UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

COMMUNITY HEALTH FUND (CHF)

OPERATIONS GUIDELINES

Table of Contents

LIST OF ANNEXES

FOREWORD

The economic crisis, which took place in 1980's in Tanzania, has affected provision of social services greatly. The Government, in order to improve provision of these services introduced cost sharing in the sector of health. Cost sharing was introduced from July 1993 where the patients had to contribute a token amount whenever they visit hospitals for treatment. After further thoughts it was now planned to introduce a system where the people pay for their services before they fall sick entitling them to receive treatment when they fall sick without demanding on the spot payment. It is now planned to rollout CHF to all districts in Tanzania Mainland in phases. The phasing will go hand in hand with the local government reform programme.

These guidelines aim at assisting all those participating in implementing the CHF in the country.

The main focus of these guidelines is to define approaches to expanding the CHF scheme to districts not implementing the pilot-test. In this regard the programme overview and rollout techniques have been highlighted in the first two chapters. The role of key stakeholders is also discussed since CHF is not expected to be a single player operation but rather a joint effort between the Government, NGOs, local and external financiers and communities in the respective district. Other areas described in the guidelines include matching or equalization grants, participation in CHF, sources and use of funds and more importantly guidance on financial management and accountability. Past experiences show that communities will quickly remove their cooperation from any public scheme if mismanagement of funds occurs or where there is lack of transparency in collection procedures and in expenditures. Proper management of revenue accrued from CHF is strongly emphasized and should receive priority considerations.

The Ministry of Health welcomes suggestions for improvement of these guidelines especially from the implementers. Your advice and suggestions will assist the Ministry of Health in providing practicable guidelines for implementation of the project which will be developed after pre-test.

May I take this opportunity to thank all those who participated in compiling these guidelines.

I make a special plea to all those involved in the CHF implementation to work closely together and cooperate fully with the stakeholders so as to ensure success and subsequent expansion f CHF into he remaining district of Tanzania.

Hon. Dr. Aaron Chiduo, MP
MINISTRY OF HEALTH

ACKNOWLEDGEMENT

The preparation of the CHF Operations Manual involved several organizations and individuals, too many to be listed herein. The Ministry of Health is grateful for the inputs each one of them contributed to this important task. In addition, however, the Ministry would like to mention in appreciation those who have been much closer to the production of this document.

- The World Bank, through the Health and Nutrition Project, for funding the activity.
- Merit International Limited for production of the draft guidelines
- The VHF Team of Mr. R. M. Shirima and Dr. F. Njau for providing information, conceptual and logistical support.
- The Editorial Team of Dr. H.Y. Simbaulanga, Mr. S.E.S. Ngatunga, Dr. D.O. Simba, Dr. Y. Ipuge, Ms. P Magere and Ms. Joyce Chitalika.
- Members of the Igunga District Administration, DHMT and Ward Communities in Choma Village and Igunga Town for providing baseline information.

The Ministry hopes that the production of the guidelines will provide the necessary impetus to accelerate CHF Implementation country – wide.

Dr. G. Upunda
Chief Medical Officer

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BOD	Burden of Disease
CCM	Chama cha Mapinduzi
CDD	Control of Diarrhea Diseases
CG	Central Government
CHF	Community Health Fund
CO	Clinical Officer
CQN	Chloroquine
CTU	Confederation of Trade Unions
DAC	District AIDS Coordinator
DANIDA	Danish International Development Agency
DDH	Designated District Hospital
DDS	Doctor of Dental Surgery
DED	District Executive Director
DHB	District Health Board
DHMT	District Health Management Team
DHO	District Health Officer
DHS	District Health Secretary
DMCHCO	District Maternal and Child Health Coordinator
DMO	District Medical Officer
DNO	District Nursing Officer
DOTS	Directly Observed Treatment, Shortcourse
DPLO	District Planning Officer
EDP	Essential Drug Programme
EMS	Expedited Mails Service
EPI	Expanded Programme of Immunization

FP	Family Planning
GOVT	Government
GMP	Growth Monitoring and Promotion
HCs	Health Centres
HFs	Health Facilities
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
H&NP	Health and Nutrition Project
HPA	Health Project Abroad
HSR	Health Sector Reform
IBN	Impregnated Bed Nets
I/C	Incharge
IDA	International Development Agency
IDD	Iodine Deficiency Disease
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illnesses
KCMC	Kilimanjaro Christian Medical Centre
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aide
Moi/c	Medical Officer incharge
MoH	Ministry of Health
MSD	Medical Stores Department
MTUHA	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya
MUCHS	Muhimbili College of Health Sciences
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NORAN	Norwegian Agency for Development
NTLP	National Tuberculosis and Leprosy Programme
OC	Over the Counter
OG	Obstetrics and Gynecology
OHC	Oral Health Care
OPD	Out Patient Department
PHC	Primary Health Care
RHC	Rural Health Centre
RHO	Regional Health Officer

RHMT	Regional Health Management Team
RMA	Rural Medical Aid
RMO	Regional Medical Officer
SDC	Swiss Development Corporation
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TB/LP	Tuberculosis and Leprosy
TH	Traditional Healer
Tshs	Tanzania Shilling
URTI	Upper Respiratory Tract Infection
USAID	United States Agency for International Development
VA	Voluntary Agency
VC	Village Council
VIP	Ventilated Improved Pit (Latrine)
VHC	Village Health Committee
VHW	Village Health Worker
WDC	Ward Development Committee
WEO	Ward Executive Officer
WHC	Ward Health Committee

1.0 PROGRAMME OVERVIEW

Tanzania has initiated a health sector reforms whose aim is to improve quality of health service provision through introduction of alternative financing options that focus on sustainability and equity. In these reforms the Government intends to establish Community Health Fund in the districts one of the options of reducing the financing of gap in the health services. The CHF is a potential means ensuring greater security of access to health care, empowering households and community in health care decisions, promoting cost sharing with strong local participation and providing a stimulus to local health care providers.

From a household, or client perspective, a Community Health Fund will provide households in Districts with the opportunity to acquire a health card. The health card will be issued to members after paying contributions agreed upon by the community and will contain benefit to a basic package of curative and preventive health services. The contributions will be made at a time when the household is most able and willing to pay, thus providing security of access to a dispensary and health centre throughout the year. Pre-payment will likely take place at harvest time, with the option of installment payments for members with more regular sources of income.

Households will be fully informed about their benefits and will pre-select a public, or private health facility from a network of available providers. CHF members will jointly make their choice of a health facility at the beginning, but will have the opportunity of changing their source of health care if they are not satisfied with services offered by the provider. Normally, the community will be expected to choose the facility closest to where they live.

From the Community Health Fund management perspective, funds are being pooled from many households, so as to incorporate the fundamental insurance principles of pooling risks. This will enable the Community Health Fund to cover expensive hospital costs of major illness or injury. Households unable to pay for the membership fee will be classified as such by the Ward Health Committee and awarded a Community Health Fund card by the community.

Community management of Community Health Fund will induce people to join the fund. Contribution is per house hold and this will entitle members to access health care when they falls sick. Households unwilling to join the Community Health Fund shall be required to pay predetermined user charges for services at health facilities. The community will set such fees but will require the endorsement of the District Health Board.

The principal stakeholders in the CHF include the community, ward and district leadership, local authorities, health providers and central government.

Stakeholders participate as follows:

a) The Ministry of Health predetermines a standard package of health benefits and introduces the CHF concept to respective districts before the programme starts. Annex 1 shows an example of a bank health services package for district level health services.

b) If district authorities accept the CHF concept and programme, the district council passes a by-law to establish CHF in the district. The by-law will include among other things, creation of District Health Board (DHB), and District Health Management Team (DHMT)

c) After the CHF by-law becomes effective and members of the DHB and DHMT appointed, the MOH carries out a training of trainers (TOT) targeted to the District Health Management Team (DHMT). For details of composition and terms of reference for various boards, committees and CHF personnel refer to Annexes 3-9.

d) After completion of the TOT, the district level personnel introduce the CHF scheme to community level stakeholders including Ward Development Committee (WDC), Village council, households and health providers.

e) Upon learning of their community's eligibility to participate in the CHF scheme from the district representative, the ward health committee prepares a tentative ward health plan, which identifies and prioritizes the health needs of the community and sends the plan to WDC. The ward health committee will derive the ward plan after getting feedback for the village council.

f) The district training team remains in the ward to train the Ward Development Committee, Ward Health Committee, Health Providers and fee collectors on the CHF scheme as soon as the Ward Health Plan is completed and approved by meeting of the ward community representatives. These will include village leaders, extension workers, health facility workers and selected community members appointed by village communities.

g) The Ward Executive Office (WEO) submits the approved ward health plan to the District Medical Officer (DMO) who subsequently compiles a comprehensive district Health plan.

h) The DMO forwards the District health plans to the District Health Board (DHB) for approval. The DMO then sends back the approved plans to the respective wards.

i) The WDC conducts its fundraising campaign, appoints a fee collector at ward and village, households pay CHF contributions and the money is deposited in the CHF district account.

j) The WDC again calls a meeting of the ward community representatives halfway through the operational year or earlier if necessary. Those assembled will review the ward's progress in implementing the plan, receive an accounting of how the CHF funds were spent, and raise more contributions from new households, which are willing to join CHF.

k) The WDC calls a meeting of the ward community representatives at the end of the year. The meeting reviews the ward's progress in implementing the first year's plan and receives an accounting of how the CHF funds were spent.

l) The cycle repeats itself every year.

The government and other stakeholders may contribute to the CHF in the form of equalization or matching grants. The level of community contribution will depend on the cost of the package of health benefits as decided by the community and the level of user fee.

1.1 Organization Structure and Management of CHF

CHF organization structure builds on the existing structure of government operations to avoid building up new and parallel structures. At ministerial level, two ministries are involved; the Ministry of Health (MOH) and the Ministry responsible for local government which is currently the Ministry of Regional administration and Local Government (MRALG). The MRALG involvement in CHF is basically at the level of District Council while that of MOH is though the RMO and DMO. At the MOH headquarters, the CHF is supported by the Division of Policy and Planning. In the Regional Secretariat, the RHMT which provide technical support, capacity building, monitoring and evaluation in support of the district CHF implementation.

The district is the centre of CHF activities. At district level CHF is managed by the district council (DC) through a District Health Board (DHB) through its Ward Health Committee (WHC). At village level CHF is managed by Village Council (VC) through its village government, which is advised by a Village Primary Health Committee (VPHC).

2.0 ROLL-OUT OF PILOT ACROSS DISTRICTS

2.1 Pretest and Roll Out Districts

CHF was first pre-tested in Igunga District, Tabora Region in 1996, 1997 and 1998. Other pretest districts joined the programme in 1998 including Nzega in Tabora Region, Iramba and Singida Rural in Singida Region, Hanang in Arusha Region and Songea Urban and Songea Rural in Ruvuma Region, making a total of seven pretest district. Table 1 shows the roll out districts and annex 2 shows details of selection criteria for roll out districts.

Table 1: Roll Out Districts

YEAR	DISTRICTS BY FOLLOWING REGIONS					
	TABORA	SINGIDA	ARUSHA	RUVUMA	MOROGORO	IRINGA
1996	Igunga	-	-			
1997	Igunga	-	-			
1998	Igunga Nzega	Singida Rural Iramba	Hanang	Songea Rural Songea Urban		
1999				Mbinga	Kilosa	Iringa Rural

2.2 CHF Roll Out

After promising results of the pretest in Igunga and ongoing CHF activities in roll-out districts, the government has decided to expand the CHF programme through the whole country. There are however preparatory limitations in introducing the CHF country wide all at once. One limitation is the possibility and speed with which training can be carried out simultaneously in all districts. Another limitation is financial resource. So questions arise as to how best is one going to pick CHF phase. The government has decided is roll-out CHF in phases according to the local government reform programme.

The local government reforms will be carried in three phases each including 35 districts from 1999 to 2002. In order to conform and work better with the ongoing local government reforms it is proposed to introduce CHF in district that have undergone the reform.

3.0 HEALTH FACILITY ELIGIBILITY FOR PARTICIPATING IN THE CHF PROGRAM

3.1 Registration as a health facility

Participating health facilities must be registered to operate as a health facility in Tanzania. Facilities can be run by government, religious organizations, communities, or other non-government entities. The DMO shall provide the current regulations for non-government providers to become registered to operate as a private CHF provider.

3.2 Development of Three-Year Plan and Contract with Ward Community and the Government

The health provider must enter into a formal contract (*Memorandum of Understanding),* with the district health board to qualify for participation in the CHF program. The contract will be based on the District Health Plan developed by the DMO taking into consideration the needs of the ward communities.

4.0 REQUIREMENT FOR CONTINUED PARTICIPATION IN THE CHF

4.1 Fulfill Program Requirements

To remain in the program, district councils and wards must fulfill all program requirements as specified in this document. They must prepare and comply with their own plans and budget, carefully procure inputs in an open and transparent manner, issue contacts in a reasonable manner, keep accurate records of expenditures, and make full reports on progress in fulfilling their plans and budgets to their communities and the government. In addition, they cannot deny exempted patients who are unable to contribute from being treated.

5.0 PERMISSIBLE SOURCES AND USERS OF CHF FUNDS

5.1 Sources of revenue for CHF will include: -

a) All moneys received in respect of contributions by each household. The level of contribution per household will be determined by members annual meeting.
b) Grants from district council, central government, donors, and other Organisations.
c) User charges payable for using a Government health centre or dispensary.
d) District Council allocations
e) Any other money law-fully derived by the fund from any other source not expressly specified in the district council's by-law establishing the Fund.

5.2 Eligible Uses of CHF Revenue

CHF revenues will be used for health related purposes specified in the District Health Plan. The health related goods and services eligible for purchase under this program include drugs, hospital equipment, rehabilitation and/or maintenance of health facility, furniture and equipment for the facility, materials and supplies for facility use; uniforms for nurses, top-up and/or double shift allowances for clinical staff and nurses, travel and per diem expenses incurred by staff on duty if specified in the ward health plan.

6.0 PROJECT ACTIVITIES

6.1 Training of Trainers

The Ministry of Health or its representative will hold a training of trainers to the DHMT in each of the districts prior to the first year of VHF activity. The training will consist of five days of meetings on all aspects of the scheme. The District Medical Officer from each participating district will bring to this training a list of all health facilities selected by the district to be eligible for the CHF. This list will include (i) the name and location of each facility, (ii) the name of the in-charge of each facility, (iii) the name of the Ward Health Committee chairperson for each Ward, (iv) the name of the Ward Development Committee (WDC) chairperson for each Ward, and (v) the number of members comprising the Ward Health committee and the WDC. Prior to the TOT, the Training Team for TOT will be sensitized by MOH.

6.2 District-Level CHF Introduction for Ward Level Health Providers and Ward Leaders

The District Medical Officer is responsible for notifying health providers that they have become eligible for the program. One of the methods though which this can be accomplished is to distribute a letter to the respective health providers who announce their eligibility for the program and the dates of information meetings for the providers and Ward leaders. The meetings are held at district level on dates that will be set by the DMO in consultation with the DHMT. The DMO then holds the meeting for one day at district headquarters to explain this program to providers of participating facilities and ward leaders. However, other ward-level personnel, WDC representatives, ward health committee members, and interested ward community members are welcome to attend as well. At the end of the meeting, the DMO makes appointment to conduct training sessions in Wards interested in participating in this program. Annex 11 details the content and structure of this introductory meeting.

6.3 Ward Community Decision to Participate in CHF Program

Upon learning of their ward community's eligibility to participate in the CHF programme from the DMO the Ward Health committee prepares a tentative plan for Ward health improvement which identifies and prioritizes the health needs of the ward. The ward health committee agrees on basic ideas for the ward's health plan and its fundraising

strategy. After the tentative plan is cleared by the Ward developing council, the ward development council calls a meeting of participating villages in the ward to coincide with the first day of the visit by the district training team. During that meetings, the Ward Executive Officer and the district training team explains the program, and the community as a whole decides whether or not to participate. The ward community's decision is determined by majority vote. The ward development committee chairperson appoints a secretary to keep minutes for these meetings (which include a record of the major issues and the decision of the meeting, including vote counts). The minutes are kept with other ward records.

If the meeting agrees to participate, those assembled will:-

(a) Provide feedback on the ward health committee's tentative plan for ward health improvement.
(b) Agree on the amount of CHF contributions for the year and
(c) Determine the amount of funds, if any, to be raised through other local fundraising efforts during the year (to supplement CHF contributions). In the cases of households which the ward development committee determines to be unable to afford the CHF contribution, the WDC may either (a) fully or partial exempt the households from making the required contribution in materials or labour determined to be of equivalent value by the WDC.

The Ward Executive Officer will fill out a Memorandum of Understanding for stating that the ward community has decided to participate, that this decision was made by a majority vote during a public meeting, and that the ward community understands the programmes regulations and obligations. This form is to be signed and stamped by the WEO and by the chairpersons of the ward health committee and WDC. A copy of the blank form can be found in the Book of Forms that accompanies the CHF ward health plan. The ward health committee retains one copy of this form, and the other is submitted to the district representative. A copy of the minutes from the public meeting in which this decision was made must be attached to the form.

6.4 Ward Level Training

The DMO sends a team of two officials to spend three days at each ward that is interested in participating in the program. The WEO and ward health coordinator will join district representative personnel in conducting this training. The Ward Executive Officer has primary responsibility for informing health providers, CHF fund collector, ward health committee and WDC about the training and encouraging them to participate, based on the information received at the information meeting at the district.

Upon arrival in the ward, the district training team will assist the WEO in presenting the CHF program to the above-described meeting of the ward community. Provided the meeting agrees to participate in the CHF the district representative training team remains for tree days to train the WDC, the ward health committee, the health providers, the CHF fee collectors, and other ward level personnel in the following topics; (i) how to make a

three year health plan (ii) how to tender for goods and services (iii) how to evaluate bids and (iv) how to keep records of cash inflows and expenditures

6.5 How to Develop Ward Health Plan and Prepare for Fundraising

Following the ward level training, the ward health committee prepares a draft Three-Year Plan and fundraising strategy for the year, based on the amount of CHF contribution determined at the first ward community meeting. The CHF Health Plan document contains a form for a Three-Year Plan, instructions for its completion, and a sample of a competed form. Annex 11 contains a list of issues which communities should consider in conducting a fundraising campaign.

That means prior to the war community meeting; the WEO should ask village governments and WEDC to pre-select CHF fee collectors for approval at the ward community meeting. Qualifications of CHF fee collectors are presented in Annex 5 to this manual.

6.6 How to Establish and Maintain a CHF Bank Account

All districts participating in this program are required to establish and maintain a bank account reserved exclusively for ward community and government contributions to this program. The DMO has primary responsibility for the CHF banking transactions and record keeping. The CHF Training Manual contains a description of how the District Health Board (DHB) should open and maintain a bank account for this project. The CHF Training Manual details the project's requirements for depositing and withdrawing money and checking expenditures against the CHF bank account balance.

6.7 How to Disseminate Information for First Year Fundraising Drive

Community Health Fund (CHF) is a new concept and constitutes a departure form what the people are already used to. Therefore serious marketing and promotional campaigns in all districts to ensure that CHF is clearly understood and appreciated by the community, health providers and all levels of leadership will be conducted. Marketing will be a constant feature in the overall CHF operations to build sustainability. The training manual details the marketing strategy for the CHF.

6.8 How CHF Contributions will be collected and Recorded during First year Fundraising Drive.

Households will begin paying their contributions immediately following completion of ward level training and community marketing and promotional campaigns. The aim of the campaign is to ensure that the CHF is clearly understood and appreciated by the community, health providers and all levels of leadership. Those who cannot afford to pay at the launching of CHF should be allowed to do so during harvest time.

The WEO has primary responsibility for collecting CHF contributions from households through collectors, issuing receipts and keep track of funds raised from user fees and non-fee contributions such as crop levy, livestock levy and private contribution. Selected village level CHF fee collectors will collect CHF contributions from households in their respective villages and issue receipts to contributors. Village communities will agree to a location such as school, dispensary contributions from households. The collections will be sent to WEO at least once a wee (or when more than Tshs 50,000 has been collected) and gets receipt for contributions submitted.

The WEO receives and deposits collections in the safe at ward-level office. WEO keeps record of all collections submitted. WEO should be the only person who has access to the safe. WEO transfers and deposits collections to CHF Bank account and submit deposit slips to DMO on weekly basis. WEO keeps copies of paying slips for deposits made. The WEO informs ward health committee on collections and banking by end of each month. The DMO reports on the CHF collections to the District Health Board and submit to the Ministry of Health a quarterly report on all collections made in the district.

The CHF Training Manual contains a description for carrying out these activities, samples of the receipts and record-keeping form to be used for this purpose, and an example of the completed form.

6.9 Launching CHF Membership

The fund collection drive launched by each ward will last for at least three months preferably during crop purchase season for rural districts, and any other period for urban district. The community is responsible for keeping a calendar on CHF collections. The CHF membership year will last for one year from the day of CHF membership launch.

After the collection period, the WEO in consultation with WDC and DHB announces CHF launch day and the communities respectively stage the CHF launch day ceremonies at ward level. The launch day ceremony in each ward is graced by issuance of health cards to households that have contributed CHF fee or those given waivers by the community.

6.10 How to collect User Fees, Issue Receipts and Record Funds Received by Health Providers.

Households unwilling to join the Community Health Fund shall pay user fees when procuring health services at Government health facilities. At the beginning of every year, the District Health Board sets the level of user fee contributions per visit for an individual at a dispensary, a health centre and a district hospital and will specify which curative and preventive services are covered and not covered under that cost sharing.

The health provider will collect the user fees and the patient will be issued with a receipt. The user fee collector at the health facility will bank the money at lease once every wee in the district CHF account. The health facility collector will send to the DMO pay-in-slips for money collected and banked and send to WEO copies of corresponding pay-in-slips. The health facility will maintain copies of similar records. The CHF Training Manual contains a description for carrying out these activities, samples of the receipt and record keeping form to be used for this purpose and example of the completed form.

6.11 Government Transfer of Matching Grant to District CHF Account

The DMO recommends amount of matching grant for each ward to DHB, which reviews documents and forwards request for matching to the District Council. The District Council reviews documents and transfers funds to the district CHF Account.

6.12 How to Procure Goods and Services under CHF

Procurement of goods and services under the CHF programme will be done at district levels. At district level, the DMO will purchase CHF goods and services on behalf of wards, based on ward health plans and indent list received from health facilities. Purchasing at district level takes advantage of bulk buying and therefore reasonable cost. Bulk purchases will include goods such as drugs, medical supplies equipment and other goods or services, which many wards will request. When purchasing at district level, the DMO will follow the same tendering system adopted by the local government.

6.13 Public Meeting to Account for Expenditures to Implement the Annual Plan from the First Installment of Funds and Kick Off of Fundraising Drive for Second Installment of Funds

After beginning implementation of the Annual Plan, the ward will spend the funds it raised and the first installment of the government's matching grant. The WDC upon request from the ward health committee calls another public meeting when about 9 months have elapsed since the launching of CHF programme, to account to ward community what was procured. The health facility will also produce a report of patents treated during the period including CHF members and non-CHF members with their corresponding user fee contribution. During the meeting both the CHF contributions and user fee will be discussed as necessary, and the second year of collection of CHF contribution launched.

This meeting presents an opportunity for those assembled to comment on progress and to make adjustments as necessary. Any changes to the Annual Plan or procurement plan must be approved at this meeting. The WDC chairperson appoints someone to take minutes at this meeting. The ward keeps a copy of the minutes from the meeting.

6.14 Government Review of Ward Procurement Plan for Second Year Installment

Following the end of the first year of the ward's fundraising drive, the WEO visits the DMO at the district centre. The WEO presents the DMO or his representative with of the following documents:

(a) the receipts for the purchases made at ward level under the procurement plan,
(b) ward's statements of deposit and pay in slip to the CHF district account,
(c) all wards Quarterly Report Forms that should have been completed since the ward's last request for funds and indent list,
(d) the ward's new procurement plan (only necessary if there have been changes)
(e) Ward's Vote Book to compare balance of ward funds in the District CHF Account and reconciliation thereof.

The DMO verifies that the receipts are in order and match the ward's previous procurement plan. He/she checks the bank statement and receipts and verifies that the ward has spent ward community and matching funds it received during its first fundraising campaign correctly. He or she reviews any changes to the wards Procurement Plan for the wards second year of purchases. He/she informs the WEO of the size of the matching grant that the ward is eligible to receive from this second installment is based on the amount the ward has deposited in the CHF district bank account as a result of the second fundraising drive. The CHF training manual contains a blank copy of the matching grant calculation form, instructions for its completion, and an example of the completed form.

6.15 Government Transfer of the Second Installation of Matching Funds to District CHF Account

Once the district presents the necessary documentation, the District Council reviews them and instructs transfer of funds to the CHF Account. The documentation includes:

a) District CHF account statement
b) Summary of each ward's new deposits including copies of pay-in-slips
c) District quarterly reports that should have been completed by the time the request is made.
d) Summary of each ward's expenditure

6.16 District Medical Officer Site Visit to Health Facilities

Each year, the DMO will conduct site visits to at least 2 randomly selected wards participating in the CHF. In addition the DMO visits any facility requesting assistance or where the DMO has reasons to believe that the facility is not in compliance with program regulations. When the wards to be visited make their subsidy claim, the DMO arranges a date and time to visit the ward community. The DMO will offer assistance in areas where the ward and facility may be encountering problems.

6.17 DMO quarterly Reporting to RMO

The DMO prepares quarterly progress reports for the RMO. The report has three sections. The first section summarizes monitoring performance indicators; the second summarizes the ward financial performance under the pilot, and the third reviews results from the client consultation visit. The RMO will compile and submit a quarterly CHF report containing information of all the districts in the region.

6.18 Year End Financial Process and Performance Audits

The District Health Board contracts with an external auditor to conduct year-end financial audits in some randomly selected wards. The DMO uses the results of the quarterly performance reports submitted by WEO and findings from his site visits to recommend to the District Council additional wards that might benefit from a financial and /or process and performance audit.

6.19 Year Two Program Operation

Activities in year two are basically the same as in year one except that there will be no start-up, ward level training for wards already participating in the program. Information and dissemination activities in the second year will centre on how to increase access in health facilities and how to increase membership in order to improve the insurance principle. The District Health Board should emphasize implementation of public health plans.

6.20 Procurement, Storage and Dispensing

The DMO will procure on behalf of wards drugs, medical supplies and equipment based on ward health plans and indent made by wards to take advantage of bulk purchasing to cut cost. The procurement process will follow laid down government procedures on a monthly basis for all drugs required over and above the kit supply, depending on facility budget plan, actual requirement and availability of CHF funds. Drugs will be stores and dispensed properly as outlined in the training manual.

7.0 GUIDANCE ON FINANCIAL ACCOUNTING AND MANAGEMENT

7.1 How to open a CHF Bank Account

DHB opens a CHF district account with the nearby bank where all contributions are deposited. The account is managed by DHB who appoint two signatories in Category A and DMO appoints two signatories in Category B. The bank will only accept a cheque, which bears tow signatures one from category A and another from category B. The bank will not accept a cheque signed by two signatories from one category only. Bank reconciliation is done on monthly basis. DMO is responsible for custody of cheque books and other banking documents.

7.2 How to Record CHF member contributions

- CHF member contributions are recorded in a CHF member's register
- Every ward has at least one register located at ward headquarters
- Registration is done by a CHF collector
- The CHF member is provided with a small index card registration bearing CHF number
- The District Health Office maintains an up to date register for all CHF members. The register is to be updated from time to time.

7.3 How to Record Payments by CHF

DMO maintains a register showing payments made on behalf of each ward. Where payment is made directly to suppliers on behalf of ward, notification is sent to the ward concerned. Where a facility is paid for services rendered to CHF member, such payment is recorded in their register and adjustments made in the registers without involving actual cash transaction.

7.4 How to prepare bills for payment by CHF

- The facility records all CHF clients and Non-CHF clients' attendance every day.
- The facility compiles attendance for the whole month
- The facility sends to the DMO a compiled attendance every end of the month
- DMO compiles attendance of all facilities and forwards to the DBH
- DHB sends a feedback to the ward committees on expenditures incurred to each facility.
- Ward committees inform the Community on expenditure and status of their finances as reflected in the District CHF account books.

7.5 Bank Reconciliation and report on CHF

- Bank reconciliation is carried out monthly
- District Council accountant makes bank reconciliation
- DMO goes through the vote book to see if the balance in the bank tally with the balances in the vote book/cash book

7.6 How to Control Revenue Collection

Receipt Books

The District Executive Director will issue district council receipts to all collectors. The collectors will sign in registers against the receipts, which are prenumbered. The revenue collection receipts are accountable documents therefore, every officer having in his/her charge any kind of official receipt will be fully responsible for them until such time he/she is properly relieved.

Copies of issued receipts should be kept at a safe place for future references. All collectors shall be required to maintain a Revenue Collectors Cash Book (RCCB) indicating the total collections and particulars of revenue receipts. All collections shall be kept in a cash box for safe custody until such a time when funds can be deposited in bank. The maximum amount of money a collector can keep in the cash box is Tshs. 50,000, beyond which, funds should be deposited in the bank. A Bank pay-in-slip clearly indicating the number of bank account, denomination and cash receipt particulars must be presented to the District Medical Officer and a copy retained by the collector for future reference.

Recording in the Cash Book

Main cash book shall be maintained by an assigned District Council Accountant. The Cash Book shall record all the collections and payment, the collection particulars, RCCB, acknowledgment Receipt and total amount collected. Total amount banked and particulars of bank pay-in-slip should also be indicated. All payments shall be recorded in the CashBook indicating the date, Payment Voucher Number, Payee, item of expenditure, amount paid and cheque number. The CashBook shall be balanced daily. The DMO shall check the entries each week and shall sign to acknowledge the correctness.

Exemption Control

As regards to exemptions to the poor members of the community, the ten cell leaders shall list the households which cannot afford to pay CHF membership contributions. Hamlet leaders shall submit the list of households to be exempted to the village council who after approval will send the list to the Ward Health Committee for consideration before submission to the District Health Board which will consider and approve.

Expenditure Control

Expenditure from the Fund shall be made in accordance to the plan approved by the District Health Board. CHF fund will not be diverted to other district use.

Authority for Purchase and Payments
The District Health Board shall approve the estimates of the collections and expenditures. After the approval, the Wards shall submit their requirements to the District Medical Officer for procurement processing in accordance to the procurement Regulations.

Authorization of Payments and Local Purchase Orders (LPO)
All payment vouchers/LPOs shall be authorized by the District Medical Officer. The approved payment vouchers/LPOs shall be submitted to the Hospital Accountant for payment.

Responsibility and custody for Financial Documents
The DMO shall be responsible for supervision of the Community Health Fund Account. The cheque books and all financial documents shall be in the custody of the District Hospital Accountant.

Encashment of Cheques
Money shall be withdrawn form the Bank account in accordance with the Financial Regulations of the District Council.

Bank signatories
There shall be two categories, A and B of bank signatories. Group A shall be two members appointed by the DHB and Group B shall be the DMO and the Accountant of the DMO responsible for the health funds.

CHF Financial Management
District Health Board is responsible for the following activities:-

- Management of CHF fund at the district
- Make sure that selected CHF fund Collectors from different wards within the district are trained in basic principles of financial management and control
- Make sure that financial regulations and guidelines governing the operations of the scheme are strictly adhered to in the district
- Ensure that, CHF fund Collectors collect CHF contributions and health providers collect fee from patients and deposit the money in CHF bank account
- Monitor on routine basis, collections and expenditures of CHF funds in the district
- Enforce disciplinary action incases of financial irregularities and embezzlement of CHF funds.

8.0 MONITORING AND EVALUATION

In order to check on progress made by CHF and to identify problems encountered the scheme will be monitored closely and evaluated by the Ministry of Health. Both process indicators and quantitative measures of impact shall be applied. A baseline survey should be conducted, with follow up surveys at the interim and other stages of the implementation. The surveys us qualitative and participatory methods i.e. focus group

discussions, in depth interviews to establish the nature and likely constraints to household contributions and facility based management. Annex 13 contains a detailed analysis of indicators for monitoring and evaluation, which have been adopted from a study by TFNC.

However, in nutshell some of the council performance indicators that will be used to monitor and evaluate the success of the CHF programme include:

- A record of increased proportion of households enrolled with CHF in the district.
- Increased proportion of households satisfied with services provided by health facilities
- Increased proportion of health facilities stocked by standard package of drugs and equipped with basic medical equipment
- Successful introduction of user fees in public health centres and dispensaries
- If cash prepayment rises above 30% of total collections of user fees and contributions
- Formation of functioning DHBS
- Presence of District Health Plan and Community/ward health plan.
- Availability of essential drugs and supplies for at least 25 days each month of the year
- Evidence of additional drugs and supplies by using CHF funds
- Availability of standing imprest at health facilities for replenishment of sundries and off the shelf purchases

8.1 Monthly Financial Reports

Flash Report

The DMO shall submit monthly Flash Reports to the District Council and RMO not later than 6th of the following month. They shall indicate the following:

a) Previous month collection;
b) Collections of the month;
c) Total collections (a + b);
d) Previous month's payments;
e) Payments of the month;
f) Total payment (d + e);
g) Balance;
h) Each ward performance shall be indicated in the table.

Monthly Progress Report

The DMO shall submit to the District Council Monthly Progress Reports not later than 12th of the following month.

Quarterly and Mid Year Report

The DMO shall prepare quarterly and Mid Year Reports of the Income and Expenditure. Reports shall be submitted to the District Council and RMO not later than 15th of the following month.

Bank Reconciliation

The DMO shall prepare a Bank Reconciliation statement and submit the original statement to the District Health Board.

ANNEX 1: COSTING PACKAGES OF HEALTH CARE BENEFITS

Initial costs estimates to provide a basic package of health care benefits were established on the basis of four sources of information. Firstly, rough estimates were derived from secondary sources and expert opinion. These estimates were prepared using the costing framework from the World Bank study, "Better Health in Africa" (BHA). The BHA package is a generic package of preventive and curative services that health care expert in the World Bank, WHO, and UNICEF proposed as a minimum package in a typical low-income African county. The empirical information used to cost this package derives from well-functioning district health systems in rural areas of Africa counties.

A second source of data was based on the BHA costing framework, but revised the unit cost figures provided to more accurately reflect conditions and costs in Tanzania. This exercise used expenditures from non-government facilities.

Thirdly, a consultant was engaged to undertake two "field" assessments of costs in government and non-government facilities. One task of the consultant was to estimate per capita costs for a dispensary and its first-referral hospital to provide predefined basic package of preventive and curative services. This produced a per capita cost figure to provide such services to a typical rural resident. The consultant based his assessments on a government as well as non-government hospital, and dispensary in Igunga District, which pre-tested the CHF pilot. The costing activity was completed in April, 1996. Using this study the recurrent cost of the basic overall package of health services for Igunga district was US$ 7.50 per capita. On the other hand based on partial cost indicative client CHF contribution for dispensary and health centre was US$ 2.57. When this figure was adjusted for wastage increase in utilization and 10% inflation the per capita contribution rose to USD 4.68%. For a farm household of 5 members, the benefit package is USD 25.70. Detailed calculations are found in E. Mkusa report[1].

The fourth source of costing information could be derived from the pre-tested completed in Igunga and on going roll out districts. This information will apply only to costs of preventive and curative services provided by dispensaries. It will be based on a close assessment of utilization rates for preventive and curative care as well as recurrent expenditures to accommodate client demands.

From the four aforementioned sources of information, it will be possible to (i) assess the nature of services that can be provided for a specified amount, (ii) assess costs and potential appeal of different options or packages of service benefits that might be made available to CHF members, and (iii) negotiate with providers on the basis of informed assessments of costs to provide services. This is also the kind of information that will eventually be required by Government in its endeavours to assess costs and feasibility of different benefits in urban-based insurance programs.

In addition to costs of providing health care benefits, the CHF Programme requires information on unit costs of administering the CHF fund itself. The information in the

following table represents indicative costs per CHF member, assuming 100,000 members and a one year time period, and the procedure used to establish them.

Administrative Costs to Operate CHF: District Level Model

CHF Salary Items	**Rate (Tshs)**	**Yearly Amount (Tshs)**
Manager	80,000/mo	960,000
Accountant	60,000/mo	720,000
Secretary	40,000/mo	480,000
Driver/Maintenance	30,000/mo	360,000
Security Person	20,000/mo	240,000
Non-Salary Items		
Facility (rental)	50,000/mo	600,000
Furnishings	[1 million Tshs]/20 yrs	50,000
Utilities (water/elect.)	10,000/mo	120,000
2 Motorcycles (100cc)	[2 x 1.5 million Tshs]/5 yrs	600,000
Gas & Repair	4,166/mo	50,000
Telephone/Fax	100,000/mo	1,200,000
Photocopy	[750,000 Tshs]5 yrs	150,000
Other Supplies	20,000/mo	120,000
Health Card Expenditures		
Printing	[20 Tshs/card]x100,000 mem	2,000,000
Incentive Payments		
CHF Village Agents	(1) x (2) x 5% (1) = premium value 1000 Tshs (2) No. members = 100,000	5,000,000
Contracting Out		
Technical Advisory Committee		100,000
Travel & Night Allowance		
Manager Only		100,000
Marketing Costs		
Pamphlets	20 Tshs. X 25,000/yr	500,000
Advertisements		500,000
Total Administrative Costs		**14,170,000**
Cost per Member		**142**

ANNEX 2: CRITERIA USED TO SELECT ROLL OUT DISTRICTS FOR INCLUSION IN THE CHF PILOT

The design of CHF pilot was seen to be a complex process. At the same time the government desired to get its planning right. Such fund was seen as a means of ensuring greater security of access to health care, empowering households and communities in health care decisions, and promoting cost sharing with strong local participation. To develop meaningful selection criteria for pretest districts was based on: (a) A district with well functioning health facilities, (i.e. public, private, mission and community based health activities) for optimal competition among providers and community choice (b) Areas where the government health facilities have been rehabilitated with regular availability of drugs and supplies and (c) Districts where levels of income permit assessments of willingness and ability to pay membership fees. Thus Igunga district in Tabora Region was selected for being one of the ten districts under the Health and Nutrition Project (HNP) with rehabilitated health facilities. Results of Igunga pretest operations have attracted six more districts into extended pretest of the CHF with improvement in selection criteria for districts to be included in the CHF.

The six roll-out districts were selected on entirely new criteria as a result of Igunga pretest.

Region	District	Selection Criteria
Tabora	Igunga	• Rural based district with rehabilitated government health facilities under HNP
	Nzega	• Rural based district with rehabilitated government health facilities under HNP • Closeness to Igunga to facilitate coordination and cost effective by MOH
Singida	Iramba	District under HNP
	Singinda Rural	District under HNP
Ruvuma	Songea Urban and Songea Rural	Songea District leadership visited Igunga district CHF and requested to be included in CHF pilot. The district was selected on responsiveness and willingness to try community based health financing. The Urban district was included to test CHF in Urban setting
Arusha	Hanang	District leadership showed a lot of enthusiasm about CHF and district selected as control.

ANNEX 3: RESPONSIBILITIES OF VARIOUS STAKEHOLDERS

Ministry Responsible for Local Government

a) Supports the implementation of health policies and strategies
b) Allocates government funds for purchasing drugs for the health centres and dispensaries
c) Oversees the District Council in the supervision of CHF
d) Endorses by laws

Ministry of Health (MOH)

a) Develops and disseminates health guidelines, regulations an standards
b) Training of Health personnel
c) Provides operation guidelines
d) Mobilises resources for health
e) Promotes the implementation of CHF
f) Provides Technical backstopping

Regional Secretariat

a) Provides technical assistant to district committees
b) Links and advises on the health development activities for the districts in the region
c) Receives, analyzes reports and provides feedback to the districts
d) Supports the districts in developing District Health Plans
e) Monitors adherence of districts to Ministry of Health's guidelines
f) Provides and Regional Commissioner with district health reports on CHF
g) Monitors and evaluates progress being made on CHF activities in the districts

District Councils (DC)

a) Provides operational guidelines for health activities to DHB
b) Receive instruction guidelines from PMO and provide the same to implementation teams in the district
c) To provides guidelines that facilitate for ownership and management of the fund
d) Receive CHF management report
e) Guide the District Health Board to submit various reports as required
f) Ensures that funds from the Government (local and central) are timely disbursed
g) Ensures that the District Health Board is autonomous as in management of CHF
h) Ensures that CHF Health Board works harmoniously with other implementing agencies such as Ward Committee, Health care providers, Councilors and CHF members
i) Ensures funds are available for health development activities in the district
j) Ensures that essential drugs and medical supplies, vaccines are timely available.

District Health Board (DHB)

a) Responsible for overall routine monitoring of CHF operations
b) Works in consonant with DHMT to ensure quality care and professionalism
c) Administers, mobilizes funds and open bank account
d) Set exemption policy and targets for CHF
e) Review reports from Ward Committees and other sources
f) Monitor and, make verification on collection, expenditure and control of funds

District Health Management Team (DHMT)

a) Monitor activities of both private and public health facilities
b) Set a mechanism of monitoring and evaluation of CHF
c) Assure quality assurance of services provided
d) Supervises all health activities in the District
- assesses performance of the referral system
- Provides technical advice on CHF activities and progress to CHF District Board
- Arbitrates grievances with clients, community and health providers
- Receives and acts on report from village health committee, WEO and DMO on client satisfaction
- Carry out supervision visits at least once a month to check prescription procedures, what has been collected, use of registers, use and storage of drugs and any other issue pertaining to the operation of the scheme as the need may arise.

Ward CHF Health Committee (WHC)

a) Mobilizes communities to join CHF membership
b) Prepare membership lists and supervise the collectors of fees
c) Review specific cases and situations on their own communities and resolve the problem or make recommendations to the DHB
d) Monitor the number/proportion of CHF members in the community
e) Monitor the level of contributions and user-fee revenues
f) Review CHF operations, make recommendations and take remedial actions
g) Initiate and coordinate community health planning
h) Implement and monitor the community health plans
i) Attend bi-annual general meetings of members

ANNEX 4: COMPOSITION OF HEALTH BOARD AND COMMITTEES

Members of the District Health Board

The DHB is composed of 15 members, eight representing community from every Division and three representing women. The composition is stated below:-

a) Chairperson-elected by District Council among the CHF members
b) Chairperson of the District Social Service Committee
c) Two (2) members from each division as recommended by the ward committees
d) District Executive Director (by virtue of his position)
e) Three (3) women members elected by the District Council as recommended by the Ward Committees

Members of the Ward Health Committee

a) Chairperson elected by members amongst themselves
b) Councilor from the ward
c) Ward Executive Officer
d) Clinical Officer or Assistant Clinical Officer in-charge of NGO/private health facility
e) Head Teacher from a primary school located in the ward
f) Two (2) members elected by ward community
g) Secretary nominated by the committee from amongst its members.

ANNEX 5: TERMS OF REFERENCE AND QUALIFICATION FOR CHF COLLECTOR

Terms of Reference

a) Collection of CHF contributions
b) Issuing receipts against each contributions
c) Enter contributions into a ledger
d) Keeping of contributions in a cash box
e) Handing over the collections to WEO and receive a receipt against the submitted sum
f) Keeping record
g) Writing monthly reports
h) Prepare a plan of collection of contributions and household visits
i) To promote CHF activities

Qualifications and Qualities

Collection of CHF funds is done by a collector who is identified by respective communities. The collector should have at least the following qualifications and qualities:

a) 25 years old or above
b) Tanzanian resident of the ward
c) Minimum education Std 7
d) Acceptable to the Community
e) Have self-confidence and drive
f) No criminal record
g) CHF member
h) Basic accounts knowledge or good in mathematics

ANNEX 6: TERMS OF REFERENCE FOR WEO IN CHF

a) Overall coordinator of all activities in the ward including CHF
b) Promotion of CHF in the Ward
c) Receives collections from the collectors and keep (money) in the custody after issuing receipts to the collector
d) Keeps record
e) Bank CHF money and sends the pay-in-slips to the DMO
f) Informs the ward committee on the collections/expenditures
g) Deal with grievances occurring within the ward
h) Write a monthly report on CHF and submit to the DMO/DED/Ward Committee.

ANNEX 7: RERMS OF REFERENCE FOR DMO IN CHF

a) Overall in-charge of health matters in the district including CHF
b) To promote CHF activities in the district
c) Secretary of DHB
d) Chairperson of DHMT
e) Responsible for bank reconciliation's on CHF
f) Compiling of requirements form health facilities and submit to the DHB for approval
g) Preparing a cheque for payments after being authorized by DHB
h) Procure drugs/supplies for Health Facility
i) Distribute drugs to health facility
j) Compiling of monthly, quarterly, annual report on CHF
k) Communicate with ward committees PIU, region and Steering Committee on issues concerning CHF
l) Supervise the Health Facility on drug prescription, storage and dispensing according to National treatment guidelines
m) Control expenditures
n) Monitoring and Evaluation of CHF activities in the District
o) Receives and act on grievances raised from the community

ANNEX 8: TERMS OF REFERENCE FOR DHMT

a) Prepares the District Health Plan including CHF
b) Provide technical advice to DHB and DPHC team
c) Set mechanism of monitoring and evaluation of health issues/matters including CHF in the district
d) Implementing health activities as directed by the Ministry and RHMT
e) Receive directions/orders from the RHMT and DHB acts upon them and send feedback
f) Receive grievances from the Community and act upon them
g) Organize monthly quarterly and annual DPHC meetings.

ANNEX 9: TERMS OF REFERENCE FOR DISTRICT COUNCIL ACCOUNTANT

Each DHMT will have an Accountant employed by DHB and will assist DMO to keep all records of CHF by:

a) Receiving and recording bank slips
b) Prepare bank reconciliation statements on monthly basis
c) Report to DMO any discrepancies arising from bank reconciliation
d) Keep in safe custody of receipt books, registers, cash book etc.
e) Supervise the CHF collectors
f) Direct proper maintenance of funds to CHF collectors
g) Supervise facility level collections
h) Carry pre-audits of facility funds and CHF collections
i) Prepare quarterly and annual reports on CHF financial activities
j) Prepare CHF monthly financial statements
k) Ensure CHF books are properly audited by external auditors
l) Ensure all purchased stocks are delivered to the appropriate facilities and entered into the ledgers
m) Prepare bills and follow-up payment of the issued bills
n) Attend to all CHF financial obligations.

ANNEX 10: TERMS OF REFERENCE AND RESPONSIBILITIES OF HEALTH CARE PROVIDERS IN CHF

Terms of Reference

Health care providers are workers working in all health facilities. They are the executors of health services in their service areas. The health care providers are employed by either the government, voluntary agencies, parastatal organizations or the private sector. They work in Dispensaries, Health Centres and Hospitals. For success operations of CHF in each District, health will be guided by the following terms of reference:-

a) Know and conform to their job descriptions
b) Procure drugs through indenting
c) Procure medical supplies and technical equipment
d) Provide management of health units and address the referral system objectively
e) Ensure prescribed minimum national standards of quality of health care
f) Attend CHF meetings
g) Attend and complete successfully the approved upgrading medical courses
h) Have prescription knowledge
i) Maintain the health unit in good condition
j) Request CHF funds from ward CHF committee
k) Keep records of CHF members at the health facility
l) Advise the Community on Health matters
m) Promote preventive services in line with PHC guidelines

Responsibilities

Health care providers will have the following responsibilities in relation to CHF

a) Educate the community on CHF
b) Solicit CHF contributions from the communities
c) Keep confidentiality of patient reports
d) Report at work in time
e) Be polite to clients/patients
f) Avoid long queues for clients/patients
g) Collect user charge fees, bank the money and send copy of paying-in-slip to DMO
h) Be answerable to the DMO on technical and management matters of the Health
i) Units and catchments population served under CHF
j) Prepare financial report to CHF committee on a monthly, quarterly, biannually and yearly basis.

ANNEX 11: DISTRICT – LEVEL INTRODUCTION TO CHF PROGRAM FOR HEALTH PROVIDERS AND WARD LEADERS

The District Medical Officers holds a meeting at the district centre to explain this program to ward-level health actors. The meeting is open to whoever would like to participate but is designed to explain the program to WEO. Health providers, ward health coordinator, WDC representatives, and Ward health committee members. The meeting may be repeated if necessary for wards that did not send a representative the first meeting or which would like clarifications of how the program works and who does what.

The agenda for the meeting is as follows:

I. Brief Summary of CHF (distribution and review of CHF information leaflet).

II. Discuss the exercise of formulating a tentative plan for ward health improvement. (The DMO will lead the meeting n this exercise, in which the needs of the ward health are identified and prioritized. This tentative plan is cleared by the WDC prior to the arrival of the District Training Team in the ward).

III. Set a date sometime during the following month for the District Training Team to visit each ward to assist the WEO in presenting the CHF to the ward community and, in those communities which elect to participate, to train the WDC, WHC, health providers and fee collectors.

IV. Distribute a letter to the chairperson of each ward development committee announcing the program and the dates of the District Training Team's visit to the ward. The letter will request that (i) the tentative plan for ward health improvement be formulated by the ward health committee and cleared by the WDC prior to the arrival of the District Training Team, (ii) that the WDC convene a meeting of the ward community to coincide with the first day of the visit by the District Training Team.

ANNEX 12: COMPONENTS OF A CHF FUNDRAISING CAMPAIGN AND ISSUES TO CONSIDER IN DEVELOPING ONE

After agreeing to participate in the CHF program and developing a ward health plan of needs the meeting must decide how it raises the funds required to fulfill the plan.

Types of Fundraising Activities

Communities can raise funds by:

a) applying use fee to this project
b) levying CHF contribution
c) collecting other cash contributions from communities, other people in the ward community or local businesses;
d) holding special auctions of in-kind contributions;
e) applying a crop levy to the project

Since all ward community funds raised under this program must be used for health programmes, the ward community cannot raise funds by accepting a loan, which must be repaid. Also, while a ward community can agree on a mandatory fee on households and/or the ward community at large, the ward cannot exclude patients from poor familiar that cannot pay from being treated.

Length of fundraising Campaign

Communities must decide how many fundraising campaigns they will have in a year and the length of time that each campaign should last. Communities can raise funds as many times per year as they want but the government only release its matching contributions in two installments per year.

Setting a CHF Contribution

If the ward development committee decides to ask households and /or the war community at large to pay a CHF contribution, the wad community must determine:

a) The size of the fee;
b) How CHF contributions are assessed (e.g. household, or per adult in the ward community);
c) Whether low-income households are partially or totally exempted from paying the CHF contribution
d) Whether higher income households are asked to pay more than the standard CHF contribution;
e) Whether contributions are accepted in installments for households who cannot pay the entire fee at one time;
f) Whether in-kind payments are accepted in lieu of cash. Note, however, that the government only matches the total cash contributions realized by the ward.

Some Possible Means of Converting In-Kind Contributions into Cash

There are several ways in which the ward community might convert in-kind contributions into cash so that these contributions are eligible for the matching grant:

a) Contributions made in agricultural products or other goods could be sold or auctioned;

b) The ward community as a whole could pay the fee for poorer household with the understanding that family would contribute a specific amount of work to health facility buildings or grounds. However, the work must be specified in advanced and poor household must consent to perform it.

ANNEX 13: INDICATORS FOR MONITORING AND EVALUATION CHF[1]/

Development of Indicators for CHF

The process of monitoring and evaluation entails development and use of indicators as a means of tracing implementation through inputs, process, output and impact. Monitoring is a continuous watching over the changes brought by use of resources while evaluation is the exercise of assessing the impact reached as part of the overall goal. CHF indicators were developed through review of data and information sources of variables from the CHF project documents, discussion with CHF personnel and other sources of information. The indicators developed with help to measure clearly the inputs, process, output and impact of CHF.

Input Indicators

Table 1 shows indicators which can monitor progress of project implementation at the input level. These indicators measure achievements in activities and strategies such as supply of drugs, provision of basic equipment at health facilities, marketing of CHF, preparation and dissemination of information, education and communication (IEC) materials and management of CHF as inputs.

[1]/ Source: TFNC

Table 1: Input Indicators

Improved Availability of Drugs and Basic Equipment			
Area	**Input Indicators**	**Means of Verification**	**Source**
Drugs availability and Utilization	- Number of dispensaries and Health Centres stocked by standard/kit package of drugs	- Analysis of Stores records at Health Facility - Analysis of CHF Monthly/Quarterly/Annual reports	- Stores records at health facility
	- Rate of drug utilization by health facility	- Analysis of store issue record	- Stores records at health facility
	- List of drugs accumulating over time	- Analysis of store issue records	- Stores records at health facility
Facilities and Equipment	- Proportion of health facilities rehabilitated	- District Medical Officer's report	- District Commissioner's Office
	- Proportion of health facilities with supply	- District Medical Officer's report	- District Commissioner's Office
	- Proportion of dispensaries and health centres equipped with basic equipment	- Analysis of stores records against standard facility equipment at health facility	- Stores records at health facility

Acceptable Financial Resource Base Health Care Established			
Marketing of CHF	Number of CHF ward caretaker committees formed and functioning	Analysis of CHF monthly/Quarterly report	CHF Monthly/ Quarterly report
	Number of meetings and mobilization activities	Analysis of CHF Monthly/Quarterly reports	CHF Monthly/ Quarterly reports
Dissemination of IEC on CHF	Number of households with information on CHF	Analysis of baseline survey data	Household
	Itinerary on educational material supplied	Analysis of CHF Monthly/Quarterly reports	Health facility records
	Proportion of households with knowledge on CHF	Analysis of baseline surveys data	Household
	Proportion of CHF members/non members by households size	Analysis of CHF cards	Household
	Proportion of CHF members/non members by level of education of.	Analysis of baseline survey data	Household
CHF Membership	Proportion of CHF members main activities	Analysis of baseline survey data	Household
	Proportion of CHF members by occupation	Analysis of baseline survey data	Household
	Proportion of CHF members/non members by gander of household head	- Analysis of CHF cards. - Analysis of baseline survey data	Household
	Proportion of CHF members/non member with specific prolonged illness	Analysis of baseline survey data	Household
	Proportion of CHF members/non member permanently settled	Analysis of baseline survey data	CHF Monthly/Quarterly reports
	Number of households and villages visited by CHF agents	Analysis of CHF Monthly/Quarterly reports	
Management of CHF	Proportion of CHF committee members by sector and gender	Analysis of CHF Committee composition	District Commissioner's office
	Pattern of expenditure of CHF and user fees fund by health facility	Analysis of CHF and user fees Accounts books	Health facility
	Frequency of CHF committee managerial meetings	Review meetings minutes	CHF District coordinator
	Number of supervisory visit form district to health facility	Analysis of visitor's book	Health facility

Process Indicators

During implementation and through the inputs achievements can be assessed using process indicators. The activities and strategies which can be measured by process indicators include:- community involvement, participation and control of health and services; and enhanced capacity and capabilities of health service providers and key actors as shown on Table II.

Table II: Process Indicators

The Capabilities of Health Providers and Key (CHF) Actors Enhanced			
Area	**Process Indicators**	**Means of Verification**	**Source**
Capability Building	Number of health staff trained on disease management	Analysis of CHF Quarterly reports	CHF Quarterly reports
	Number of staff with formal qualifications required	Analysis of staff records at health facility	Staff records at health facility
	Percent of community leaders sensitized on disease control	Analysis of Quarterly and Proceeding reports	Quarterly reports and training proceeding/reports
	Percent of TBAs trained on safe delivery methods	Analysis of Quarterly and Proceedings reports	Quarterly reports and training proceeding/reports
	Number of CHF committee members attending sensitization workshops	Analysis of CHF Workshop Proceedings	CHF workshop proceeding/report
	Number of health workers attending training on prescription and dispensing	Review CHF Quarterly reports and Seminar Proceeding documents	CHF Quarterly reports and proceeding documents
	Number of District and Ward Executive Officer trained on financial management procedures	Review Training report documents	CHF Training reports/documents
	Number of Ward Community CHF Collectors trained on bookkeeping	Review District CHF manger Training reports	District CHF reports/documents
	Proportion of community members aware of CHF	Analysis of Baseline survey	Household
Community Participation	Number of CHF regular meetings convened	Actual meetings against planned	CHF ward reports
	Number of wards preparing community health plans	Analysis of CHF Quarterly reports	CHF Quarterly reports

Output Indicators

Outputs are the achievements expected as the products from effective use of CHF contributions and user fees. In other words they are outcomes of realizing the project specific objectives. The output indicators of the CHF scheme is as listed in Table III measure the levels reached form establishing a financial resource base for basic preventive and curative health care.

Table III: Output Indicators

A Financial Resource Base (CHF) for Health Care Established			
Area	**Output Indicators**	**Means of Verification**	**Source**
	Total contributions and trend of contributions by wards	Analysis of CHF Monthly/Quarterly reports	CHF Monthly/Quarterly reports
	Total user fees collected by health facility / ward	Review accounts books at health facility	Health facility
	CHF/user fees funds available in the bank by ward	Bank Statement	Specified bank branch
Contributions from Target Households and other Financiers	Number of household enrolled	Analysis of CHF Monthly/Quarterly reports	CHF Monthly/Quarterly reports
	Trend on enrollment overtime by ward	Analysis of CHF Monthly/Quarterly reports	CHF Monthly reports
	Number of CHF cards distributed	Analysis of CHF Monthly/Quarterly reports	CHF Monthly/Quarterly reports
	Number of Providers with signed contracts	Signed contracts	CHF Monthly/Quarterly reports
	Amount of Financiers contributions	Analysis of amount released by financiers	CHF Quarterly reports

Impact Indicators

Impact indicators measure the achievement of general goal of the project. In the case of the CHF the impact indicators will assess if all the community members have an improved coverage, accessibility and equitable health services as shown in Table IV.

Table IV: Impact Indicators

Improved Accessibility and Equity to Health Care Achieved			
Area	**Impact Indicators**	**Means of Verification**	**Source**
Coverage, Accessibility and Equity	Proportion of facility attendance by women and children	Patients register book at health facility	Patient registered book at health facility
	Number of indigents and destitute households identified and exempted per ward	Review meeting minutes of CHF committee. Focus group discussion.	CHF register and records at ward
	Proportion of households enrolled by distance to CHF health facility	Analysis of baseline survey data	Household and focus group discussion
Service Utilization	Proportion of household preferred source of Health care	Baseline survey data	Household
	Rate of visits to major source of Health care by household	Baseline survey data	Household
	Proportion of households satisfied with services provided at the health facility	Baseline survey data	Household
	Proportion of health staff satisfied with the working conditions at the health facility	Baseline survey data	Household
	Trend of utilization of non CHF health facilities	Baseline survey data	Household