acts to patients mainly because of the high HIV prevalence rate in the region which feeds into the stigma attached to being HIV positive. Similar conclusions were also reached in studies in Nigeria by Reis and colleagues (2005), and Ezedinachi and colleagues (2002).

Conclusion

The first part of this chapter explored the perception of health workers of nursing. The perceptions seem mainly to provide the basis for the nurses' motivation in choosing nursing as a career option. It also demonstrated what nurses value and de-value in their job. The major finding in this section is that there is a strong indication of nurses being more intrinsically motivated and this seems to shape their career options.

In the discussion section, the association of care-giving with intrinsic motivation seems to be supported by other studies in Tanzania and elsewhere. Although informants in my study are not highly qualified in nursing and have limited options in their work stations, it might not be enough to dismiss the indications of altruism and intrinsic motivation. I further argued using Ryan and Deci that the provision of external rewards, like salaries and allowances is a necessity to any worker in any profession, to fulfill their obligations in society. There seem to be more than the need of external rewards that keep informants in this study in nursing.

The second section of the chapter looked at the working condition and environment of health workers in the study area. I argued that the working conditions can be considered as *external regulation to introjected regulation* (the most controlled forms of extrinsic motivation). Narrations from health workers demonstrated that the external regulation is not favourable evidenced in low salaries and absent allowances. The continued perseverance by health workers in giving care cannot in all fairness be seen as the only option open for them to eke out a living but as evidence of the existence of intrinsic motivation. What has been shown beyond doubt is that the negative working conditions dampen workers morale which in turn affects their performance.

Conclusively therefore, providing a strong and reliable incentive mechanism is one way of providing health workers with external conditions which may boost their morale and may enhance their performance at work. The introduction of P4P which can be defined as the external regulation in the context of this study seemed to be welcomed by health workers in this study but largely treated with caution. The next chapter will present health workers' perceptions, expectations and experiences with P4P, and these are greatly shaped by the views expressed by health workers in this chapter.

Chapter 8

Pay for Performance: Perceptions, experiences and expectations

Chapter six discussed the working environment and the general perception of nursing as work from the nurses' point of view. The perceptions of the nurses about to their work seem to shape their perception for, experiences and expectations to pay for performance (P4P). This chapter is divided into four sections. The first section will examine to what extent health workers in the study area were aware of the implementation of P4P at their health facilities at the time of the study. In the second section I present the perceptions of my informants on P4P. The third section discusses issues raised in the first and second sections, while the fourth section concludes the chapter.

Awareness of pay for performance

All informants seemed to be aware that P4P has been introduced to certain health facilities. Their level of awareness to what P4P involves, demands or gives varied a lot between individual health workers. Health workers with four years of secondary education known as form 4/ordinary level in Tanzania seemed to be more knowledgeable and confident to talk about P4P and its indicators than those with primary education. In addition, those with more qualifications in nursing and senior ranking seemed to be more knowledgeable than junior staff about P4P. Considering that P4P had been in operation for a year preceding my fieldwork, the general impression I got was that the sensitization process before implementation of pay for performance was not adequate for a programme of that magnitude in Tanzania. The majority of health workers were not so sure if the programme had been implemented already or if they were still waiting for it. The knowledge of P4P in the study area seemed to be characterized by a high level of confusion and uncertainty.

When I asked the health workers if they knew about the pay for performance programme and if so how, the following are the responses I got from my informants:

‘We had a seminar’

There was a pay for performance sensitization seminar in Morogoro town. Senior ranking health workers attended the seminar and were expected to give a feedback to their health facilities. Kudzai, a clinical officer at Hembeti dispensary attended:

“P4P is still in the process. We are still waiting, but we had a seminar where we were talking about P4P and it is Payment for Performance in full. We have the indicators we are using and almost 90 something percent of them focuses on MCH.”

As he was present at the sensitization seminar, Kudzai is aware of P4P and its indicators. However, he is not sure about the status of pay for performance at his health facility, which by the time of my fieldwork was already a year in operation in Mvomero district. The uncertainty in Kudzai’s response might be explained by the fact that by the time of this interview, Kudzai was yet to receive his first P4P bonus which was due. Throughout the interview, Kudzai was able to demonstrate beyond my doubt that he was aware of P4P and he even spelt-out the indicators for P4P in the interview.

Mama Kuzini, a medical attendant at Hembeti dispensary, like Kudzai is also aware of P4P and she has a positive attitude to P4P especially because of the bonuses involved. She also referred to the sensitization seminar in Morogoro about P4P. She is aware that the bonuses for P4P are conditional, that is, the improvements in service utilization have to come first before the payment:

“I heard about it, there are some workers who went for a seminar or something. Me personally I think it is a good thing. If we will reach the target then we will improve our services and get paid. I would say it’s a good program. There is no bad program when you are getting paid, hehehe.”

Health workers at Hembeti dispensary seemed to be quite aware of pay for performance, however, the prospect of getting paid extra incentives seemed to overshadow other evaluation criteria for P4P for health workers in general. At Hembeti dispensary I carried out three interviews, with Kudzai, Mama Kuzini and Nema. All these three informants seemed to be aware of P4P, and the conditions attached to it.

‘I have heard about it’

Rose is also aware that there is a programme called P4P; however she is not sure if the programme has already started at their facility or not:

“Yes I have heard about it. I think if it starts here, that will improve our work. The information we got is that it will improve the service to be of high standard and that standard will lead us to have more patients and thereby meeting our targets for P4P.”

Rose who is a midwife at Makuyu dispensary, seems to understand the P4P logic on quality and utilization. The underlying rationale of pay for performance is that improved service quality impacts positively on utilization. P4P targets attitude and behaviour change in individual health workers to achieve the organizational goal.

Nema has also heard about P4P and already has some expectations for it:

“Yes I have heard about it and my expectations are that one day I will get money. If they will give out this well I think there will be some improvement somehow [...] yeah I think we will be united at work. You know, like sometimes we do go on mobile duty, but we don’t see that money so that brings down our motivation, but we have to do our job.”

Nema’s interpretation of P4P is closely linked to financial bonuses. She acknowledges that if bonuses are given then there will be some improvements presumably in attitudes and quality of care.

‘Ooh that we have’

Mama Joyce, who is a midwife at Makuyu dispensary, is also aware that there is pay for performance programme at their facility. Mama Joyce and Rose work at the same facility but their level of awareness around P4P seems to differ. We have seen above that Rose is not sure about the status of P4P while she is able to understand the main logic between quality of service and utilization. On the other hand, Mama Joyce is sure that P4P is already in operation at their facility. She is also aware that the bonuses from P4P are conditional on improved utilization and performance. However, her understanding is that P4P is in all departments:

“Ooh that we have. If all the departments reach the goal or have done very good then we get a bonus. Well for us we haven’t got any but we hope to do so.”

P4P in Tanzania covers the mother, newborn and child section (MNCH). However, Mama Joyce’s understanding might be shaped by the fact that she works at a dispensary where by its nature and size, almost everybody participates in any department. However, the case of Mama Joyce and Rose highlights the level of uncertainty and variation of awareness on pay for performance among health workers on the same health facility.

Memory, an enrolled nurse at Mvomero dispensary, in the following quotation is well aware of P4P, its conditions and benefits:

“Yes, it’s a good program. For us we have certain goals to reach so that we can get a bonus, as we have been told that we have to reach a percentage of the target so that we can get that money and if we haven’t reached that target then we won’t get that bonus.”

Memory is expressing her knowledge of the P4P programme and the fact that they have to reach a certain percentage threshold in order to meet the target. Furuwa expresses her liking of P4P and the benefits involved, she reports that P4P will bring motivation to the workers and generate more effort from them so that they will meet their targets:

“Well personally, I like it so much because that is a big motivation to us to know that we will be rewarded so we can put more effort into it. In addition this programme will make us generate more effort to bring here (health facility) those who don’t want to come, so we will get them as there will be a bonus to us.”

‘We don’t have that’

At Milama health centre, I conducted two interviews with Maidei and Lydia. Maidei is a midwife while Lydia is a laboratory assistant, both of these informants were not aware of P4P. Unlike in other four dispensaries where health workers expressed different levels of awareness to pay for performance, Maidei and Lydia were not aware of this programme. At their health facility, a faith-based health centre, P4P has not yet started, despite the claims by

the district medical officer's office that P4P was running in all health facilities in the district including faith-based facilities.

Perceptions and Expectations of P4P

Health workers viewed pay for performance in many ways. The Swahili word *motisha* meaning motivation was used as a synonym for P4P. In addition, P4P was discussed in relation to competition, cooperation, attitude change, goal displacement, and result orientation. P4P was also received with skepticism as a strategy only in MNCH by the informants.

Competition

As one health worker puts it: *“every person wants to be the winner”*. To most health workers, P4P was seen as competition between health facilities. This was reported in many interviews. Like in any other service delivery, health facilities' catchment areas overlap and as such, health workers believed that they needed to offer better services to increase service utilization. In addition, having better relations with the community members was seen as another strategy to increase health service utilization which is critical in meeting P4P targets. Furuwa had this to say:

“Well I know we have to work and now we are [working], but bringing P4P will bring more energy here [at our clinic]. As you know this will be a competition between clinics so we will put more energy and effort to reach our targets and get the rewards.”

Furuwa perceives pay for performance as a programme that motivate health workers to put more effort into their work. In order for health facilities to meet their P4P targets, there is a need for the facilities to be able to provide services that are satisfactory to the community members in the catchment area. Pay for performance targets behaviour and attitude change in health workers by rewarding them with extra incentives after meeting set targets. Health workers need to come up with innovative ways to retain their client base and recruit more reluctant patients to meet P4P targets. In the following statement, Memory is giving out one of the strategies that can be used to attract and retain a potential client base:

“Well mostly I will put more effort to the women who come here for visiting [antenatal care] and encourage them to come and give birth here and not at home and telling them the importance of giving birth at the clinic as well as telling them the disadvantages and complications involved by giving birth at home. Yeah I will be very motivated through this P4P program as I want to get more income here [to our clinic] and not only to other clinics (...)”

Health education to community members on the benefits of health facility delivery is one of the strategies that can be used to attract new clients to a health facility. At Hembeti dispensary, health workers had to offer health education to mothers first in the morning before attending to them on the antenatal clinic day²³. This method was described by health workers as effective as it was difficult for them to have access to community members on a regular basis for health education other than through the antenatal clinic. However, Memory seems to be focusing on idiosyncratic factors in MNCH, where health workers externalize the problem of underutilization of maternal services. However, general impression I got from my fieldwork experience both from focus group discussions and in-depth interviews is that, on average community members appreciate the need for health facility delivery.

Kudzai also shared the view with Memory and Furuwa on pay for performance as competition. He describes P4P as a ‘fight’ between health facilities:

“(...) as we said before P4P is part of a competition and every person wants to be the winner. Even when you are fighting you want to win and this is so because we have several health facilities and we have the same design and same indicators and most health workers will say why not here. And that one will say why not here also. And from that only some changes will happen. But those changes don’t mean that we are underperforming now, but because you need to achieve a target now you will have pressure to punish and reward yourself. So I can say yes P4P will make some changes to a health facility and to individual health workers.”

Pay for performance in Tanzania aims at improving mother, newborn and child health (MNCH) services through motivating health workers. Motivated health workers are seen as key to improved health services. One element that measures the quality of health service

²³ Clinic day- is a day that is set aside by a health facility for antenatal care

offered is the responsiveness of a health worker to a patient. The time a patient waits for upon arrival at the health facility is critical in averting delays in maternal health. Kudzai in his statement agrees that P4P will make health workers more responsive to their clients. One of the community members' complaints against health workers as discussed in chapter 5 is poor staff attitudes; once staff attitude at health facilities improves the assumption is that utilization of health services will also increase.

Cooperation at health facility and beyond

The informants generally perceived P4P as a programme that brings more unity of purpose, cooperation and self-monitoring. As one informant puts it that: *"P4P will create more unity"*. This is linked to their view of P4P as a competition between health facilities. For a health facility to meet its P4P targets there is need for unity of purpose and teamwork among the health workers. In addition, some informants extended the cooperation beyond health facilities to community members. They reported that not only is the cooperation among from co-workers important but also the cooperation with of community members, council members and traditional birth attendants (TBAs) is important for the success of P4P. Health workers described common targets for a health facility as something that bodes well for cooperation. Furuwa shares her opinion on this: *"I think P4P will create more unity at work as facilities want to meet common targets."* The same sentiments were also expressed by Mama Joyce:

"If I am chosen to run the programme, well first of all I will try to cooperate with my co-worker and then to the elders, municipal representatives, members of the society, and then to the villagers so that if I meet some challenges that I can't handle then I can seek help and advice."

Cooperation with the community encourages community participation. Community participation enables programmes to be tailor-made to suit local realities in a particular context. In all my three focus group discussions with community members, participants were not aware that there is a new programme that had been introduced in health facilities. This could be because P4P in Tanzania focuses on rewarding the provider-side and not the user side. However, as Kudzai illustrates in the following statement, the inclusion of certain members of the community is critical for the success of programmes of this nature:

“P4P is just addressing health workers but health workers don’t work alone or with no assistance, our assistants are TBAs and traditional healers for example, but if the government had also said ok we have some incentives for those traditional health workers. If they pick women from sub-villages and brought them to the health facilities for facility delivery and know that they will get incentives for that ohh surely we will never miss the targets we want. But because P4P is just for health workers the TBA will say ‘aah it’s for health workers and if I reach there (health facility) it’s the health worker who will benefit so why bother to assist them’. This gives us much workload because we need to go to the villages to educate the people about health facility delivery benefits and home delivery risks etc. It means we have double duties but if it could be divided into 2 parts so that the health workers will only concentrate at facilities and TBAs in the villages and we work together, integrate and share, the results will be wonderful I guess.”

The importance of cooperation and coordination on maternal services with the community members especially the TBAs was a concern to many health workers. Traditional birth attendants sometimes do play an important role in maternal health especially in cases where huge barriers for health facility delivery exist. In interviews with health workers and discussions in focus groups with community members, it was noted that there are cases where the accessibility of a health facility for delivery is difficult especially in emergency cases such as the immediate onset of labour during the night or short labour and when the distance between the nearest health facility and the patient’s home is huge.

Motivation

My informants reported that they will be motivated in their work with the introduction of P4P. They argued that the relationship between them and the patient will improve. P4P will cause a positive staff attitude mainly because the workers will need to meet P4P targets. The only way possible for facilities to meet their targets is through increased utilization of health services. In order to meet the organizational goal at facility level, there is need for some individual attitude and behaviour changes:

“So you find that if there is some motivation, we call P4P motivation. If health workers are motivated they can make a follow-up insisting that the people take health facility deliveries other than home deliveries. (Kudzai in in-depth interview)

Among the five indicators for pay for performance which are listed in Chapter 2 (*see table 2 page 15*) health workers seemed to emphasize on facility deliveries than the other four indicators that cover antenatal, postnatal and child health. Regardless, the indicators are closely related and the important aspect in the interviews besides the varying levels of awareness to P4P is that in most cases, health workers associated pay for performance with motivation, quality and utilization of services which is the rationale behind the programme. Like Kudzai, Mama Joyce also sees pay for performance as a programme that will motivate her to do her job and her attitude towards the programme is positive:

“I think it is very good to have that programme. You know when we get that I will be very motivated.”

Memory also agreed that P4P will motivate her since she will be getting monetary rewards for improved performance and increased utilization of mother, newborn and child health services. She also acknowledged that her attitude towards mothers will have to change if she is to meet the targets for P4P.

“I will be very motivated through this P4P program and my attitude will change, yeah because you know that you will be getting paid so if you had bad attitude and maybe temper, you need to avoid it in order for mothers to come.”

Poor staff attitudes as discussed in chapter 6, is one of the barriers to the acceptability of maternal services in the study area. Memory notes that good attitude is critical for health workers to meet P4P targets. Rose pointed to the same issue that P4P will increase staff motivation and work input:

“Really, if this P4P is introduced, I will be happy for myself and for my colleagues and this will stimulate us to work hard knowing that if we won't work that good - well we won't get big bonuses.”

Pay for performance principles and nursing ethics

As the above quotations demonstrate, health workers associated P4P with motivation, unity, cooperation and competition. However, the more I asked them about P4P in relation to nursing as a profession and what it means to be a nurse, their responses seemed to be tainted with pessimism on whether P4P was the right way of rewarding the health care sector. Health workers were caught in a dilemma between monetary rewards and ethical considerations to the approach of their work. As such the quotations in this section show a delicate balance between performance incentives and the general approach to work. Mama Joyce, a midwife at Makuyu, captures this dilemma in the following quotation:

“Yes it’s good to get P4P, maybe according to my work ethics it might not be good but it’s a good programme. You know in this job you swear an oath to do your best under all circumstance, good or bad. But yes P4P will bring extra motivation”

These sentiments had been expressed by health workers in Chapter 7, who described their work as work that needs commitment and dedication, especially considering the working conditions they are subjected to. There is a dilemma between nurses doing their job which they see as duty, and on the other hand getting conditional monetary bonuses to influence the way they carry their duty.

‘My approach to patients is the same’

Mama Kuzini, a medical attendant at Dakawa dispensary who probably was the most skeptical about pay for performance in care giving had this to say:

“Well it will just motivate us so if you motivate people well that’s it, the job will be the same nothing will change its just that the extra payment will change the level of motivation but doing our job will be basically the same.”

The more the workers reflected on ethical issues in nursing, the more they showed some mixed feelings towards P4P as a strategy of improving service utilization. Some health workers felt that P4P was a tool to motivate them but it does not necessarily mean that

something is wrong in their current approach to the patients. Rumbi feels that her approach to work is the same regardless of P4P:

“My approach to patients is same, I can’t say that my approach to patients is different because there is no P4P, no it is the same and when they will put that well I don’t know if it will rise or I should say our work approach is the same, if they will bring that motivation fine, but if they don’t bring it, well we will still work because we came here to work.”

‘I just do it as my duty’

Nema shares the same view with Rumbi and Mama Kuzini on the issue of motivation, attitude change and approach to work with the introduction of P4P. However, she introduces the issue of nursing as duty to society regardless of rewards associated with it. In her quotation in this chapter (*see page 76*), Nema’s perception on P4P was very positive though tainted by her previous experiences where she was not given mobile duty allowance. It is important to see how my informants’ perceptions towards P4P evolved during the course of the interview. This is demonstrated by Nema’s quotation below:

“For me I just work like how it is supposed to be. If it is to educate the society I will do it and I was doing it even before. So I am not doing it for P4P I just do it as my duty. My work is normal; this P4P has been there I think from last year. My work is the same. I’m not doing it because of P4P, no.”

Kudzai, probably the most optimistic informant on P4P’s benefits also show a shift during the course of the interview. In questions that were asking about P4P purely as an economic concept, he was very optimistic about the changes it can do to an individual health worker. However, on the questions that were focusing on nursing as a profession and the use of P4P, he showed a shift:

“P4P, yes it can improve accessibility of care. P4P is part of an incentive package if I am right. For myself I cannot say I will perform more because of P4P, no, because this is my job within my blood. P4P is just an addition that just adds to my happiness at work but not necessarily change the way I do it. It won’t like change me to work so or very hard whatever because that is what I always do.”

Balancing extrinsic motivation such as rewards offered by P4P and intrinsic motivation in care giving seemed to be a point of conflict for some informants. Not all health workers in my study were able to reconcile the need for motivation through monetary rewards while declaring their ‘passion’ for work. However, this might be explained by the social desirability factor, as individuals might not in any setting want to be perceived as bad, asocial or egocentric. In this setting, while health workers agreed generally that conditional incentives are good in health care; they might not want to be seen prioritizing money over the liking of their job and patients, which might be interpreted as unethical according to social norms and values.

Result Orientation and Goal Displacement

There were some mixed reactions on whether targets are the best way to reward health workers. Some informants felt that the use of targets in health leads to goal displacement. In other words, they argued that targets will lead them to concentrate more on meeting those targets than offering quality service to patients. On the other hand others argued that targets and goals are good because they can guide performance.

Increased utilization versus quality care

Furuwa is one of those against P4P as a strategy to increase service utilization:

“No [...] I don’t think it’s a good idea (P4P) it’s ok because I will be getting my money but I think it will convince you to concentrate more on getting money by meeting rewarded targets [...].”

Furuwa is highlighting that health workers might become too result oriented and therefore neglect some areas or departments that are not covered by P4P. Her fears are drawn from the fact that P4P indicators cover mostly MNCH department and not all departments at a health facility. This might not be good as some patients might be neglected as health workers concentrate on rewarded targets. This might lead to a scenario where health facilities meet targets for P4P while the quality of care in general is going down at a health facility. As suggested by Lydia:

“It’s not good to use targets, for example, if you will get maybe 100 patients’ per day I don’t think you will treat them accordingly, you will just rush them. If you have few patient you will treat them good because firstly you won’t get tired. But if you will have 100 patients per day you will be angry [...] and somehow the language you use with the patients will change as you will be tired. So I think there should be an average number of patients, not putting certain patients’ target, that won’t be good.”

In general, the quality of care might decrease with the increase in the utilization of services. This is so because under normal circumstances the time spent with each patient by a health worker decreases as the number of patients per health worker increases.

Target leads to cheating

Besides the effect pay for performance has on the quality of care, there is also danger that health facilities might cheat in order to meet targets if monitoring is not strict. Nema shares this view:

“Maybe they should do it in another way, just like reward people if they are doing well. They have to think of something that can motivate us and not the P4P way which says when you do this that’s when we will give you a bonus. I think it creates problem where people will forge data at health facilities to meet the target.”

Targets seemed to put emphasis on the results and not the process of getting those results. Due to the pressure to meet targets, health workers can either compromise on quality or create some fictitious data at the facility to get bonuses. This is possible especially in government health facilities where monitoring and supervision mechanisms are not so effective.

Targets guide performance

However some Informants felt P4P is the right way to reward health workers, they argued that the use of targets is important; the basis for their argument is that targets can guide performance. When I asked Kudzai on whether it’s right to use targets in health care, here is what he said:

“Yes it’s good because if you don’t have targets you move like a car without indicators and the person coming in the other side doesn’t know which direction you are going. Even personally you must have a target. Like now I am here and I want to reach there, when and how? From that point some other relevant questions comes, like do I need assistance to reach there and if yes what type of assistance? And if you don’t know where you are going you will never consider the assistance for sure.”

Mama Joyce also shares the same view with Kudzai on the importance of targets. She emphasized the importance of an effective recording system that can guide performance:

“I look up to the statistics before and if there were very few mothers coming then I will try to improve my work so that more can come and I will give more information to patients especially on health education. You know, just to improve my work. Looking up the statistics as guidance before and after and how it can be improved more for the better.”

P4P and fairness

Other informants like Rose felt that P4P should be introduced in all departments other than MNCH or at least everybody should be paid same bonuses despite the department they work in. However when asked to single out one department that needed prioritization if resources were limited, almost all informants singled out MNCH. Regardless of the prioritization, the following are the sentiments expressed by some informants:

“I think if they will only concentrate on MCH the programme won’t succeed because hospital work strives on cooperation from all departments. What if other departments are treating more patients than in MCH then they won’t get anything? I think it will be very bad that is why P4P should be in all departments.”

A concern on the issue of fairness with P4P was a major issue, as it targets one department only (MNCH). Tanzania as a country is also concerned with other health issues such as malaria. These other health concerns are not being directly addressed by P4P. Furuwa expressed a fear of the same nature as Rose:

“Because if that P4P focuses on MCH only you never know the mother maybe will need to go OPD (out-patient department) as she may have malaria and she will get treated there first. I think that the bonuses should be divided to all the departments at the clinic so I don’t know how they will do it but for me I think it should be divided to all.”

Hospital work thrives on cooperation from all departments. As such any rewarding mechanisms to health workers must reflect fairness. Furuwa is also highlighting lack of knowledge on how exactly will the bonuses or to whom will they be given despite showing the knowledge of P4P. The lack of knowledge and details of P4P as discussed in the first section of this chapter seems to indicate that the programme was implemented without enough sensitization to the targeted group of beneficiaries.

Skepticism around P4P

Some informants treated P4P with skepticism. To them P4P was just another new name given to the allowances which they are entitled, the only difference was that P4P had some conditions to meet first. Others were skeptical about the amount of money they are supposed to receive and what that money might change. To others, the conditions of their health facilities and shortages in supply made them to be unsure if they can meet the targets as spelt out by P4P.

‘Its better they bring instruments’

Furuwa thinks that it is better for the health authorities in Tanzania to prioritize supplies at health facilities than individual bonuses:

“I think P4P will help but what I think mostly is that the facilities and equipments have to improve you know we can have P4P but if there is no equipment we will not be able to reach those targets or we will not be able to give proper treatment and care needed, so you can’t reach the target. So I think facilities and equipments are very important.”

Supply shortages discussed in chapter 6 seemed to be prioritized over personal bonuses by health workers. Some health workers reasoned that health facilities with supply shortages cannot reach P4P targets. Memory sees the success of the programme as hinged upon the

availability of supplies at health facilities. With no supplies, there is little prospect that P4P targets can be met:

“Yeah the work is ok. It’s just that we don’t have those equipments and that is hindering us to reach the targets, like gloves, so telling mothers to come with like 3 pairs of gloves or a rubber to lie on, it is difficult for them because some of them cannot afford that.”

Memory highlights two issues; supply shortages and the lack of money from the users’ side. Mothers cannot afford to contribute to the delivery kit whenever there are shortages in supplies.

‘How much will we get anyway?’

The informants received their first bonuses for P4P in October 2011, about a month after my fieldwork period. The amounts they received for a period of a year were around plus or minus T.Shs 40.000²⁴ (which is approximately US\$30), this translated to about US\$2.5 per month. In anticipation to this low amount, Nema had already said:

“Its better they bring instruments because how much will we get anyway from P4P? Hehehe, well instruments for dressing we don’t have, sterilizer [...].”

‘P4P is just another name’

Kudzai, whom I described as the most optimistic informant on P4P, demonstrates the shift during the course of the interview on his perceptions on P4P. He actually labels P4P as another name for the allowances they are entitled to:

“In fact this P4P is just another name coming for allowances we used to have. That is how I see it, for example, we have had caller allowance, like when you are called after work. You know in this profession of ours we are supposed to work 40hrs a week but it is impossible [...]. We also used to have risk allowances like, if you accidentally prick yourself with a needle you might be infected but all that now have been omitted so we just assume that P4P is just a new way of calling these allowances like caller allowance or extra duty allowance.”

²⁴ Disbursement report accessed at the Mvomero district Offices.

This skepticism by Kudzai for P4P can be seen to be informed by the conditions of work and the general work environment for the health workers in the study area discussed in chapter 7. The lack of trust that probably P4P is a new strategy and that the implementers might adhere to the letter is shaped by the experiences the health workers have had during their career. The fact that workers had not been getting their allowances such as ‘caller’ or risk allowances made them to assume that P4P is not anything new but ‘another name’ for usual allowances.

Discussion

As demonstrated in the first section of this chapter, health workers were not fully informed on what P4P is. P4P in Tanzania in its current form is characterized by a certain level of uncertainty and confusion. The reason for this confusion can be argued to be the lack of adequate sensitization prior to the implementation phase. For programmes to be effective and achieve the desired objectives there is need to sensitize the programme implementers. According to Chen (2005) the competency and commitment of programme implementers has a direct effect on the quality of the intervention delivered to clients. Thus the effectiveness of any intervention largely depends on the enthusiasm, competency and commitment of programme implementers (Chen, 2005).

We learnt health workers at the same health facility have varying levels of awareness of the status of P4P to the extent that some health workers are not even sure if P4P is implemented or not. This is not expected to be the situation considering that by the time of my fieldwork, P4P in Mvomero had been running for one full year. However, the lack of adequate information at facility-level is symptomatic to the lack of agreement on how the first phase of P4P was to be implemented in Tanzania between the MOHWS and the donor group of the basket-fund. The subsequent result of these disagreements on the planning level can be mirrored in this first phase of implementation.

According to an anonymous P4P expert interviewed by Eichler and Morgan (2011) the MOHWS and other donor group members preferred a less costly sensitization process despite the recommendations from research institutions that participated in the designing of the first draft of the programme. The costly sensitizing process which had a total budget of USD1 million, ensured that all district level managers and facility level health workers will be sensitized to understand P4P, the rationale behind this perceived costly method was that ‘for

incentives to work, people involved should understand the scheme' (Eichler & Morgan, 2011).

However, the MOHSW preferred a less costly way and this resulted in the workshop in Morogoro referred to in this chapter. The workshop in Morogoro on P4P was attended by selected participants from facility, district and regional level to give their inputs for P4P. Those who attended were supposed to give feedback to their colleagues who were not present. Although this was a cost-effective strategy, it seemed from this study not to have worked well.

Health workers perceived P4P in both positive and negative way. On one hand, the scheme was perceived to contribute to team-work, cooperation, a competitive spirit and motivation. All these attributes can be seen to be positive for service delivery. Studies in Tanzania and elsewhere also find this to be true. In Rwanda, Meessen and colleagues (2007) found that P4P motivated health workers to be more in control over service outputs. Health workers engage in self-monitoring when there is an incentive strategy and that increases their productivity at work by spending most of their time doing productive work. Similar results were also reported in other studies in Rwanda by Basinga and colleagues (2010) and Soeters and colleagues (2006).

An evaluation study by Canavan and Swai (2008) in Tanzania on a P4P programme by Cordaid, a Dutch nongovernmental organization, in some catholic health facilities in Bukoba, Rulenge, Kigoma, Arusha and Sumbawanga, found that the programme was characterized by low and erratic bonuses but regardless, health workers in Cordaid P4P health facilities scored higher than their counterparts in non-Cordaid government health facilities on team work and staff empowerment. The health workers in Canavan and Swai's study reported that the existence of P4P enabled them to communicate better with their colleagues and make decisions they otherwise would not make. In other words, as also this study indicates, P4P may encourage unity of purpose at health facilities which presumably might bode well for health service provision. However, intrinsic motivational factors associated with the use of P4P may prove not to be adequate in increasing service utilization as the case of Cordaid sponsored P4P in Tanzania demonstrates.

Despite the existence of positive aspects associated with P4P mentioned above, health workers had some doubts if P4P is the right way of providing motivation in health care. This view was supported but the claim that conditional incentives like P4P may lead to practices not beneficial to the health care. These practices can vary from the inflating of output figures, goal displacement, as well as being result oriented. These practices were also reported in Rwanda in studies by Basinga and colleagues (2010) and Meessen and colleagues (2007). In Basinga and colleagues' study, it was discovered that health workers ended up sending outreach health workers into communities to canvass for pregnant women to deliver at health facilities as deliveries had the highest payment per unit of USD4.59. This practice encourages the prioritization of the highly rewarded service at a health facility and in the process lead to the neglect of services are unrewarded which consequently has a negative effect on overall quality of care. In this study, we have learnt that health workers prefer P4P indicators to cover all departments if possible in order to avoid prioritization pitfall.

As in this study, Meessen and colleagues (2007) found that P4P can lead to health workers to focus more on the quantity and not quality of services delivery. This is so because health workers are given targets to meet even in cases where there is an acute shortage of staffing at health facilities. We have heard Lydia's worries (*see page 86*) about the amount of time they have to give to each patient if the number of patients increases. There is a sense that with increased utilization, the quality of care can be compromised if precautionary measures are not taken into consideration such as deployment of more health personnel.

In addition, Nema (*see page 86*) feels that if targets are not met, it might lead to cheating by health facilities by reporting an inflated rate of delivery of remunerated services. Soeters and colleagues (2006), in Rwanda found the monitoring and verification of results as a major challenge of P4P. In Tanzania, health facilities performance is monitored by council health management teams (CHMTs). The CHMTs are supposed to analyze and validate performance data at health facilities. One problem with this mechanism as noted by Eichler and Morgan (2011) is that the CHMTs are also beneficiaries to the strong performance of health facilities in their district. The interest the validators (CHMTs) have on good performance might make it difficult for them to be objective in the monitoring process as well (Eichler and Morgan 2011).

When answering questions that connect P4P and their work experiences, health workers showed some level of skepticism. The reason for this may be due to the bad experiences the health workers have had with their work. In chapter 6, I have argued that the bad experiences and poor conditions for health workers have a bearing on their expectations to and perceptions of P4P. This seemed to be the case as health workers are doubtful about the targets they are required to reach without an enabling environment.

Chen (2005), defined inputs as salient in sustaining any programme, inputs of a programme include all the necessary infrastructure for a programme to be effective and these includes, equipments, personnel among other things. In this study, health workers complained about supply and staffing shortages. Nema (*see page 89*) thinks it is better to buy medical equipments and other supplies with the money earmarked for bonuses. In any case health workers are aware that it would be difficult for them to meet P4P targets if health facilities continue to experience supply shortages.

Kudzai (*see page 89*) considers P4P as 'just another name' for the allowances they are entitled to. These kinds of perceptions remove the novelty in the P4P initiative. In chapter 6, we have heard health workers complaining about allowances they do not get and one can only wonder how health workers will relate to P4P especially as indications are that it started on a wrong footing. However, comfort maybe provided in the fact that MOHSW declared that they are 'muddling through' with P4P and one advantage of incrementalism²⁵ is that it incorporates changes as feedback from the programme comes in.

Conclusion

The chapter presented and discussed the perceived advantages and disadvantages of P4P in its current form in Tanzania. The first section presented varying levels of awareness of P4P, which I argued to be largely due to lack of a proper sensitization process prior the implementation of the programme. Health workers as primary implementers are critical if P4P is to achieve desired results hence their commitment, willingness and enthusiasm is required. One way to make them feel important in the process is to sensitize them and make sure they understand the goals of P4P.

²⁵ A strategy in policy implementation of making gradual changes to a new policy

The chapter discussed some perceived positive attributes of P4P. There are some indications in this study that P4P may boost cooperation, unity and empowerment of health workers, as other studies have shown (Canavan and Swai 2008; Meessen et al 2007; Basinga et al 2010; Soeters et al 2006). These positive aspects are largely driven by and foster intrinsic motivation in health workers. However, by and large, skepticism and negative attributes to P4P seem to outweigh the positive attributes especially in that in the Cordaid P4P in Tanzania perceived positive intrinsic factors did not have an impact on service utilization and the quality of care which can be argued to be the cornerstone assumption of P4P programme in any setting.

Chapter 9

Final Remarks

P4P as an intervention to increase health worker motivation was introduced in order to bring down maternal mortality in Tanzania through increasing availability, accessibility, acceptability and quality care of maternal health services. The aim of this study was to explore health workers' and community members' experiences and perceptions of service provision in the first phase of programme implementation.

One year into P4P programme implementation, health workers expressed mixed feelings to the use of incentives in care provision. Both health workers and community members highlighted many barriers that impede AAAQ and the motivation of health workers. The view of health workers and community members as to why many women did not deliver in hospitals seemed to largely converge.

However, the community members tended to put blame on the health workers for inadequate services, while the health workers tended to blame both the health system for inadequate supplies on one hand and community members for sticking to some traditional beliefs such as preference of traditional medicine and TBAs on the other hand. These issues will be discussed in this final chapter. The chapter also presents my final thoughts on the topic of P4P based primarily on the empirical data as well as literature consulted during the course of writing this thesis.

Health system factors: AAAQ and P4P

Based on the research findings, I have argued in Chapter 6 that provider side factors seem to play a major role as barriers to the utilization of health service. The barriers presented in this thesis include supply shortages, understaffing, unqualified staff, poor responsiveness, abusive language and informal payments. These factors affect all the aspects of the AAAQ framework. P4P in Tanzania focuses on strengthening motivation of health workers which is presumably a precursor for improved performance which has a positive effect on service utilization and health outcomes. P4P in its current form cannot address all health system problems, especially factors that deal with the availability of health services, but poor health

worker attitudes might be addressed. Health workers acknowledged that for them to meet the targets set by P4P they need to change their attitudes towards patients. If these perceptions are anything to go by, P4P might directly improve the health worker/patient relationship. In addition, financial bonuses have the potential of reducing the problem of informal payments. In this way P4P might make maternal services more acceptable, on the basis of good staff attitudes to patients and accessible, on the basis of not discriminating those who cannot afford bribes. As noted in the discussion of chapter 6, health workers seem to create artificial shortages and embezzle drugs when supply shortages and unfair remuneration systems existed as a way of soliciting extra payments from patients (Mæstad and Mwisongo, 2011; Serneels and Lievens, 2008).

Unfortunately, motivated health workers need at the least the basic equipments and provisions to work effectively and to maintain their motivation. Informants felt that it was better if the problem of supply shortages is resolved first, since without addressing supply shortages, health facilities cannot meet P4P targets. According to Hunt and De Mesquita (2008), for maternal health to be available, there should be an adequate number of goods, services as well as sufficient and qualified staff. It is therefore arguable that in its current form P4P does not address the need to make health services available to the community.

Lack of such basic necessities is a reason for health workers to be demotivated as demonstrated in chapter 6 and 7. By the time of my fieldwork, P4P had been implemented for 1 year but my informants in the study area reported more of deteriorating standards on health facilities than improvements. The electricity supply was a challenge at health facilities in the study area and the problem was further compounded by newly installing pre-paid electricity meters at some of the health facilities. This means that health facilities could not have access to electricity unless they had bought some units in advance to use. While these shortages affect the motivation of health workers, they also hinder the accessibility and availability of maternal health services. Patients might prefer to deliver at TBAs, if they are aware of acute shortages of supplies at health facilities. A 'dark' health facility does not pull potential clients. The shortages in supplies have been documented in other studies in Tanzania (Mrisho et.al 2008; Mæstad, 2007).

The availability of BEmOC is key to the success of P4P. The implementing of P4P in Tanzania did not attempt to create minimum conditions for the success of the programme.

While it is still too early to dismiss or ascertain its contribution, at a general level it appears to be a hurried option. If health services are not available, they cannot be accessible, acceptable or of good quality.

Chapter 7 has demonstrated that health workers' working conditions are not conducive to optimal performance. Low salaries, lack of allowances and benefits are some of the perceived negative factors noted in this study. Nurses talked about their job in altruistic terms. The profession was described more as a helping behaviour to the community and their families than salaried work. We have heard Rose describing nursing as '*Christ's work*', an indication of the perceived goodness and a charitable view of nursing. Many studies have also suggested that there could be an innate '*goodness*' in nurses or nursing (Prendergast 2007; Delfgaauw and Dur 2008; Brekke and Nyborg 2010).

At the same time, informants acknowledged that although they are committed and dedicated to their work, external rewards, like bonuses are necessary and important for their motivation and for the day to day living. These contrasting views of viewing work as a charitable work while expecting external rewards from the same work seems to be ambiguous. However, Deci and Ryan (2000), argue that pure intrinsic motivation, where people do duties or things for the sake of their liking without expecting external reward becomes more and more difficult as they are integrated in an adult society where several responsibilities and obligations have to be met and fulfilled.

Social, cultural and gender dynamics

The findings of this study emphasized the importance of strengthening health system limitation but user side factors cannot be dismissed completely. The user side factors presented in chapter 6 are: lack of money, lack of transport, decision making, the role of TBAs and local knowledge systems.

Men's major role in maternal health in this study was identified as sourcing and provision of money for health bills and transport. More importantly, it was generally agreed that it is mainly men's role to decide where the delivery should take place. Mrisho (2008) also had similar findings in rural Tanzania. The conversation I had with Rafiki and Mzee which I presented in Chapter 5 (*see page 40*) seems to shape the way in which gender roles in

reproductive health are perceived in the study area. Fatima and Bwana reported that it is considered a male's role to make the decision for the place of delivery.

While it can be argued that the decision making process itself is mainly influenced by the husband's privileged economic position, it cannot also be denied that decision making is perceived as men's prerogative as defined '*by the dominant sexual codes*' of a society much to the contrary of what modern liberal states defines as equality between men and women (Connell, 2002, p. 56). While Rafiki seemed to be shocked and fascinated that I was in the labour room when my wife gave birth, in the context of the study area it might be considered culturally inappropriate for men to be in the labour room.

Hunt and De Mesquita (2008) in their AAAQ framework emphasized sensitivity to culture and gender as important factors in making maternal health more acceptable. Furuwa, a nurse/midwife acknowledged that some women might prefer TBAs because they want to use traditional medicines which they believe lessens labour pain. One might argue that local knowledge systems should be incorporated more in the conventional medicine if lack of it affects the acceptability of maternal health services in a particular context. If in western medical episteme *epidural analgesia*²⁶ can be used to lessen labour pain, then some traditional medicines might have the same effect and what is needed is to identify TBAs with the right local knowledge. In addition, Nema a nurse/ midwife reported to have had an incident with one woman who did not want to give birth lying on a bed, the perceived '*conventional way*' by Nema. The acceptability of maternal health services is seriously compromised when a health system is not sensitive to the cultural and traditional beliefs of the community it serves.

The cases I presented show the insensitivity of the 'conventional health system' to cultural particularities and preferences. This is also further demonstrated when community members were not aware about the implementation of P4P. Of the 17 participants in focus group discussions, only 3 had somehow heard of P4P in the study area. This lack of community awareness in the study areas raises questions on when and how far should the target population be made aware of a new programme which is supposed to improve their well-being. Lacks of eliciting community perceptions on service delivery promotes supply induced demand which affects the acceptability of health services.

²⁶ A western medicine method of relieving pain that is used in labour which can potentially relieve all the labour pain

P4P: mixed perceptions

In chapter 8 it has been demonstrated beyond doubt that health workers treat P4P with mixed feelings. What was interesting was that there was a noticeable shift in health workers' perceptions on P4P throughout the course of the interview. The most positive views on P4P were on questions that asked P4P as an economic concept and its rationale in the Tanzanian health system. However, as questions shifted to connect P4P and care-giving and its suitability in this industry, health workers started to be skeptical. One good example is how Kudzai's views on P4P shifted throughout the course of the interview (*see Kudzai's view on P4P on pages 81 and 89*).

There were some positive perceived attributes to the use of P4P. The potential for changing individual health worker's attitudes through the motivation provided by financial incentives was one of the most reported positive attributes P4P might have. Health workers reported that P4P leads to peer and self monitoring and this has a positive impact on service outputs and outcomes. Canavan and Swai (2008) in the Cordaid P4P in Tanzania found that P4P had the potential of fostering team work and staff empowerment. Health workers in their P4P health facilities scored higher on intrinsic factors and as they result they linked these scores to the effect of P4P. In this study health workers mentioned these factors as possible benefits from P4P. Since the implementation level was still low, it was difficult to ascertain the existence of these factors. If the perceptions on P4P by health workers in the study area are anything to go by, P4P might have a positive effect on the acceptability of maternal health service.

Despite the positive attributes for P4P offered above, it seems by and large that P4P might not be the correct way to increase health service utilization and health worker motivation. Informants reported perceived unethical vices that might be associated or caused by P4P. Among them is the prioritization of rewarded services, emphasis on quantity against quality, inflating of out-put figures and provider induced demand. Meessen and colleagues (2007) found that P4P can be beneficial to health systems but attention should be paid to the risks associated with it. The unethical behaviours linked to P4P needs a very strong monitoring system if P4P is to achieve desired results in Tanzania. Unfortunately, the monitoring of health facility performance is done by the CHMTs which are also beneficiaries to the strong performance by health facilities in their area. Eichler and Morgan (2011) found this to be a major disadvantage for P4P in Tanzania.

Motivation revisited

Motivation is the driving force behind P4P rationale. One major question is whether P4P maintains the same level of motivation it establishes in health workers after some time of implementation. What is particularly intriguing is the effect P4P might have on the perceived intrinsic motivation in health workers as argued in chapter 7. Can P4P maintain this intrinsic motivation or ‘*crowd it out?*’ Intrinsic motivation in this sense is guided by Deci and Ryan (2000) who defined it as “*when a person is moved to act for the fun or challenge entailed rather than external prods, pressures, or rewards*”. As argued elsewhere, most scholars seem to argue that health workers are more altruistic than people who work in other professions (Prendergast, 2007; Delfgaauw and Dur, 2008; Brekke and Nyborg, 2010; Jacobsen et.al, 2011). If there is an inherent ‘*goodness*’ in nurses, what will happen if this natural value is undermined by ‘*external prods*’, which is performance incentive in this case? And if this external pressure (like bonuses) to perform vanishes after a brief introduction, what will happen to the performance levels of nurses? Will nurses adjust to a less amount but still give optimal care?

One of the challenges associated with the use of performance incentives is the neutralizing effect incentives might have. This was reported by Canavan and Swai (2008), when their informants considered their P4P bonuses as just a ‘salary top-up’. In case of this study, I did the interviews with health workers before the first performance bonuses were given out and therefore could not encounter this concern from my informants. But from their expectations, based on their previous experience with their employer, they doubted the sincerity and the amounts that could be given. According to Toonen and colleagues (2008) acceptance of salary supplements and trust to the rationale behind P4P has a great effect on the effectiveness of the programme.

Is P4P the panacea or a ‘one size fits all’ programme?

There seems to be a danger in ‘*cutting and pasting*’ development projects. P4P might not be one of them but the way it has suddenly become the panacea to all maternal, newborn and child health problems raises some fundamental issues in development. Out-put based financing seem to be the ‘*fashionable*’ option in MNCH and almost gaining status as the dominant financing option in the quest to meet MDGs 4&5. This is not to dismiss some

marked progress of P4P in countries like Rwanda, the most quoted examples, Haiti, Cambodia and Bangladesh. It has come to a level where almost any incentive programme in health is called P4P or its synonyms, even in cases where no clearly laid out business plan, performance indicators or necessary basic preconditions exists. Blanchett (2003) notes that the impact of result-based financing (synonym of P4P) is contextual and depends on the organizational, demographic and provider characteristics and this should be factored in when designing such a programme.

Furthermore, it is noteworthy that the word motivation might mean many different things when translated in different languages. In Tanzania *motisha*, meaning motivation only seemed to be associated with financial benefits. I tried to ask if there could be a different word that might show the different types of motivation, which is intrinsic and extrinsic. There is a word *motisha ya ndani*, meaning intrinsic motivation, but this was rarely associated with P4P and yet studies show that P4P can be an external type of motivation which might lead to intrinsic motivation, at least according to Canavan and Swai (2008). In Shona (my mother language), for example, rewards associated with performance are called '*muripo*', which does not really show a difference with a salary or salary 'top-up'. In such contexts where incentives are seen as just 'salary-top ups' there is need for an extensive and rigorous sensitization before implementation to 'providers' in order to achieve the desired impact. Local meanings and particularities in the way that performance incentives are understood should be taken into consideration to avoid '*one size fits all*' programmes.

Conclusion

The use of P4P in health care as this study has demonstrated is that the concept has some pros and cons. In the current Tanzanian P4P the cons seem to outweigh the pros. In certain countries, like Rwanda and Haiti, P4P is credited with tremendous achievements both in increasing health worker motivation and health services utilization. Even in these perceived success stories of P4P, certain practices not beneficial to health care have also been noted.

These practices include the prioritization of rewarded services, emphasis on quantity against quality, inflating of out-put figures, provider induced demand among others. These vices need a very strong monitoring system for P4P to be beneficial to health systems. What the Rwanda case demonstrates is that given a conducive environment, P4P can be beneficial to MNCH.

However, even the success story of the Rwandan case needs to be treated with caution as evaluations of programmes in early phases might tend to have positive effects which might wear out with time, especially when it is a bonus system there is a danger that workers will get used to it and start to consider it as part of their salary.

The national P4P in Tanzania seems to be a hurried option which did not create minimum pre-conditions for its success. However, it is difficult to dismiss its success and contribution in this early implementation phase. The hope is that the planned '*official*' pilot which might start in Pwani region in the first half of 2011 will greatly learn from the shortcomings of this hurried and '*learning by doing*' which was rolled-out in 2009.

There is so much interest in P4P in Tanzania and many donor and development organizations seem to be interested in funding the initiative in Tanzania. All these organizations are interested in one programme with some slight differences when it comes to the intervention strategy and side. There is an opportunity for these organizations to pull their resources together in the interest of the women and children driving towards MDGs 4&5.

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Appendices

Appendix A: Interview Guide for health workers English version

Research Title: Incentive Based Maternal Health Systems: Expectations and Perceptions of Health Practitioners in Mvomero district Tanzania.

Interview Date.....
Place of Interview.....
Informant name/Pseudo name.....
Recording Code.....
Duration of Interview.....

Note: The interview is for the collection of information for academic purposes only. All information given will be treated in strict confidence.

Preamble: This research is being undertaken by Victor Chimhutu as part of the requirements for the Masters of Philosophy in Gender and Development (MPhil GAD), with the University in Bergen (UiB). The aim of the study is to explore the contribution of incentives to maternal health functioning.

Your cooperation towards the fulfilment of this objective is sincerely appreciated. Your responses will go a long way in the conclusion of this study. The findings of the study might inform the success of future similar programmes. You are assured that your responses will be treated with utmost confidentiality and any information identifying the informant will not be disclosed to anyone under any circumstances. Your participation will be acknowledged in the study.

Thank you

Section A: Expectations Related to the Introduction of P4P

1. What are your expectations for the P4P Programme?
 - Probe: In terms of income, workload, work relations, quality of services
2. To what extent do you think your expectations will be met?
 - Probe: In terms of income, workload, work relations, quality of services
3. What do you think about P4P?
 - Probe: Is P4P an approach that you think is useful? - If yes or no, why?
Who does it benefit?
How do you think it benefits/disfavours you?
How do you think it benefits /disfavours the patient?
4. If you were to introduce a P4P programme. How would you do it? What would you try to avoid? What would you stress?
5. How do you think your work will changed with the introduction of P4P?
 - If yes, why and how?

Section B: Prioritization of Work within the Health Facility

1. Do you think P4P will influence the way you work in the delivery ward?
 - Probe: in terms of time, workload, work pressure, extra duties
2. What is your work like now before the P4P programme?
 - Probe: in terms of time, income, workload, work pressure
3. Do you think the P4P programmes have to be introduced to other health departments other than MCH?
4. Do you think the P4P programme should be introduced to other hospitals and health centres in Tanzania?
5. Do you think P4P for MCH will divert attention and resources from other departments and issues?
 - Probe: If yes, what are these departments and issues?
6. Do you think MCH deserves the attention it is getting through the P4P programme?
 - Probe: if yes or no, in what ways?

7. Do you think the working relationship between the delivery section staff and other workers in the facility will be affected in any way by the introduction of P4P?

<p><i>Section C: Nurses' Perceptions and Experiences of Midwifery as Work And as Care Provision</i></p>

1. What do you like about your job?
-Probe:
2. Is there anything you do not like about your job?
3. Do you ever think that you should have chosen a different profession?
-Probe: if yes, which one and why?
4. If you were to choose your education today. Would you have chosen to become a nurse? If yes, why? If no, why not?
5. Have you ever regretted doing this job?
6. If you are to stop this job today what would you miss?
7. What is the most demanding part of your job?
8. What is the most exciting part of your job?
9. If something could be done differently in your work, what could it be?
10. What do those close to you say about your job?
-Probe: family, friends and colleagues
11. Do you think this is a job someone can do for a lifetime?
-Probe: if yes or no why?
12. If you have a child, would you like him/her to become a nurse-midwife?
13. Can you please describe to me in detail your typical day at work?
- A specific day like yesterday

<p><i>Section D: Perceptions about Access, Acceptability and Quality of the Care provided to Women in Childbirth</i></p>
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1. How do you consider women's access to EmOC in this area? Is it adequate?
Probe: If not, what could be the main barriers for that?
2. What could be done to make maternal health services more accessible in this area?
3. Do you think the services offered in maternity ward in general and the delivery room in particular is acceptable to patients?
-Probe: Do you feel that women are treated with respect?
Do you feel that the services are culturally appropriate? In terms of

birthing position, clothing, relations

-If no, in what ways?

4. What in your opinion could be done in the maternity ward to improve the acceptability of maternal health services?
5. How in your opinion will the introduction of P4P affected the accessibility, acceptability and quality of care?
6. Do you think that women have adequate access and that the services are acceptable, and of sufficient quality?
7. If not, do you think the lack of AAAQ may prevent women from delivering in this health facility?

-Probe: In what ways

<i>Section E: Health Workers Perceptions of Reproductive Health Rights</i>
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1. In your opinion, is maternity care a service that women should be able to claim as a right or is it a service that is granted out of charity or maybe as a commodity on the market?
2. Do you think to women in this area adequate maternal care is considered a right or as a privilege?
-Probe: By the service providers and by the women.
3. Have you ever been reported by a patient for negligence or for poor quality of care?
4. Do you know of someone who has been reported by a patient for negligence?
5. How do you feel if the management decides against you in case of a complaint?
6. Has that ever happened in this facility? Have you ever heard about such a case?
7. Will the introduction of P4P changed your responsiveness to patients?
-Probe: If yes, in what ways?
8. Will your attitude towards patients been affected by the introduction of P4P?
-Probe: If yes, in what ways?
9. Do you think you are accountable for whatever happens to your patient in the delivery room?
10. Who has the responsibility of a patient in the delivery room?

Section F: Biographic Information

1. Age.....
2. Sex.....
3. Marital Status.....
4. Number of Children.....
5. Education.....
6. Job Title.....
7. Number of years at Work.....
8. Other working Experience.....
9. Other sources of income.....
10. Religion.....

THANK YOU FOR YOUR COOPERATION

Appendix/Kiambatisho A1: Interview Guide Swahili version

Mwongozo wa mahojiano kwa wahudumu wa Afya

Mada ya utafiti: Motisha katika Mfumo wa Afya ya Uzazi:

Maturation na mtazamo wa wahudumu wa Afya katika Wilaya ya Mvomero, Tanzania

Tarehe ya mahojiano.....

Mahali pa mahojiano.....

Jina la mtoa taarifa/Jina lisilo la kweli.....

Namba ya kurekodi.....

Muda wa mahojiano.....

Dokezo. Mahojiano kwa kikundi ni kwa ajili ya kukusanya taarifa kwa lengo la ki taaluma tu. Taarifa zote zitakazotolewa zitatunzwa kwa siri

Dibaji: Utafiti huu unafanywa na Victor Chimhutu kama sehemu ya Shahada ya Uzamili ya Falsafa katika Jinsia na Maendeleo (MPhil GAD) na Chuo Kikuu Bergen (UiB). Lengo la utafiti ni kuangalia mchango wa motisha katika utendaji (utoaji huduma kwa) wa Afya ya akina mama.

Ushirikiano wako katika kukamilisha lengo hili unathaminiwa. Majibu yako yatachingia katika hatima ya utafiti huu. Matokeo ya utafiti yanaweza kuchangia mafanikio ya baadaye katika programu zinazofanana kazi na hii. Tutahakikisha kwamba taarifa utakazotoa zitatunzwa kwa usiri mkubwa, na taarifa zitakazomtambulisha muhojiwa hazitatolewa kwa yeyote kwa hali yeyote. Ushiriki wako katika utafiti utathaminiwa.

Asante

Sehemu A: Maturation kuhusiana na kuanzishwa kwa P4P (malipo kutokana na utendaji)

5. Je ni nini matarajio yako katika mpango wa P4P? (malipo kwa utendaji) Dodosa: Kupitia kipato,uzito/mzigo wa kazi,mahusiano ya kazi,ubora wa huduma.
6. Ni kwa kiwango gani unadhani matarajio yako yatafikiwa?
 - Dodosa: Kupitia kipato, uzito/mzigo wa kazi,mahusiano ya kazi,ubora wa huduma
7. Je unafikiri nini kuhusu P4P (malipo kwa utendaji) ?

Dodosa: Je unadhani Mfumo wa P4P unafaa? Ikiwa ni Ndiyo au Hapana, je ni kwa sababu gani?

Je, (mbinu hii) inamnufaisha nani?

Je, unadhani ni kwa jinsi gani (mbinu hii) inakunufaisha/kutokunufaisha?

Je unadhani ni kwa jinsi gani inamnufaisha/kutokumnufaisha mgonjwa?
8. Ikiwa ungeelekezwa/ungefundishwa mpango wa P4P (malipo kwa utendaji), je, ungeufanya vipi? Je ni kipi ungejaribu kukiepuka? Je ungesisitiza nini?
9. Je unadhani kazi yako itabadilika kwa kuanzishwa kwa P4P?

Ikiwa Ndiyo, je ni kwanini na namna gani?

Sehemu B: Kipaumbele cha kazi ndani ya kituo cha tiba

8. Je P4P (malipo kwa utendaji) imetakuathiri namna unavyofanya kazi katika wodi ya uzazi?

-Dodosa: Kupitia muda,uzito/mzigo wa kazi, msukumo wa kazi, kazi za ziada
9. Je, kazi iko vipi kabla ya mpango wa P4P (malipo kwa utendaji) ?

-Dodosa:Kupitia muda,kipato,uzito/mzigo wa kazi, msukumo wa kazi,
10. Je unadhani mpango wa P4P (malipo kwa utendaji) unapaswa kuanzishwa katika vitengo vingine vya Afya mbali na Afya ya mama na mtoto (MCH)?
11. Je unadhani mpango wa P4P (malipo kwa utendaji) uanzishwe katika hospitali na vituo vingine vya afya katika Tanzania?

12. Je unadhani mpango wa P4P (malipo kwa utendaji) katika Afya ya Mama na mtoto (MCH) utabadili/utachepusha lengo na rasilimali kutoka katika vitengo na masuala mengine?

- Dodosa: Kama Ndiyo, je ni vitengo gani na masuala yapi?

13. Je unadhani kitengo cha afya ya mama na mtoto (MCH) kinastahili umakini kinaoupata kupitia mpango wa P4P(malipo kwa utendaji) ?

Ikiwa ni Ndiyo au Hapana, je ni kwa njia zipi?

14. Je unadhani mahusiano ya kikazi kati ya wahudumu wa kitengo cha kuzalia na wafanyakazi wengine yataathiriwa kwa namna yeyote kwa uanzishwaji wa P4P (malipo kwa utendaji) ?

Sehemu C: Mtazamo na uzoefu wa wahudumu katika ukunga kama Kazi na kama Utoaji wa huduma.

3. Je ni kipi unachokipenda kuhusiana na kazi yako?

- Dodosa

4. Je kuna chochote ambacho hukipendi kuhusiana na kazi yako?

3. Umewahi kufikiri kwamba ungechagua kubadilisha fani tofauti?

-Dodosa:Ikiwa ni Ndiyo,je ni ipi na kwa sababu gani ?

10. Kama ungekuwa unachagua elimu/taaluma yako leo, ungelichagua kuwa muuguzi? Ikiwa ni Ndiyo je ni kwa sababu gani? Ikiwa ni Hapana ni kwa sababu gani ?

11. Je umewahi kujutia kufanya kazi hii?

12. Ikiwa utaacha kazi hii, ni kitu gani utakachokikosa/kukikumбуka?

13. Ni sehemu gani ya kazi yako inakuhitaji zaidi?

14. Ni sehemu ipi ya kazi yako inayokuvutia?

15. Ikiwa kuna kitu kinatakiwa kufanyiwa maboresho, je kingekuwa kipi?

10. Je, watu walio karibu na wewe wanasemaje kuhusu kazi yako?

- Dodosa: familia,marafiki na jamaa

11. Je, unadhani hii ni kazi ambayo mtu anaweza kufanya kwa maisha yake yote?

Dodosa:Ikiwa ni Ndiyo au Hapana,je ni kwa sababu gani?

12. Kama una mtoto, je ungelipenda awe mkunga?

13. Je unaweza kunielezea kwa kina kuhusu ufanyaji wako wa kazi tangu unapoingia asubuhi mpaka unapotoka?

Siku maalum kama jana?

Sehemu D: Mtazamo kuhusu Ufikiaji/upatikanaji, Kukubalika na ubora wa huduma itolewayo kwa akina mama katika Uzazi wa watoto

8. Je unachukulia vipi wanawake kuhudhuria huduma za EmOC (huduma za dharura za uzazi) katika eneo hili? Je inatosha?
Dodosa: Ikiwa ni Hapana, ni kipi kinaweza kuwa ni kikwazo katika hilo?
9. Je ni kitu kingefanyika ili kufanya huduma za afya ya uzazi (akina mama) zipatikane zaidi katika eneo hili?
10. Je unadhani huduma zinazotolewa kwa ujumla katika wodi ya uzazi na hususani chumba cha kuzalia, zinakubaliwa na wagonjwa?
-Dodosa: Je unadhani wanawake wanahudumiwa kwa kuwajali/kuheshimiwa?
-Je unahisi kwamba huduma hizi zinakubalika kiutamaduni? Kwa maana ya nafasi ya kujifungulia, uvaaji/mavazi, mahusiano
- Ikiwa ni Hapana, je ni kwa njia zipi?
11. Je kwa maoni yako, nini kifanyike katika wodi ya uzazi ili kuboresha kukubalika kwa huduma za afya uzazi?
12. Kwa maoni yako, je ni kwa namna gani kuanzishwa kwa P4P (malipo kwa utendaji) yataathiri upatikanaji/ufikiaji, ukubalikaji na ubora wa huduma?
13. Je unadhani kwamba wanawake wana nafasi ya kutosha kupata/kufikia huduma na kwamba huduma zinakubalika, na zenye ubora wa kutosha/kuridhisha?
14. Ikiwa Hapana, je unadhani kukosekana kwa ufikiaji/upatikanaji, ukubalikaji na ubora wa huduma inaweza kuzuia wanawake kutojifungulia katika kituo cha tiba?
Dodosa: Je ni kwa njia zipi?

Sehemu E: Mtazamo wa wahudumu wa afya katika haki ya afya uzazi

11. Kwa maoni yako, je huduma ya afya ya uzazi kwa wanawake ingelikuwa ni haki au, huduma itolewayo kama msaada au inaweza kuwa kama bidhaa katika soko?
12. Je unadhani wanawake wa eneo hili, wanachukulia huduma ya Afya ya Uzazi kama haki au upendeleo?
Dodosa: kupitia watoa huduma na wanawake
13. Je umekwishawahi kuripotiwa na mgonjwa kwa kutomjali au kumpatia huduma yenye ubora duni?
14. Je unamfahamu yeyote aliyeripotiwa na mgonjwa kwa kutomthamimi/kutomjali?

15. Unajisikia vipi ikiwa uongozi unaamua tofauti na wewe katika hali ya malalamiko hayo?
16. Je hilo limekwishawahi kutokea katika kituo hiki? Je umekwisha wahi kusikia kuhusu jambo hilo?
17. Je uanzishwaji wa P4P (malipo kwa utendaji) utabadilisha mwitikio wako kwa wagonjwa?
- Dodosa: Ikiwa ni Ndiyo, ni kwa njia zipi?
18. Je mwelekeo/fikra zako kwa wagonjwa zitaathirika kwa kuanzishwa kwa P4P (malipo kwa utendaji)?
19. Je unadhani unawajibika kwa chochote kitakachotokea kwa mgonjwa wako ndani ya chumba cha Uzazi?
20. Je ni nani ana jukumu kwa mgonjwa aliye katika chumba kuzalia/Uzazi?

<i>Sehemu F: Wasifu/Taarifa Binafsi</i>

11. Umri.....
12. Jinsia.....
13. Hali ya Ndoa.....
14. Idadi ya watoto.....
15. Elimu.....
16. Cheo cha kazi.....
17. Idadi ya miaka katika kazi yako.....
18. Uzoefu mwingine katika kazi.....
19. Vyanzo vingine vya mapato.....
20. Dini.....

NINAKUSHUKURU KWA USHIRIKIANO WAKO

Appendix B: Topic Guide English version

Topic Guide for Focus Group Discussions

Research Title: Incentive Based Maternal Health Systems: Expectations and Perceptions of Health Practitioners in Mvomero district Tanzania.

FGD Date.....
Place of FGD.....
Number of Informants.....
Recording Code.....
Duration of FGD.....
Group Number.....

Note: The FGD is for the collection of information for academic purposes only. All information given will be treated in strict confidence.

Preamble: This research is being undertaken by Victor Chimhutu as part of the requirements for the Masters of Philosophy in Gender and Development (MPhil GAD), with the University in Bergen (UiB). The aim of the study is to explore the contribution of incentives to maternal health functioning.

Your cooperation towards the fulfilment of this objective is sincerely appreciated. Your responses will go a long way in the conclusion of this study. The findings of the study might inform the success of future similar programmes. You are assured that your responses will be treated with utmost confidentiality and any information identifying the informant will not be disclosed to anyone under any circumstances. Your participation will be acknowledged in this study.

Thank you

1. What do you think about P4P?
 -Probe: Is P4P an approach that you think is useful? - If yes or no, why?
 Who does it benefit?
 How do you think it benefits/disfavours you?
2. If you were to introduce a P4P programme. How would you do it? What would you try to avoid? What would you stress?
3. Do you think that P4P programme should be introduced to other health departments other than MCH?
4. Do you think the P4P programme should be introduced to other hospitals and health centres in Tanzania?
5. Do you think P4P for MCH will divert attention and resources from other departments and issues?
 -Probe: If yes, what are these departments and issues?
6. How do you consider women's access to EmOC in this area? Is it adequate?
 Probe: If not, what could be the main barriers for that?
7. What could be done to make maternal health services more accessible in this area?
8. Do you think the services offered in maternity ward in general and the delivery room in particular is acceptable to patients?
 -Probe: Do you feel that women are treated with respect?
 Do you feel that the services are culturally appropriate? In terms of birthing position, clothing, relations
 -If no, in what ways
9. What in your opinion could be done in the maternity ward to improve the acceptability of maternal health services?
10. How in your opinion will the introduction of P4P affect the accessibility, acceptability and quality of care?
11. Do you think that women have adequate access and that the services are acceptable, and of sufficient quality?
12. If not, do you think the lack of accessible and acceptable quality of care may prevent women from delivering at a health facility?

13. In our opinion, is maternity care a service that women should be able to claim as a right or is it a service that is granted out of charity or maybe as a commodity on the market?
14. Do you think to women in this area adequate maternal care is considered a right or as a privilege?
15. Do you know of someone who has been reported by a patient for negligence?
-if yes what happened to the health worker?
16. What are your perceptions on Reproductive rights?
17. What are the challenges you face in care giving and receiving?
18. Do you think the relations with health workers will be affected with the introduction of P4P?
- If yes how and why is that?
19. In your opinion why is the start to the implementation of the P4P programme taking so long?

Appendix/Kiambatisho B1: Topic Guide Swahili version

Mwongozo wa mada kwa mahojiano katika kikundi

Mada ya Utafiti: Motisha katika mfumo wa afya ya uzazi: Uzoefu na mtazamo wa wahudumu wa afya katika Wilaya ya Mvomero, Tanzania

Tarehe ya mahojiano.....
Mahali pa mahojiano.....
Idadi ya wahojiwa.....
Namba ya kurekodia.....
Muda wa mahojiano kwa kikundi.....
Namba ya kundi.....

Dokezo: Mahojiano kwa kikundi ni kwa ajili ya kukusanya taarifa kwa lengo la ki taaluma tu. Taarifa zote zitakazotolewa zitatunzwa kama siri

Dibaji: Utafiti huu unafanywa na Victor Chimhutu kama sehemu mahitaji ya Shahada ya Uzamili ya Falsafa katika Jinsia na Maendeleo (MPhil GAD) na Chuo Kikuu Bergen (UiB) Lengo la utafiti ni kuangalia mchango wa motisha katika utendaji (utoaji huduma kwa) wa afya ya akina mama.

Ushirikiano wako katika kukamilisha lengo unathaminiwa. Majibu yako yatachingia katika hatima ya utafiti huu. Matokeo ya utafiti yanaweza kuchangia mafanikio ya baadaye katika programu zinazofanana na hii. Tutahakikisha kwamba taarifa utakazotoa zitatunzwa kwa usiri mkubwa, na taarifa zitakazomtambulisha mhojiwa, hazitatolewa kwa yeyote kwa hali yeyote. Ushiriki wako katika utafiti utathaminiwa.

Asante

1. Je unafikiri nini kuhusu P4P (malipo kutokana na utendaji) ?
 -Dodosa: Je unadhani mbinu P4P inafaa?-Kama Ndiyo au Hapana je, ni kwa nini?
 Je ni nani hufaidika/humnufaisha nayo?
 Je unadhani ni kwa jinsi gani inakufaidisha/kutokukufaidisha
2. Ikiwa ungeelekezwa/ungefundishwa mpango wa P4P (malipo kutokana na utendaji), je ungeufanya vipi? Je ni kipi ungejaribu kukiepuka? Je ungesisitiza nini?
3. Je unadhani mpango wa P4P (malipo kutokana na utendaji) uanzishwe katika vitengo vingine vya afya zaidi ya Afya ya mama na mtoto (MCH)?
4. Je unadhani mpango wa P4P (malipo kutokana na utendaji) uanzishwe katika hospitali na vituo vingine vya afya katika Tanzania?
5. Je unadhani P4P (malipo kwa utendaji) katika Afya ya Mama na mtoto (MCH) utabadilisha/utachepua lengo na rasilimali kutoka katika vitengo na masuala mengine?
 -Dodosa: Kama Ndiyo, je ni vitengo gani na masuala yapi?
6. Je unachukulia vipi wanawake kuhudhuria huduma za EmOC (huduma za dharura za uzazi) katika eneo hili?Je inatosha?
 Dodosa: Ikiwa ni Hapana,ni kipi kinaweza kuwa ni kikwazo katika hilo?
7. Je ni kitu kingefanyika ili kufanya huduma za afya ya uzazi (akina mama wajawazito) zipatikane zaidi katika eneo hili?
8. Je unadhani huduma zinazotolewa kwa ujumla katika wodi ya uzazi na hususani chumba cha kuzalia, zinakubaliwa na wagonjwa?
 -Dodosa: Je unadhani wanawake wanahudumiwa kwa kuwajali/kuheshimiwa?
 Je unahisi kwamba huduma hizi zinakubalika katika mila na tamaduni zetu?
 -If no, in what ways? Ikiwa ni Hapana,je ni kwa njia zipi?
9. Je kwa maoni yako,nini kifanyike katika wodi ya uzazi ili kuboresha kukubalika kwa huduma za afya uzazi?
10. Kwa maoni yako, je ni kwa namna gani kuanzishwa kwa P4P (malipo kwa utendaji) kutaathiri upatikanaji, ukubalikaji na ubora wa huduma?
11. Je unadhani kwamba wanawake wana nafasi ya kutosha kupata/kufikia hizi huduma na kwamba huduma zinakubalika, na zenye ubora wa kutosha?
12. Ikiwa Hapana, je unadhani kukosekana kwa ufikiaji/kupatikana na ubora unaokubalika wa huduma, unaweza kuzuia wanawake kujifungulia katika vituo vya tiba?

13. Kwa maoni yako,je huduma ya afya ya uzazi kwa wanawake ingekuwa ni haki au huduma itolewayo kama msaada au inaweza kuwa kama bidhaa katika soko?
14. Je unadhani wanawake wa eneo hili wanachukulia huduma ya afya ya uzazi kama haki au upendeleo?
15. Je unamfahamu yeyote aliyeripotiwa na mgonjwa kwa kutomthamini/kutomjali?
- Ikiwa ni Ndiyo, je ni kitu kilitokea kwa mhudumu huyo wa afya?
16. Je ni ipi mitazamo yako katika haki za uzazi?
17. Je unakabiliana na changamoto zipi katika utoaji na upokeaji huduma?
18. Je, unadhani mahusiano na wauguzi wa afya yatabadilika kwa kuanzishwa mpango wa P4P (malipo kwa utendaji)?
Ikiwa Ndiyo, je ni kwa namna gani, na kwanini?
19. Je, kwa maoni yako, ni kwa nini utekelezaji wa mpango wa P4P unachukua muda mrefu?