Tanzania

Review of Exemptions and Waivers

February 2006

Submitted to:
Ministry of Health and Social Welfare

Submitted by:
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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
APHTA	Association of Private Hospitals Tanzania
CCHP	Comprehensive Community Health Plan
CHMT	Council Health Management Team
CHB	Council Health Board
CHF	Community Health Fund
CSSC	Christian Social Service Commission
Danida	Danish International Development Agency
DDH	Designated District Hospital
DED	District Executive Officer
DMO	District Medical Officer
DP	Development Partner
EHG	Euro Health Group
GTZ	Gesellscaft fur Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
HRS	Health Reform Secretariat
HSPS	Health Sector Programme Support (Danish Embassy / Danida)
HSR	Health Sector Review
HSRS	Health Sector Reform Secretariat
IEC	Information, Education and Communication
MCH	Maternal and child health
MDGs	Millennium Development Goals
MOH	Ministry of Health and Social Welfare
MSD	Medical Supplies Department
MTEF	Medium Term Expenditure Framework
NGO	Non-governmental organisation
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
OC	Other charges
PHC	Primary health care
PORALG	President's Office, Regional Administration and Local Government
PPP	Public Private Partnership
PRS	Poverty Reduction Strategy
REPOA	Research on Poverty Alleviation
SDC	Swiss Development Co-operation
Tsh	Tanzanian Shillings
TOR	Terms of Reference
WDC	Ward Development Committee
WHO	World Health Organisation

Exchange rates – average during January 2006
€1 = 1330 Tanzanian shillings (Tsh)
US$1 = 1080 Tanzanian shillings (Tsh)
Fiscal year: July – June

ACKNOWLEDGEMENTS

The team received constructive support throughout from the Ministry of Health, development partners, NGOs and organisations associated with health and welfare issues. On the field visits to the north and the south of the country the co-operation and engagement of the people met, including officials, providers and users of the health system, was extremely useful and productive and allowed various options and possibilities for refining the exemptions and waivers systems to be tested and re-tested.

Thanks to all of those with whom discussions were held in Iringa Region, Morogoro Region, Tanga Region, Kilimanjaro Region, including the regional and district officials, village leaders, health facility committees and health personnel, as well as individuals in villages and at health facilities. All of those met were interested in finding ways to improve the health system and offered opinions and suggestions to the team. Their participation in and contribution to our work is very much appreciated.

The work was carried out under the aegis of the Health Sector Reform Secretariat and funded by Danida.

EXECUTIVE SUMMARY

The work which is presented in this report reflects a need identified by the Ministry of Health to improve the functionality of the exemptions and waivers systems which had been introduced to reduce the financial burden on groups of the population who need access to health care and who either cannot afford to contribute to the costs or who have an illness or disease which threatens the public good and for which no direct charges should be imposed. The exemptions and waivers systems, while potentially very effective in principle, were deemed not to be working well in practice.

A significant body of work already exists on the health sector in Tanzania, with plenty of references to the exemptions and waivers systems. The task of the team undertaking this study was not to replicate the work of previous studies but rather to find ways to make some of the recommendations happen. The 'how to' element was seen as the most crucial aspect of the work, and the aspect which presented the greatest challenge. The results from all the available documentation were used, and were augmented by field visits to a number of regions and districts in the north and south of the country, where proposals for reinforcement of the waivers and exemptions systems could be tested with practitioners and users of the health sector.

The strategy proposed in the document is divided into a long term strategy and an interim strategy. The long terms strategy is to have the whole population of Tanzania covered by one or another insurance scheme, from a selection of current and proposed schemes: the National Health Insurance Fund scheme for civil servants, the Social Security Fund health benefits scheme for formal sector employees, the proposed social insurance scheme for informal sector workers, the CHF or a scheme to cover those who are not eligible or cannot afford to participate in any of the others.

The interim strategy identifies ways and means of strengthening the systems to ensure more equitable access to health services for those who are entitled to exemptions and waivers, with recommendations about how those systems can be refined to target those who most need them. Successful examples from the field are used to show the way forward. The interim strategy includes refinement of the exemptions system; expansion and consolidation of the Community Health Fund (CHF); development of TIKA, the urban equivalent of the CHF; the development of an ID card scheme for those who cannot afford to pay or to participate in any of the schemes; and the strengthening of the institutions which provide health care and which plan and monitor the services provided. The ID card scheme, being new to the stable of proposals for strengthening the exemptions and waivers systems, is fully elucidated from the rationale, through the principles behind it, to the identification process for those eligible, the issuing of the card, the roles of each of the institutions at leach level of the administrative structure, the financing of the scheme and the advocacy required to endure that it works the way it is intended by providing for those most in need.

Inevitably, the proposals cannot be implemented in a vacuum and where there are risks involved, either general or specific, these have been identified.

1. INTRODUCTION AND BACKGROUND

This report is the output from a study undertaken in response to a request from the Ministry of Health, Health Sector Reform Secretariat (HSRS), to Danida. The original impetus for the study came from recommendations from earlier studies, including specifically a report by L.A. Msambichaka et al., titled Assessment of the impact of exemptions and waivers on cost sharing revenue collection in public health facilities. The objectives of the study, as developed by the Ministry of Health, were to identify and articulate practical options to improve the current exemptions and waivers systems in the health sector, in order to better ensure that the poor have access to appropriate health services. Specific objectives include:

- To review current policies and application of exemptions to ensure that the most vulnerable groups are exempted while those who are able to pay and currently also exempted are made to pay
- To recommend various options on how to improve waivers and exemption systems to make them cover the poor and vulnerable groups effectively
- To suggest how exemption and waivers should be reinforced in their implementation
- To suggest how poor people can be protected against catastrophic health events
- To analyse and suggest incentives to motivate health staff in facilities to make exemptions and waivers work and reduce demand for bribes[1]

The Terms of Reference for the work are attached in Annex 1.

Euro Health Group (EHG) was commissioned by MOH / Danida to recruit two international consultants to undertake the work, both of whom were approved by the Ministry of Health. Three national consultants were provided by the Ministry of Health. The team included Monica Burns, Michaela Mantel, Lucian Msambichaka, and Deograsias Mushi, and Faustin Njau. The mission took place during January and February 2006.

The study was undertaken in response to concerns about the apparent ineffectiveness of the exemptions and waivers systems in the health sector and the slow uptake of recommendations which had been made to resolve the situation. The consultant team was asked to identify practical and do-able actions and to articulate those as clearly as possible, in order to strengthen and improve the exemption and waivers systems and so contribute to an increased access to services of those who are particularly poor. There is a wealth of documentation already available on health sector issues, many of which provide insight, analyses and recommendations relating to the exemptions and waivers systems.

While the consultant team was required to focus on finding practical ways of strengthening and improving the exemptions and waivers systems, it is clear that these cannot be addressed in a vacuum. Some of the issues which impact on the implementation of the regulations need to be addressed in the context of the wider health system.

Health services in Tanzania are provided by a range of government, NGO and private facilities. The team looked at the potential for strengthening the exemptions and waivers systems in government and NGO facilities but did not consider private-for-profit facilities.

The Ministry of Health requested that, rather than re-presenting information about the exemptions and waivers system, which is already well established in the sector, the team should concentrate in their report on identifying *how* to achieve improvements. To this end, the report is divided into five main section headings: Introduction and background;

[1] Equity implications of health sector user fees in Tanzania by I.Latterveer, M. Munga and P. Schwerzel, ETC Crystal, the Netherlands

Methodology; Findings; Recommendations; and Risk factors. The section on findings relates specifically to the findings of this team rather than findings in general about the exemption and waivers systems which are already well documented. Section 4 Recommendations is restricted to a logical flow of recommendations ranging from the ideal scenario, to an interim approach for targeting the poor and marginally poor as well as the very poor (who are unable to contribute), through to practical amendments to current practice to make the system more effective. As far as possible the suggestions and recommendations made in the report have been 'reality checked' by those working in the health sector in rural areas and at central level.

For the purposes of this report the following definitions of exemptions and waivers are being used:

> Exemption: *An exemption is a statutory entitlement to free health care services, granted to individuals who automatically fall under the categories specified in the cost sharing operationalisation manual; MCH services, including immunisation of children in all Grade III services; children of 5 years of age and below; patients suffering from TB, leprosy, paralysis, typhoid, cancer and HIV/AIDS; cholera, meningitis, plague, and long term mental disorders* (from CHF design manual)
>
> Waiver: *A waiver is granted to those patients who do not automatically qualify for statutory exemptions but are in need of the same, and classified as 'unable to pay, in the operationalisation manual* (from CHF design manual)

2. METHODOLOGY

The approach to the work was prescribed by the TORs and included an in-depth review of all available literature in hard copy and from the internet, as well as discussions with stakeholders from the health sector and from among the development partners and NGOs.

Documentation available to the consultant team was trawled for information and the information specifically relating to exemptions and waivers has been culled and synthesised. The synthesised information is available at Annex 2. Other documents consulted included legislation, regulations, official guidelines, implementation manuals and other official documentation: while these were all consulted, not all of them are referred to in the text of the report.

Discussions with stakeholders took place at all levels, including users of services, local health workers, regional, district and local government officials, and academic and Ministry personnel.

Field visits to villages and districts were made to the north and south of the country, and included discussions in villages, at dispensaries, health centres, district and regional level hospitals, and with a wide range of users, providers and officials.

Working sessions with the consultant team took place on an ongoing basis with frequent sessions devoted specifically to addressing the practicalities of some of the options and ensuring that what was being proposed was actually achievable. Where necessary, follow up discussions with colleagues working in the field were held by telephone and email.

The study undertaken was necessarily qualitative rather than quantitative and no new empirical data was collected.

3. FINDINGS

3.1 RESULTS OF LITERATURE RESEARCH

In the context of the poverty reduction strategy adopted by the Tanzanian Government and the Millennium Development Goals (MDGs) for Tanzania, health care financing in general and access of the poor and vulnerable population to quality care in particular have been subject to numerous assessments and studies. Most of the literature consulted confirms that (a) access for the poor and vulnerable to health care in terms of availability of services and quality of care is adversely affected both with and without user fee systems in place; and (b) the implementation of exemption and waiver systems is widely ineffective and does not meet the objective of ensuring access to quality services for the needy poor (see also Annex 2 Synthesis of findings and recommendations from the literature). A summary of the literature findings is presented in Table 1.

It was agreed with the MOH and the HSRS that there was no need for a further detailed study to establish the weaknesses of the exemptions and waivers systems and that existing literature should be used, in tandem with observations in the field, to form the basis for the recommendations of this study. In addition to the Msambichaka report mentioned above, two studies should be referred to which are of particular importance in this context: the study on *Performance and future potential of the user fee exemption and waiver mechanism in Dar Es Salaam* by the Swiss Tropical Institute, May 2005, and the *ETC Crystal Study on Equity Implications of Health Sector User Fees in Tanzania*, July 2004. Both studies provide comprehensive and detailed information on the current implementation and performance of the exemption and waiver systems as well as recommendations for possible improvements.

Table 1: Summary of relevant findings from the literature review of exemptions and waivers

Major limitations:
• Exemptions might benefit the better off more than the poor; most of the exemptions are for children under five, chronic diseases and pregnant women which are the highest cost items; many of those exempted belong to households which would be able to pay the public service fees or for community health fund (CHF) • The poorest who are not able to pay often do not have access to waivers; either due to lack of information and/or denial of the waiver by a provider • Waived patients experience stigmatization and disadvantages while attending health services compared to those who pay for services • With the introduction of user fees and CHF at primary level of care, there is the risk that access of the poorest to essential health care is substantially decreasing • Identification/application procedures and screening criteria for waivers are unclear • The exemption and waivers procedures have loopholes that allow the misuse and sometimes abuse of the system • There is a potential conflict between the attempt to generate revenue and protection of the vulnerable social groups

Main recommendations:

- The public health system should make waivers more widely available and easy to obtain, in order to reduce spending of poor people on medical care
- Review the exemptions and waivers with the objective of making them more applicant friendly and operationally efficient and more focused on targeting the poorest households
- Blanket policies should be avoided. Instead, a mechanism should be put in place to enforce transparency and accountability as well as to monitor and evaluate implementation of the system
- Policies for exemptions and waivers should be refined: clarification of the eligible poor; specification of free services for each group; targets at ward level for the number of poor people who should be given waivers based on local poverty rates; examine whether the exemption and waivers categories chosen exclude any specific vulnerable group, such as HIV affected households or households with a high dependency ratio
- Public sensitisation and communication of the new policy to health staff and community
- Improve access to all free services for exemption and waiver categories and improve quality of care particularly of drug supply; capacity building required
- Reduce the red tape for poor people. Waivers should come to the poor rather than the poor having to seek for waiver; granting of waivers should not be left to health workers
- Special identity card for the poor with photo attached for a longer period of time; at present, the letter from the community leader is only valid in one specific area
- Standardisation of exemption and waiver mechanism
- Design incentive mechanisms for management of cost sharing that will reinforce an effective implementation of the policy for waivers and exemptions
- Involvement of communities at grass roots level in the management and oversight of health services

3.2 FINDINGS AND OBSERVATIONS FROM THE FIELD VISITS AND CONCLUSIONS

The field visits undertaken in the context of this study confirmed what has been written in previous studies and mission reports. The field visits also confirmed that most of the recommendations previously made by experts and politicians in regard to the exemption and waiver systems are still valid and feasible. However, most of the recommendations remained quite broad and did not give clear guidance on **how** to implement them in practice. The field findings and observations presented below form the basis of the recommendations contained in the following chapter.

~~3.2.1~~3.2.1 Findings and observations in respect of exemptions

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- *Understanding of the exemption system*

The exemption system is quite well understood among villagers and health personnel. Where drugs and supplies are available, patients apparently do not need to spend additional money at private pharmacies and drug and supply outlets or at the health facility itself.

- *Risk of abolishing general exemptions*

The majority of villagers and health personnel interviewed in the districts regarded a possible approach of abolishing general exemptions (especially for children under five) as a risk for the survival of vulnerable individuals. Despite the fact that many of those exempted might belong to better-off families, the risk of decreasing access to care for the poor/vulnerable would be too high as long as coverage of CHF and insurance schemes remain low and as long as the waiver system is not effective.

~~3.2.2~~3.2.2 Findings and observations in respect of waivers

- *The 'Mwanga experience' in identifying the poor*

Some districts, such as Mwanga, have been able to identify the poor and maintain lists of the poor in all health facilities, so that application of waivers is straightforward.

- *Consolidating all forms of cost sharing into a Community Health Fund*

Some districts visited have consolidated all forms of cost sharing into a Community Health Fund. Households who cannot afford to pay are identified and provided with a CHF card entitling them to services as if they have made the contribution.

- *Colour coding of registration cards*

When patients register in some health facilities, the registration cards are colour coded to indicate if they are exempted or waived.

- *Letters of authorisation from village leaders*

Some people come with authorisation letters from village leaders about patients' poverty, as recommended by MOH. The authenticity of some of the letters is often challenged by hospital staff. The field visits confirmed that the waiver procedure is obviously time consuming and difficult to access. Major problems are: low accessibility to waivers due to poor awareness of the public about the existence of waiver mechanisms; unclear definitions and procedures/guidelines; cumbersome and frustrating identification processes; a great deal of personalised negotiation around payment, particularly at the service delivery points; people not showing up with the required certification letters from village government; possibilities for misuse of power if individuals are responsible for issuing waivers; no clear guidelines at primary level facilities; and poor recording and reporting.

~~3.2.3~~3.2.3 ~~F~~Findings and observations in respect of willingness and ability to pay

- *~~W~~Willingness and ability to pay CHF membership charges*

The majority of villagers and patients interviewed (generally poor rural population) confirmed that they are willing and able to pay the CHF membership charges (5,000 Tsh and 10,000 Tsh) provided that *"drugs are available"* and diagnostic services are available at local facilities.

- *~~C~~CHF potential to create demand for quality services*

The CHF apparently has the potential to create demand for quality services (empowerment of users), which poses a challenge for the Government to improve quality of care so as to encourage people join the scheme.

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- *~~H~~Households or individuals not able to pay*

There are only a few households or individuals who would not be able to pay even a small contribution. These are easily identifiable in a rural community since they are well known to the village and/or hamlet leadership.

- *~~A~~Ability to pay in instalments*

There are others who might be able to pay in instalments; most of the villagers confirmed that the timing for payment of CHF membership would be a crucial issue , indicating that it would be best to collect the contributions during harvest.

~~3.2.4~~3.2.4 ~~F~~Findings and observations in respect of CHF

- *~~C~~CHF an appropriate scheme for poorer populations*

The majority of people interviewed regard the CHF as an appropriate scheme for the poorer populations in rural areas and as a valuable instrument to increase access of the poor to quality services mainly for two reasons:

  - CHF - where it is implemented - improves availability of drugs;
  - The payment (5,000 Tsh – 10,000 Tsh) is low and allows access to health services for the entire family throughout the year.

- *~~C~~CHF enrolment still remains low*

Despite the positive perception of the benefits of the CHF scheme, CHF enrolment still remains very low even in districts with functioning community participation. Possible reasons for low enrolment in CHF:

  - misconception of the idea of solidarity; if someone in the household doesn't fall sick in a year, the contribution is considered a loss;
  - poor marketing/advertisement, lack of information and poor mobilisation;
  - limited package of care; CHF membership not valid at referral level where it is needed most; quality of health services is not satisfactory;
  - CHF card not portable, not valid beyond district borders;
  - CHF card rarely accepted at faith-based health facilities;
  - Political announcements during the recent election campaigns

3.2.5 ~~F~~Findings and observations in respect of access to referral services

- *~~A~~Absence of systems or mechanisms to cater for higher costs in cases of referrals*

No systems or mechanisms are yet in place to cater for the high costs in cases of referrals. In addition to high costs at the point of service delivery due to specialised treatment (such as surgery), people incur opportunity costs. These opportunity costs include high transport costs and costs arising from staying away from work in the fields etc. are crucial factors hindering access to essential hospital care not only for the lower quintile of the rural poor but also for those who are marginally better-off. The high opportunity costs appear to be a significant risk for rural population to fall into poverty through major illness. Or people simply don't take up referrals to hospital services (even in emergencies), thus risking their lives, due to inability to cope with these costs.

3.2.6 ~~F~~Findings and observations in respect of community involvement

- *~~P~~Potential for communities to maintain and manage primary level facilities*

There is a high potential for communities which are empowered and responsible for maintaining and managing primary level facilities to push for significant improvements in quality of care, provided the facility has access to their own funds.

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- *Cumbersome and bureaucratic procedures for accessing funds from CHF contributions*

In some districts, community health committees experienced cumbersome and bureaucratic procedures for accessing their own funds from CHF contributions which were deposited at district level.

- *The functioning of community committees and boards*

Some community committees or boards are not functioning effectively, which puts at risk the village-based identification of the poor, quality of primary level care, and appropriate use of funds.

- *Community activities and motivation*

There seem to be large differences in community activities and motivation between the regions. Reasons are not easily identifiable; however, it was said that district leadership and lack of incentives (even if small) are crucial factors.

3.2.7 Findings and observations in respect of private health services

- *Access of CHF cardholders to private not for-profit health services*

Access to private not-for-profit health services is limited for CHF cardholders. Some faith-based organisations do not accept CHF cards (no exact data available on this in the districts visited).

- *Claims from non-government health facilities*

Experiences show that claims from non-government health facilities for reimbursement of services provided to CHF members can be extraordinarily high due to higher user fee rates and service standards which are different from Government policies and standards (with some evidence of over prescribing) at individual facilities.

- *Credit facilities*

Some facilities allow patients credit facilities, so that they can pay at a later date.

- *Acceptance of Exemptions and Waivers*

Exemptions and waivers are often not accepted at non-government facilities. Patients have to pay, but are allowed to pay in instalments, at a later point in time.

- *Service agreements for universal access to health services*

The experiences with non-government organisations show that while official service agreements are not in place, the government cannot guarantee universal access to health services, especially in places where no public facility exists.

- *Service agreements for CHF members, accepting exemptions, waivers and for providing services to the poor*

Private-for-profit health service providers are generally unwilling to provide services to CHF members and/or to accept exemptions and waivers without having service agreements in place. It is unlikely that there would be agreement to provide services to the poor without service agreements being in place on a capitation basis rather than a reimbursement or claims basis, since capitation payment provide a degree of guarantee about income for the services to be provided.

3.2.8 ~~F~~Findings and observations in respect of quality of health care services

- *~~G~~General observation*

Quality of care is a prerequisite to encourage greater uptake of financing mechanisms such as CHF by the rural poor. Though utilisation in many places (e.g. deliveries at primary level) has increased over time, to a large extent quality of care is still not at an acceptable level.

- *Specific observations*
  - Availability of drugs

Districts with continuous *"kit supply"* experience severe shortages of drugs at primary health facility level during the second half of the month. Districts, which implement the *"Indent"* drug supply system have fewer shortages of drugs at primary health care level compared to those still receiving drugs supply kits. However, despite available financial resources, occasional shortages of essential drugs and medical supplies continue due to significant inefficiencies in the Medical Stores Department (MSD).

  - Availability and motivation of qualified personnel

Shortages of qualified personnel affect provision of timely and appropriate treatment at hospital level and accessibility to quality services at primary level; non-government facilities experience movement of qualified personnel to public facilities due to better working conditions and higher allowances.

  - Health facility infrastructure and equipment

The physical maintenance depends largely on availability of funds at facility level. Training on proper use of equipment is inadequate.

  - Health facility management

Management capacities are still deficient in many places; health facility development plans rarely exist.

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4. RECOMMENDATIONS

The terms of reference for this work clearly asked the team to look at practical solutions to improving the exemptions and waivers systems. There is no shortage of recommendations from many other reports but the 'how to achieve' element was not well articulated. The approach proposed in this report offers a long term strategy of universal coverage, and an interim strategy with a number of components to support the consolidation and effectiveness of the existing policies for exemptions and waivers.

The recommendations are presented in the following sequence:

Long term strategy

- Universal coverage through social health insurance schemes (which would dispense with the need for exemptions and waivers)

Interim strategy

- Continuation of the exemption policy which addresses population groups and medical conditions which are crucial to the public good;
- Expansion and consolidation of CHF as a pro poor scheme improving access to quality care for the majority of the poor in rural areas; and of expansion and consolidation of TIKA in urban areas;
- Improvements to the waiver system during the transition to universal coverage, through the introduction of an ID card[2] and associated financing mechanism for the very poor who are unable to contribute to the cost of health care;
- Advocacy and institutional strengthening at all levels to support these strategies.

To that end, the recommendations presented here start with what is considered to be the ideal scenario for health care in Tanzania. It is recognised that this vision falls into the category of a long term strategic goal and is not immediately achievable. But it is important to highlight the long-term goal to work towards. The proposed interim strategy is achievable in the short to medium term and would contribute to the incremental achievement of the long term goal. None of the recommendations require major changes to existing policies; they are mechanisms to ensure that the policies are fully operational and effective, thereby improving access to health care for the poor and the very poor.

Long term strategy

4.1 LONG TERM GOAL OF UNIVERSAL COVERAGE

The establishment and operation of the NHIF and the NSSF have started the process of social health insurance implementation in Tanzania. The two schemes, targeting formal sector employees and civil servants respectively, are a good first step in the development of universal social health insurance, covering the whole population. Clearly the two schemes provide cover for a limited (and relatively advantaged) portion of the population, but the concept of risk pooling and cross subsidisation, which are key features of social insurance, have been established and can be built upon.

While both schemes face challenges in terms of their operation (not least in financing mechanisms to ensure cost containment), these challenges are entirely expected and are predictable. In the planning and management of any social insurance scheme, the mechanisms chosen or adopted for ensuring entitlement, quality of services, financing and

[2] The term 'ID card' is used in this report for reasons of convenience only. If the concept is accepted, the card should have a Swahili name which indicates 'entitlement' rather than identification

payment of providers, all present challenges. Some choices offer easier administrative burdens, while others offer a wider choice for beneficiaries.

It is clear that neither of the current schemes can cover the entire population, irrespective of how successful they are at extending their coverage base. The number of civil servants will always be limited, and the number of people working in the formal sector will also be limited for many years to come, while the numbers of those working in the informal sector are inevitably higher than in the formal sector. There are major challenges to establishing social insurance schemes for the informal sector, and these should not be underestimated. But it is equally true that many people working in the informal sector are able and willing to make contributions to their health services, as long as the quality of care they receive is appropriate. While all of the poor are in the informal sector, not all of the informal sector are poor, and those who are not poor should be given an opportunity to contribute to the costs of health care in a way which encourages solidarity and equity.

There will always be a group of the population who are unable to contribute directly to a social insurance scheme and for this group the government would assume direct responsibility, contributing on their behalf to one of the schemes in operation, to ensure equal access to health services for them.

Ultimately, the goal must be to have everyone covered by one or another social health insurance scheme. If and when such a system is in place, then the issue of exemptions and waivers would be redundant. Those who are unable to contribute would have their contributions paid by government funds.

With an informal sector which is increasingly mobilised and organised, there is significant potential to develop and implement a scheme which would address a large portion of the population. Such a scheme could be based on workers associations (such as taxi drivers, fishermen, market stall holders etc), culminating under one umbrella informal sector scheme. A technical note on the potential for a scheme for the informal sector, to complement the schemes for civil servants and the formal sector (NHIF and NSSF respectively) could be prepared, if requested. The potential coverage of a social insurance scheme for the informal sector could amount to approximately 25 – 30% of the population. This would leave a much smaller portion of the population uncovered by any insurance scheme.

The CHF scheme is a pro-poor scheme, given the nominal contribution rate for members (between Tsh 5,000, and Tsh 15,000). While CHF is not an insurance scheme, it does establish the concept of household contribution, however small, to pay for quality health services. The introduction of cost sharing in general, and CHF in particular, offers a further opportunity for communities to participate in the control of resource utilisation at local level. If they feel that they have a stake in the health sector through their own (admittedly minimal) contribution, this offers a direct opportunity to reduce corruption and 'leakage' of supplies and indeed to insist on improved attitudes from health staff and providers.

The CHF scheme could be developed into a social insurance scheme, with increased risk pooling and cross subsidisation. There will remain for the foreseeable future a small proportion of the population who cannot afford even the minimal or nominal contribution required for the CHF scheme, and these would be covered through direct government contribution on their behalf.

Having everyone covered by one of the social health insurance schemes is inevitably a long term goal but one which is achievable, with ongoing political will and commitment of successive governments to find ways to ensure that everyone has access to appropriate quality and level of health care.

In this ideal scenario, the population would be covered by one or another scheme, thus:

Current and proposed insurance schemes
NSSF
NHIF
Informal Sector Social Insurance Scheme
CHF (including those who cannot afford to contribute)

Interim strategy

4.2 EXEMPTIONS

The system for exemptions and waivers was originally introduced to ensure that particular groups of the population had access to appropriate health care. The groups ranged from population groups (pregnant women, children under 5 years) to group of people with particular illnesses and diseases (TB, leprosy, typhoid etc) and epidemics. The reasons for introduction of the exemption and waivers system was a recognition of the importance of providing easy access to these groups of the population, for whom appropriate care and treatment is crucial.

The system of exemptions was introduced prior to the introduction of social insurance schemes such as the NSSF and the NHIF, which provide cover for formal sector employees and their families and civil servants and their families, respectively. The exemption and waiver system was expanded with the introduction of the CHF scheme and user fees for the primary health care level. While the exemption and waivers concept is still entirely valid for poor individuals and households participating in the CHF and for those not covered by any other insurance scheme, the policy requires updating to take account of the positive impact of the NHIF and the NSSF schemes.

4.2.1 Exemption issue – for those already covered by NHIF and NSSF schemes

With the establishment of these social insurance schemes, there is no longer a need to provide centrally funded exemptions for those who are already covered by a scheme. Continuing to provide exemptions for those who are already covered by a social insurance scheme is an unnecessary burden on the health budget. At the same time, it undermines one of the core purposes of the social insurance schemes which is to create a risk pool and cross subsidisation within that risk pool. There is no doubt that the population groups and the illness groups covered by the exemption system are crucial to improving the health status of the population. It is, however, reasonable to assume that the social insurance schemes are well placed to fund provision of necessary services for their members, specifically for children under five years and for maternal care.

The capacity of the social insurance schemes to provide all necessary health services is acknowledged and understood by both organisations and, indeed, they are willing and able to take on the responsibility of providing these services for their members, based on interviews with key representatives during the study. Financing of the services could be undertaken in a number of ways and would be open to negotiation between the social insurance organisations and the providers.

In relation to preventive services, the social insurance schemes should be encouraged to expand their activities and incrementally relieve the central health budget of this responsibility as well. Both of the social insurance schemes are supported and at least partially funded, by the government. To reassign responsibility of certain core services and interventions to the social insurance organisations is not an abdication of responsibility by the

government or the Ministry of Health. Rather, it is a recognition of the transition from total dependence on the central health budget (and international assistance) towards a more viable and sustainable social insurance system.

A limitation of the social insurance scheme is that the cover provided for employees and their dependents is not extended into retirement. This is an issue which is currently under discussion in both organisations and the expansion of the schemes to include retirees is recommended. Withdrawal of entitlement to health services as soon as the person retires presents a financial challenge which could cause hardship and limit access to health care at a time when people are more likely to be in need to health care. Social insurance principles are that the healthy subsidise the sick, the young subsidise the elderly and the wealthier subsidise the poorer. The risk pooling of social insurance schemes should allow for the continued entitlement of retirees to services.

4.2.2 Exemptions for those not covered by NHIF and NSSF

The original reasons for establishing population groups and conditions to be exempted from charges are as valid today as they were when they were introduced. The population groups (mothers, children under five and the elderly who cannot afford to pay), as well as those with specified conditions and during epidemics remain crucial targets for Ministry of Health resources and should remain exempted as long as there is no universal insurance in place. Therefore, access to services for the groups currently exempted but covered by social insurance schemes would remain as it is.

Many facilities complain that there are many people within the exempted groups who can afford to pay and their exemption means a reduction in resources which could be collected for cross subsidisation and improvements to the facility. Indeed facilities report that many people who can afford to pay *would be willing* to pay for services, ~~if appropriate~~if appropriate quality of services are available. Despite arguments about ability, capacity and willingness to pay, it is recommended that exemptions – as currently specified - are retained. It is considered that the population groups and the conditions exempted are too important to the public good for the exemptions to be retracted as long as the ideal scenario of everyone being covered by an insurance system is not yet in place.

4.3 CHF expansion and consolidation

While the CHF is not an insurance scheme it is a suitable precursor to an insurance scheme for the majority of poor people in rural areas. The contribution (between Tsh 5,000 and Tsh 15,000) is reasonably affordable by almost every household at harvest times. The contribution goes towards improving quantity of services and quality of services at primary level. A number of CHF schemes are now able to include secondary level outpatient care (at district hospitals) as a benefit. Importantly, the fact of making a contribution to health care costs offers a significant opportunity for communities to participate much more in decision-making for local health care, particularly in relation to quality of services and attitude of staff. Furthermore, contributing to health care empowers the users to demand a higher quality of care.

Approximately 50% of districts currently participate in the CHF scheme, but the uptake level remains low. This is mainly due to (legitimate) perceptions by potential beneficiaries that the quality of services available at primary level remains poor and the CHF is limited because the scheme does not cover secondary care. Clearly improved quality of services is an essential precursor increasing the uptake of the CHF scheme. Where the scheme is in operation and where services have improved, it can be seen that this encourages much faster joining and uptake of the scheme by others, thus further contributing to sustainability of improved quality services. In addition, where the CHF scheme is working, there is a much greater ownership of resource allocation and local health management and better discipline about accountability. Those who are contributing feel that they have a right to participate and

influence decisions about how resources are utilised and can demand to see how the resources are spent.

It is recommended that

- the CHF service package should cover both primary and secondary services
- the contribution rates are to be set at a level which would accommodate both primary and secondary care
- the distribution of resources accrued for CHFs are distributed to facilities on a similar basis as the basket funds; i.e. 65% to primary care services and 35% to secondary care services
- further expansion and consolidation of CHF schemes should be facilitated through advocacy and IEC, to broaden the base of membership

Inclusion of full secondary care in the CHF package would encourage a much greater uptake of membership, since secondary services present a much heavier financial burden than primary services. Provision of resources from the CHF to secondary providers would encourage provision of improved services from secondary level. It will be essential to simultaneously enforce the practice of all patients accessing secondary care having a clinical referral letter. Patients arriving at the secondary or tertiary provider with CHF cards but without a clinical referral would be required to pay the common user charges. This will ensure that people do not bypass the services at primary level and will, at the same time, improve the clinical referral mechanisms in the districts.

In the spirit of the advanced decentralisation process, the government remains committed to maintaining the voluntary status of the CHF scheme, in terms of districts which opt to participate and individual households who opt to join. Clearly, a critical mass of districts and households joining offers an opportunity to consolidate the scheme and thus allow expansion of the services to which access can be provided, such as secondary care, both outpatient and inpatient.

The facilitation process needs to be undertaken through (a) media, (b) by direct advocacy from officials from districts which are successfully implementing the scheme, and (c) from Ministry of Health officials who understand the benefits of the scheme and can provide practical assistance in setting up the preparatory administrative procedures. Funding for advocacy of the scheme should come directly from MOH budget to target the poor.

Expansion and consolidation of CHF schemes increase the opportunity for communities - and specifically those who contribute to the CHF - with a voice in the allocation of resources, in the attitude and approach of providers, and in the quality of services provided. Advocacy and marketing skills need to be strengthened at both district level and MOH level to support further expansion of the CHF scheme; administrative skills, planning and resource management skills need to be strengthened at district level for those who will administer the schemes.

The CHF scheme cannot address issues of access to care due to geographical constraints or costs which are external to health but which significantly impact on access, such as transport costs, particularly for patients who are referred to a higher level of clinical care. Transport is clearly a cross cutting issue: there will be similar challenges for access to education as to health care. The scope of this report does not stretch to tackling the issue: it needs to be tackled by all of the sectors in tandem. However, the transport issue does pose a significant risk to the successful implementation and expansion of CHF~~s~~. There is a further note on this risk in Chapter 5.

4.4 TIKA

The scheme – which is still at the pre-implementation phase of planning and development – targets the urban and peri-urban poor. The legal framework models have been developed

and sensitisation and advocacy is currently under way. It is aimed to achieve 15% coverage of the urban and peri-urban population by 2010, thus expanding health care to cover those who are currently prevented from accessing health services due to the charges. The TIKA scheme also aims to significantly increase community participation and empowerment through the generation of additional resources for health facilities and associated participation in facility management by the TIKA members. The membership is based on families, but with contributions based on individuals (i.e. a simple numerical calculation, not on a weighted basis or on the basis of relative health or wealth of individual family members). A contribution is made for each family member.

As with the CHF it is recommended that, as TIKA schemes are implemented,

- the TIKA service package should fully cover primary and secondary care services
- the contribution rates are to be set at a level which would accommodate both primary and secondary care
- the distribution of resources accrued for TIKAs are distributed to facilities; i.e. 65% to primary care services and 35% to secondary care services
- expansion and consolidation of TIKA schemes should be facilitated through advocacy and IEC, to broaden the base of membership

4.5 ID CARD FOR THOSE WHO CANNOT AFFORD THE CHF OR TIKA CONTRIBUTION

4.5.1 Rationale

Despite the pro-poor focus of both the CHF and the TIKA schemes, there will remain a small percentage of the population who cannot afford even the minimal contribution required for either scheme. It is estimated that approximately 5% of the population (up to 4.5 million people) are food poor in Tanzania[3] and these are the people targeted for the ID card scheme, since they are the most vulnerable to exclusion from health care due to inability to pay.

All pro poor policies, of national governments and of international development partners, target the poor in order to achieve equitable access to opportunity and services. However, very few directly identify the poor, whom they aspire to target. Health care – both preventive and curative – is a key factor in the development and maintenance of economic capacity. Despite the policies which directly target the poor, specifically in relation to accessing health care, it is clear from all of the surveys and studies undertaken that serious obstacles remain. Not least of these obstacles in health care is that patients who fall sick and are too poor to pay must, at the time of greatest vulnerability, go though the tedious and often humiliating process of seeking authorisation for a waiver.

4.5.2 Approach

The proposed strategy follows five principles:

- The Government and/or its partners purchase services for identified eligible individuals/households
- The waiver follows the needy poor rather than the poor following the waiver.
- Waiver status entitlement is established before the event of illness
- Identification is never done at the service delivery point and is never issued by an individual; rather identification is done within local communities and by a committee

[3] While the figure of 5% is not an exact figure, it is estimated, based on the Lucas Katera, REPOA report, of September 2004 (reference 2), on Paul Smithson's report 'Health in Tanzania: What has changed, what hasn't and why?' (reference 31) and validated through observation and discussion in 14 villages in the north and south of the country

verified by higher level committees

- Dignity and empowerment of those entitled

The proposed strategy recommends that, rather than the person having to apply for a waiver each time illness hits, the waiver system should be strengthened, in a way that ensures that the entitlement to waiver is given to the person before the event of illness. It further recommends that identification of those eligible should be separated from the clinical environment and established at hamlet and village level, where relative poverty is understood by small communities.

Direct and specific identification of the poor is potentially contentious, given the possibility of stigmatisation. However, the identification of the poorest through the proposed ID card system is a mechanism to ensure entitlement to services and acknowledgement of the government's commitment to target those least able to provide for themselves. The government recognises that the current system of waivers for those unable to make co-payments is not working effectively. The card – and it's associated entitlement – acts as a guarantee that the household can access services when they need them, without having to seek verification of poverty from village leaders and then seek authorisation from the health facility to access care. Having a card provides a degree of dignity and empowerment to the household members. The proposal for an ID card for the poorest households specifically targets those who are most vulnerable, to actively encourage them to use the services available when they fall sick, while ensuring that providers are recognised and compensated for doing so.

Studies and reports indicate that the Tsh 5,000, which is the most usual CHF contribution rate (though arguably well below the capacity and willingness of households to pay), is easily affordable by most rural households, as long as the collection date is during harvest times. As recommended above, the expansion of the CHF scheme should be actively encouraged, in tandem with service quality improvements and positive incentives for health workers. But it is clear from direct observation and discussion in villages and hamlets, that a very small number of families would have difficulty even with a payment of Tsh 5,000 per annum per household. The ID card is targeting those who are unable to finance this payment; the most vulnerable in the community.

The concept of a card specifically for the very poor is one which has cross cutting potential across a number of sectors. If the card is District Council based, rather than exclusive to the health sector, then the card could *potentially* be used as an entitlement card to a number of services such as, for example, access to education, food distribution etc. Such a card offers the opportunity to directly target those most in need and provide them with clear entitlement to services. It is, however, important to note that the higher the value associated with the card, the more risk there is for abuse of the system.

Implementation of such a scheme does not require major revisions to policy: it is a mechanism to ensure access to health services for the very poor, which is already the goal of the waiver system. However, a series of actions need to be taken in order to achieve the effective coverage of the very poor in rural and urban communities:

- Eligible beneficiaries need to be identified
- Cards need to be issued to them to provide evidence of their entitlement
- The financing systems need to be established to ensure that facilities will provide appropriate services and care to the target population
- The institutions responsible for providing care and for allocating resources need to be strengthened, through increased awareness of entitlement and by monitoring and evaluation to ensure that the target population are receiving appropriate treatment and care.

4.5.3 Identification of the poor

In *rural areas* the food-poor are easily identified at hamlet level, by the hamlet leader and the community. In the 8 villages in the south and 6 in the north visited, the people who fall into the 'food-poor' category ranged between 5 and 20 individuals or households and were known to village leaders. It is proposed that assessments would be done every year, to tie in with harvest times in rural areas. Family names of poor households – and the names of each person in the household - would be taken to the village council committee (made up of all the hamlet leaders), for verification and endorsement. The full list of the poor would go to the ward development committee for information and aggregation. There are inbuilt safety mechanisms here, to avoid moral hazard, since the lists from hamlets can be challenged at village level. The lists would then be sent to the District Council for verification and endorsement. The District Council then issues the cards. Ministry of Health would provide a template of the card to Local Government Authorities, for them to procure supplies of good quality blank cards for each district. The cards would be of sufficient quality to be durable for up to three years. The District Council would be responsible to complete the cards with the names of the household members and the card would carry an official stamp. Cards would be issued to each household on the list, one card per household, with all names on the card of those in each household entitled to the services. This card is effectively a guarantee from the District Health Services Board that they are purchasing services for the poor.

The social mores in place at hamlet level reduce the risk of people being identified as poor who are not poor, just in order to access the card. Discussions at village and hamlet level, and evidence of poverty identification systems already in place in some districts, show that identification of the very poor (food poor) is very straightforward, given the interaction of small communities. The risk of allowing those onto the list who could afford the nominal CHF contribution increases, the further away from the hamlet or village the identification takes place, and the risk is also increased if it is done by individuals or leaders only.

Once the households are verified and endorsed by the District Council, the list of those entitled is distributed to the health facilities, including the District and Regional Hospitals. The list is prepared, showing village by village, with the names of the entitled households and the members of those households. The list is used to confirm entitlement, in cases where people arrive at a health facility without the household card, and / or as a cross check for the provider to make sure that the person is actually named on the list and entitled to services. In higher cost facilities, an additional control will be the clinical referral letter brought by the patients, from the health centre or dispensary.

The list of poor households would be revised every three years, with people being removed from the list as they come out of poverty. People who fall into poverty can be assessed and added to the list every year, and cards produced for them. Such a system is already in place in Mwanga District: a list of all food poor households in the district is maintained and the list issued to the health facilities in the district, to verify entitlement of households to access care without having to pay. The system proposed here builds on the successful experiences of Mwanga in targeting the food poor, to ensure that they get access to health services.

In *urban areas* the same social mores and community do not prevail; there is less social cohesion and people do not necessarily live in individual family units. In the first instance, the poor would be identified at mtaa (street) level by the street leader and committee, on the same basis as the hamlets. The names of these individuals or families would be sent to the ward development committee. Once the names of individuals and families are collected at ward level, the list would be sent to the municipal / town council for endorsement and verification; the names would be added to the list of those entitled to services without any charge, and cards would be issued.

Given the increased mobility in urban areas, the street leader would identify poor individuals and families on an ongoing basis. The cards would be valid for one year. A reassessment of

poverty status would be made one month before the expiry of the cards, on application of the individual or family.

4.5.4 Issuing the card

Templates for the cards would be produced by the MOH. Supplies of the cards would be ordered by the District Councils and Municipal Councils and would be valid for all members of eligible households for three years in rural areas and for all eligible individuals and families for one year in urban areas.

4.5.5 Institutional roles at each level

It is not proposed that new institutions should be created to support and administer the ID card scheme. It is recommended that existing institutions are strengthened to function effectively. For the ID card to function effectively, a range of institutions need to be fully aware and on board with the concepts and goals of the scheme.

At village level, the role of the village council is to certify the list of eligible people from hamlets, to inform them of their rights and entitlements, and to make the system known to everyone.

At each level of the system an understanding is needed by all health and official personnel about the mechanisms adopted to target very poor families. Advocacy of the system is needed for potential users of services and potential providers of care. Advocacy about those who are entitled to the card is also needed, to ensure that households identified are restricted to those who most acutely need the support offered by the card and not used as a bribe or gift for political favours.

The monitoring and evaluation capacity of Council Health Boards, Health Management Committees and Village Committees needs to be introduced and developed. The numbers of poor households needs to be monitored as well as an ongoing monitoring will need to be included to make sure that families with the ID card are getting access to necessary services. The provision of services and the use of funds against the facility development plans also need to be monitored, to ensure appropriate use of funds from the ID card scheme. The capacity for monitoring and evaluation is currently very limited and needs strengthening. Using pro-poor resources, institutions should be given technical assistance and support to develop this capacity.

The elaboration of facility development plans should be strongly encouraged, to enable facility health teams to use the plans as the basis for allocating resources and planning for improvements to services. The facility health plans could be used as the basis for monitoring and evaluating the quality of services provided. Training in the production of facility development plans would be needed, for health staff and for local community representatives who have a vested interest in the facility providing good quality services and care.

Facilities should be encouraged to target resources accruing from NHSI, NSSF, CHF, user fees and ID card funds to provide incentives for staff as well as for direct improvements to quality of services and in enabling health committees at facility level to fulfil their tasks.

4.5.6 Financing

The Ministry of Health would be responsible to provide the resources to support the ID card, in pursuit of the government commitment and focus on targeting the poor and ensuring access to appropriate health care for them. This scheme targets those who are unable even to make the CHF contribution and are thus identifiably the most vulnerable. The ID card scheme does not require any fundamental changes to the resource allocation policy at central level. The policy of targeting the poor is in place: this is a mechanism to

operationalise the policy to target the very poor and is in support of the broader pro-poor policy.

Resource mobilisation
The central allocation to districts should be based on the production and approval of Comprehensive Council Health Plans. Once the central allocation has been made to districts, the districts should be instructed to top slice at least 5% of the health OC disbursement, as a direct response to improving access to appropriate health care for the very poor. The health expenditure framework guidelines for allocation should be revised to include this revision to the allocation arrangements. Clearly, contributions to the pro-poor fund from development partners would be welcome, as an explicit commitment to pro-poor health policies. Given that the estimates for those who would be eligible for the scheme amount to 5% of the population, it is recommended that *at least* 5% of the district ~~H~~health budget is top sliced for this purpose. In districts that have a higher than average proportion of the very poor, the percentage top sliced should be higher, to reflect the local food poverty index.

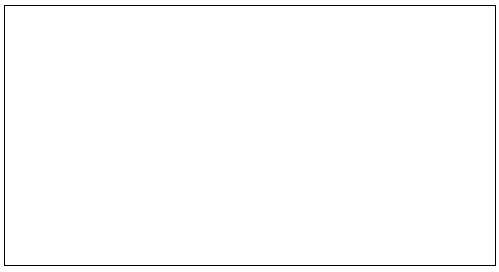
Allocation from districts to facilities
Distribution of the resources from District Councils to facilities would be allocated on a household basis, i.e. the number of households on the list identified as food poor in each catchment area, and would be dependant on production of facility development plans which indicate how the resources are to be utilised. Non government facilities which are approved by MOH would be eligible for funds, as long as they provide services to a catchment population and show in their facility development plans that they undertake to provide services to those issued with the card.

In districts which have a CHF in place, the calculation of the allocation to facilities would amount to *at least* the CHF household contribution plus the matching funds; i.e. if the household contribution is Tsh 10,000, then the amount allocated by the district to the facility per household would be Tsh 20,000. [In Mwanga district Tsh 2 million is already set aside to target 200 families who are identified as very poor and unable to make contributions to the CHF fund].

Where a CHF scheme is not yet operating, the NHIF is already in place ~~systems are not in place~~ at the primary facility level to receive cash. So, the allocations to primary care facilities should be made based on ~~a~~an ~~a~~approximated CHF contribution of Tsh. 10,000.

Districts would make allocation of resources to facilities on an agreed basis: i.e. 65% for primary care and 35% for secondary care. The 35% should be divided between all of the secondary care hospitals approved by MOH, and included in the CCHP (with defined roles and catchment areas) and not restricted to the district hospitals and designated district hospitals (DDHs).

~~**Allocation model** (can someone draw it, please?!)~~



The Allocation Model

Level of Health Care	CHF Districts	Non-CHF Districts	Service Outlets
Primary Health Care	65% to be allocated according to CHF formula	65% to be allocated according to an approximated CHF contribution of Tsh 10,000 per poor household	- To provide services to all card/CHF holders - To use 10% of their allocation for emergencies
Secondary Health Care	35% to be allocated to public hospitals (District) and to non-government providers by service agreement		- To provide service to all card holders - To use 10% of their allocation for emergencies. Emergencies include accidents, patients, who cannot afford to pay at higher levels, etc.
Regional and Referral Hospital	5% of the OC allocations/budget		- To provide services to all referred patient with the cards - To use 10% of their allocation for emergencies. Emergencies include accidents, patients, who cannot afford to pay at higher levels, etc.

Use of resources at facility level

Facilities receiving the funds would be expected to retain 10% as a contingency to accommodate people from within their own district or catchment area who become poor and do not yet have a card and for those very small numbers of people who might fall sick in a district other than their own but who are entitled to services under the ID card scheme.

A further 5% should be retained – along with 5% of all other sources of income – for administration, to provide incentives to health staff, and to facilitate meetings at local level (for example, to provide refreshments). Guidelines for this are already in place but are not operational.

Regional and referral hospitals

Regional and referral hospitals should be instructed to submit their budget proposals / budget estimates, showing that 5% of their OC budget would target those who are entitled to services under the ID scheme. This 5% of their OC budget should be divided 90% to provide care for ID card holders who are referred for treatment and 10% for contingencies, to cope with patients who are referred who are too poor to pay but who do not (yet) have a card. Accounting for the resources used to target poor patients will be required as part of the annual accounting process.

Note: in a small number of cases patients who are referred will be from families which can afford the CHF contribution, but for whom the cost of care in a regional or referral hospital would be catastrophic and would push them into deeper poverty. So that patients can access the services they need and to which they are entitled, it is suggested that the services are given without question and the details of the person should be sent to the person's district health committee or Board for notification and records. It is the district committee or Board which would then follow up.

Given the interest of development partners in specifically targeting the poorest in communities and directly influencing the improved access to health services, this proposal and recommendation provides ample opportunity for development partners to be involved both financially and practically in making this work.

4.5.7 Compatibility of the proposed pro-poor ID card with the Service Agreement

The draft service agreement between the Ministry of Health and providers is compatible in principle with the concept of the pro poor ID scheme. A number of additions would be required to the agreement to fully incorporate the pro-poor ID scheme, to ensure that those with the card would be able to access services at NGO (not for profit) facilities.

The following additions would be needed to the proposed service agreement[4]:

Schedule 4: Management outputs

4.3 A duty to provide treatment / care

(add) Treatment for the poor and those who present themselves with an ID card…

Schedule 4: Management Outputs

4.5? Costing of Health Facility Outputs

(add) no refunding, but provision of funds based on capitation, as outlined under the ID card proposal

Schedule 5: Financing

Sources of income.

(add) Funding for the ID card (pro-poor funds from the district basket)

Schedule 6: Exemption process and mechanism for reimbursement

(add) no reimbursement for those with pro-poor ID card, and on the pro-poor list. Those who are endorsed as entitled to the card by the village committee and the District Council will present the facility with an ID card showing their entitlement. Those presenting with a CHF card will also be given services free of charge.

4.6 ADVOCACY AND INSTITUTIONAL STRENGTHENING

A critical success factor of any revised or new approach to service development is the capacity of those who are responsible for implementation to adapt to the changed behaviour and practices. The impact of new and innovative approaches to improving health care delivery becomes diluted if health personnel and provider units are unfamiliar with the concepts, goals and practices required. So, 'business as usual' is re-established very quickly, if the new practices are not implemented effectively and reinforced on an ongoing basis. Many of the problems associated with failure of new practices relate to a lack of understanding and knowledge, not because of any perverse interest on the part of health personnel to undermine the system. Support, continuous advocacy (not on a one-of basis), and practical training at all levels of the health chain are required, in order to dovetail policies with practice. Targeted advocacy is needed at hamlet and village level, as well differently targeted and much more detailed advocacy and training at facility level, to provide support to staff who are expected to implement the revised practices.

At district level training is required to support the budgeting and allocation processes, to ensure that the resources are disbursed against the targets. This should be done in a way which makes them easily accessible to the facilities, while at the same time, having a checks and balances system in place by which to account for resources and monitor their use.

The Ministry of Health and Social Welfare is responsible for policy and guidelines for implementation and overall monitoring and evaluation. There is a need to review the capacity within the Ministry to achieve this. The Ministry has a role to push forward on a range of policy development, many of which overlap (in terms of their target population) and impact on

[4] The Service Agreement used in this document is a draft. The headings, labels and numbering system noted above may change as the draft is further refined

each other from a health delivery perspective. Co-ordination of effort by MOH personnel is essential in order to achieve the maximum value from the limited numbers of staff available with expertise in planning. Co-ordination of effort could produce an output which is greater than the sum of the constituent parts, and would have the effect of presenting a more streamlined policy voice.

5 RISK FACTORS

There are a series of risk factors which impact not only on the recommendations in this report to strengthen the exemption and waivers system, but which also impact on health sector functioning in the wider context.

5.1 CATASTROPHIC ILLNESS

This risk relates more to the potential for financial catastrophe rather than the illness itself being catastrophic. The risk is that an individual or family has just enough to live on and maintain payments for necessary utilities and services, including for example, the CHF fund. But a serious illness could topple them from coping into not being able to cope financially and, inevitably into poverty. At this point it becomes difficult to escape the poverty trap, since families then either sell livestock or other assets, to get the money needed to pay for health care. Or they borrow from family and friends and then spend many years trying to repay, while being unable to work to accrue resources to repay the debt or make good on the resources 'lost' through sale of assets. This group has been labelled the marginal poor, and remain vulnerable to serious financial risk.

5.2 TRANSPORT

The issue of transport is crucial to the functioning of the ID scheme. Patients who are eligible for the ID card scheme are, by definition, the poorest of the poor. While the referral rate for secondary services may not be high, there is a risk that patients requiring higher level interventions may simply not be able to afford to access the services. So while the ID scheme is ensuring access to appropriate health services in principle, patients may be denied access in practice, simply because of the logistical and financial burden of physically getting to the referral facility. ~~However, the transport issue does jeopardise the ID scheme and the expansion of the CHF scheme.~~

In some cases transport is simply not available. In other cases roads are not available by which to access the necessary services. So, despite pro-poor health policies and practices being in place, it is the obstacle of the transport cost to access care which excludes the poor. This can easily result in unnecessary loss of life and certainly contributes to patients not presenting at secondary care until much later than would be appropriate, thus making treatment and intervention more complicated and more expensive when it is accessed.

This is not something which the Ministry of Health can directly address, since it is a cross cutting issue affecting a number of the sectors. It needs to be tackled separately and is outside the scope of these TORs. This issue of transport, including costs, availability of vehicles and availability of roads needs to be addressed on a cross sectoral basis.~~, thus making treatment more complicated, and more expensive when it is accessed.~~

~~It is recommended that where CHF schemes are in place an additional community transport scheme could be developed to subsidise or supplement the resources households have available for transport.~~

~~The issue of transport, including costs, availability of vehicles, availability of roads, should be addressed on a cross sectoral basis.~~

5.3 QUALITY OF CARE

In every village visited, whether a CHF scheme was in place or not, the issue of quality of care was raised as an issue. The label 'quality of care' covers a number of issues, and relates as much to perceptions of the services which people feel should be available as to the actual care provided. In districts where a CHF is in place various quality of care indicators show that quality has improved (continuous availability of essential drugs, for example) but

clearly further improvements are both possible and necessary. In districts where a CHF scheme is not in place essential drugs are often only available for part of each month. The 'quality of care' label can refer to such issues as attitude of staff, availability of appropriately qualified staff to provide timely care and appropriate care for patients, availability of diagnostic equipment for the most common diseases and illnesses (such as malaria). It is anticipated that membership of CHF schemes would be significantly increased where 'quality of care' can be seen to be improved and where the local communities have a direct say in the management of services. The current standards of care jeopardise the potential for expansion of the CHF scheme. The severe human resources crisis in Tanzania significantly increases the risk that quality of care will not improve at the rate or to the standards necessary.

If CHF schemes and the ID card scheme are to have any chance of success, all primary care facilities must be in a position to diagnose and treat *at least* the most common causes of morbidity, thus providing a directly observable improvement in the quality of care available at local level. Such services would include, for example, the diagnosis and treatment of malaria at dispensary level (where currently patients who are suspected of having malaria have to be referred to a health centre for diagnosis and treatment, thus creating a further obstacle to accessing appropriate care).

Improvement of the skills and capacity of local medical officers to provide a higher level of technical intervention at dispensary and health centre levels would reduce the need for referrals to secondary level.

Equally, the continuous availability of essential drugs is a major quality of care issue. This is a key monitoring indicator for the effectiveness both of a CHF and the ID scheme. The increasing tendency for self medication, however, reflects gaps in the public health care system and increases the risk of non-compliance with the available insurance schemes and CHF and TIKA schemes.

5.4 INSTITUTIONAL FUNCTIONALITY

Where institutions such as village committees or facility health committees do not meet and function on an ongoing basis, this poses a risk for the successful implementation of the recommendations in this report. If local committees do not function as they should, identification and verification of the food poor will be erratic and inconsistent.

Facilities providing health care need to have an appreciation of the goals of the schemes under which they are providing care and need to be sensitised to and familiar with the procedures involved. Where knowledge and understanding about the schemes is not shared with health staff, this poses a risk to the provision of care to those entitled to services, either by prolonging the wait to access services or by treating patients entitled to services with a CHF card or an ID card with less respect that they treat other patients. Sensitisation to the fact that resources are being allocated specifically to treat very poor patients is required, so that staff who now recognise the need for cost sharing, are aware that resources are allocated to the facility to target this group.

At district level the necessary committees need to be functioning and operating on a regular basis to implement the CHF scheme and the ID card scheme. If the committees are not operating on an ongoing basis, the schemes cannot be managed effectively and will be jeopardised, thus putting the successful targeting of the poor at risk.

The Ministry of Health's role is one of policy making and guiding the direction of the health sector. Sharing of expertise and knowledge across the range of pro poor schemes is essential to gain best advantage and to ensure that all of the schemes dovetail and complement each other. The advocacy skills of the Ministry of Health for pro poor schemes are restricted by the availability of numbers and expertise of staff. This certainly poses a risk,

if the CHF schemes are to be expanded and consolidated, both in terms of the services they provide and in terms of the membership base. Ministry of Health officials need to be skilled in advocacy of the schemes and available to visit districts to promote the concepts and advantages of the schemes, and to offer technical assistance in establishing them and in resolving any problems in relation to their operation.

5.5 POLITICAL INFLUENCE

The potential risk of political influence could be anticipated in relation to identification of people to benefit from the ID scheme who are not food poor, since the benefits would be seen as a valuable commodity. While there are safety valves in place, given the verification and endorsement arrangements at each successive level of hamlet, village, and district, the potential political influence should be kept to a minimum, but it is a risk which needs to be recognised and guarded against.

5.6 FRAUD

Where there is any discretion involved, in terms of using contingency funds, for example, the potential for corruption is a risk.

If the ID card is to be developed into a one of wider applicability than health (e.g. for access to food supplementation or education, for example), then the value of the ID card to the holder increases and there is a possibility that the services to which the card holder is entitled become commodities which could be bartered or sold to others.

5.7 STIGMATISATION

Identification of the food-poor as a specific target group to ensure access to health services might be argued by some as stigmatising. The provision of a card showing entitlement to services sets people apart. However, the food poor are recognised and obvious within small communities and it may also be argued that that is stigmatising. Provision of entitlement to health services is a mechanism to alleviate the burden of poverty and is likely to be welcomed by those who are poor.

5.8 COMMUNICATIONS

Capacity at health centre and dispensary level can be enhanced through the availability of an effective communications system, so that health personnel can seek the advice of more qualified staff at hospital and secondary level. In this way it may be possible to keep patients close to their homes and treat them locally rather than having to refer them, or for effective triage treatment to be given to patients, to keep them clinically stable, prior to them being referred. Communication systems in remote areas and in many rural areas are poor. Without satellite or radio, the isolation of health facilities poses a major risk to effective treatment of patients.

ANNEX 1 TOR

TORs for consultancy to review current operations and applications of waiver and exemption and come up with practical recommendations on how best to improve the situation

~~2.~~1 Introduction

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The provision of health services in the country is guided by the National Health Policy whose vision is to improve the health and well being of all Tanzanians, with a focus on those at risk, and to encourage the health system to be more responsive to the needs of the people. A harsh economic climate pertaining has made it difficult for the GOT to allocate sufficient funds to the health sector to meet the current health demands. Currently there is an imbalance between the demand and supply of health services.
The GOT introduced health financing strategy as part of health reforms in order to mobilize resources (domestic and foreign) to reduce the financial gap. As a result of the health reforms introduced in 1999, the health budget has risen from 3.46 USD per capita in 1999 to 6 USD in 2002.In 2000/2001 a sizeable financing gap[5]was noted to be around USD 3.0 that was needed to provide quality health services in the country. Since the introduction of HIPC in 2001/2002, the financing gap dropped to USD 1.8. New domestic sources of funding were also introduced such as Community Health Fund (CHF), National Health Insurance Fund (NHIF), user fees and drug revolving fund to complement funds provided by the government. The government policy and stand is to ensure that during implementation of new financial schemes, special attention will be given to protect the needs of the poor and vulnerable groups to ensure that they have access to health services.

A cost sharing operationalisation manual that clearly spells out exempted conditions and waivers as well as categories of the intended beneficiaries has been in operation since 2002 however although the manual has been in place for 4 years the problem of application of waivers and exemptions is still there. Exemptions are statutory entitlements that are automatically granted to all maternity services, children under five years and particular diseases such as TB/Leprosy, HIV/AIDS and some chronic diseases that would drain substantial income from the patients if they were asked to pay. Waivers on the other hand comprise of cases that are in need of exemption e.g. the “poor “ but do not automatically qualify. Provision of waivers ensures that those unable to pay are attended through appropriate channels of application and assessment. According to the CHF operational manual the process for granting waivers is as follows:-

The village council or its committee identifies who are very destitute (i.e. the poorest of the poor). Then the list is presented to the ward health committee for further scrutiny and once endorsed, the list is forwarded to the Council Health Services Board which will issue a CHF membership card for those people to access health care services. The CHF Act also stipulates that the Councils shall seek funding for the CHF membership. The CHF manual further states that in exceptional cases such as accident victims, non-CHF members who are critically ill and have no money to pay are considered for exemption.

Although the government has put in place clear guidelines on waiver and exemption procedures, some studies undertaken[6] show that the exemption scheme is not functioning efficiently for a number of reasons (e.g. many people saw exemptions rather as a special favour than a right, some 50% of the poorest poor had been exempted but at the same time leakage of the scheme tends to benefit more the better off particularly for chronic illnesses and admissions which are the highest cost items).

[5] Health Sector Performance Profile in Tanzania for the year 2004
[6] The unbearable Cost of illness, evidence from Lindi district by Save the children fund 2005

The Deputy Minister of Health in his opening speech[7] reiterated the need for forging ahead with cost sharing initiatives in the country because elimination of cost sharing at any level will undermine popular community ownership of services, lead to loss of transparency and responsiveness of service providers that has been painstakingly been built over time since the inception of CHF and will place the country on permanent dependency of handouts from the rich countries. The Deputy Minister admitted that there were justified concerns over the functioning of exemptions and waiver mechanisms in support of the poor and vulnerable and requested for assistance from partners to make the exemptions and waivers work better.

The MOH as follow-up to the national health financing workshop asked for a consultancy to assist the MOH to strengthen current operation mechanisms in place for exemptions and waivers in order to eliminate present deficiencies being experienced.

~~3.~~2. Objectives

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- To review current policies and application of exemptions to ensure that the most vulnerable groups are exempted while those who are able to pay and currently also exempted are made to pay
- To recommend various options on how to improve waivers and exemption systems to make them cover the poor and vulnerable groups effectively
- To suggest how exemption and waivers should be reinforced in their implementation
- To suggest how poor people can be protected against catastrophic health events
- To analyse and suggest incentives to motivate health staff in facilities to make exemptions and waivers work and reduce demand for bribes[8]

~~4.~~3. Scope of Work

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The scope of work will not dwell on whether cost sharing should be abolished or not because the stand of the government and many development partners supporting the health sector do not support the idea of abolishment of user fees. The scope of work will focus on the identification of factors that are making waiver and exemptions inefficient and come up with practical solutions to address current weaknesses in implementation of waivers and exemptions.

The consultancy will review relevant guidelines, documents and studies undertaken in Tanzania on operational modalities and experiences with exemptions and waivers, undertake field visits to selected districts in the country that are implementing CHF to find out how exemptions and waivers are applied. The consultancy will conduct interviews with various stakeholders at Central, Regional and District level (health staff workers, Council senior management) and some users of public health services at varies levels within the district including dispensary, health centre and district hospital, to get their views on how exemptions work and how waivers are applied.
The consultancy will also identify weaknesses with current applications of waivers and come up with practical recommendation on how poor people can be identified better and cushioned from cost recovery negating factors that potentially could reduce the poor from accessing health services. Also the question how to fasten the process of granting waivers should be looked into.

The policy on exemptions provides for statutory entitlements for all maternity services, children under five years and particular diseases such as TB/Leprosy, HIV/AIDS and some

[7] Opening address by the Deputy Minister of health, Dr Hussen Mwinyi at the Health Financing workshop on 3rd May 2005, held at Golden Tulip Hotel Daressalaam
[8] Equity implications of health sector user fees in Tanzania by I.Latterveer, M. Munga and P. Schwerzel, ETC Crystal the Netherlands

chronic diseases that does not necessarily target people unable to pay and would drain substantial income from the patients if they were asked to pay. The review area is whether exemptions should cover every body in those categories who under the existing arrangements are entitled to get free services although you have individuals within those categories who can afford to pay or qualify to be paid for through CHF, NHIF, NSSF etc. through such claims improve revenue got through cost sharing and in the process target the vulnerable better.

Special attention should be given to pregnant mothers who in preparation of deliveries are often forced to obtain needed commodities such as ergometrine or gloves from out of pocket money while they are supposed to be exempted and to be treated free of charge.

The consultancy should, after assessment of present exemptions mechanisms in place, come up with practical recommendations on how exemptions could be further refined to ensure that exemptions go towards the needy not subsidizing the rich and those who can be paid for through their health insurance coverage (e.g. exempted services offered to NHIF members should be claimed for at NHIF)..

The crucial question that somebody has to pay for the costs of exemptions and to reimburse/pay the provider for exempted clients served shall be taken up by the study. In this view it should be analyzed who should fund and how should financing be done.

~~5.~~

While the study is focusing primarily on the public health facilities the consultants should look also at the option whether exemption and waivers regulations set by Government should and could also be applicable at the private sector (mainly faith based health facilities).

Methodology

Use of various documents and studies relating to financial options including waivers and exemptions, interview with various stake holders (PO-RALG, MOH, faith based health providers, NGOs and civil society groups) undertake field visit to selected health facilities both public run and faith owned to assess operations of CHF, user fees and how identification of who qualifies and how actual granting of waivers and exemptions are done. Interview with clients/users of health facilities residing in localities close to dispensaries, health centres and district hospital. Use information gathered to prepare consultancy report.

~~6.~~4. Expected Outputs

Consultancy report containing findings and practical solutions to address the objectives and scope of work. prepared and submitted to MOH

~~7.~~5. Consultancy composition

Four consultants will undertake the assignment, with the following expertise:-

- One Public Health Specialist and one Health Economist (International)
- One Public Health Specialist and one Health Economist (Local Counterparts)

~~8.~~6. Timing

The consultancy will be carried out in from November 2005, it will last for 5 weeks.

- 1 week to undertake interviews of various stakeholders in Dar es Salaam and Dodoma for PO-RALG senior management
- 2 weeks in the field
- 1 week preparation of preliminary report and debriefing
- 1 week finalizing and distribution of consultancy report

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ANNEX 2 SYNTHESIS OF FINDINGS AND RECOMMENDATIONS FROM PREVIOUS STUDIES AND DOCUMENTS

Note: The figures in brackets refer to the respective documents included in the list of references (Section C). The synthesis (Section A and B) refers to findings and recommendations of studies and mission reports specifically related to exemptions and waivers. The synthesis does not include documents of legislation, regulations, official guidelines, design manuals or implementation manuals and other related literature. Those are shown in the full list of references of documents consulted by the mission team (Section C).

A. Findings presented from literature research

Ref. No.	Findings
	General aspects
3	The primary objective of introducing user fees in public hospitals was to mobilize additional resources that would gradually enhance quality of health services.
3	To guarantee universal access to health services the government provided for exemptions and waivers to those considered potentially vulnerable to the policy.
19	The poorest quintile are roughly 20%-25% more likely to suffer infant or under-five mortality than the least poor. A gap of similar magnitude exists between the urban and the rural poor; there is a clear rural disadvantage in the probability of seeking care when sick.
	Access to quality health care for the poor
2	There seems to be a gap between intent and action as the user fees system is seen to exclude the poor and most vulnerable, the main reason being the ineffectiveness of the exemption and waiver system
12	Health services are not accessed by the very poor and by women in particular. Key obstacle are health care charges, long distances to facilities, inadequate and unaffordable transport systems, poor quality of care, and poor governance and accountability mechanisms. There have been improvements in availability of drugs, however, continuous deficiencies and costs of drugs still make them unavailable to many poor people. The shortage of skilled providers continues to persist. Discrimination to clients who are not able to pay and poor referral systems results in poor quality of care.
12	Revenue generated by cost sharing has not necessarily impacted positively on quality of care.
14	Making the drugs and medical supplies available all the time is number one condition of protecting the poor even those who cannot pay for care.
18	The availability of drugs has improved in PHC facilities The rational use of drugs targeting prescribers is good and appears to be getting better.

<table>
<tr><td>19</td><td>As regards physical access to health care, rural residents are at a disadvantage, particularly in distance to hospital – however, there is in general only a very slight association between the distance to health care and the probability of seeking treatment.

Costs seem to be a bigger barrier to access than distance, with 10% of people not seeking care for this reason. Moreover, cost shows up as a barrier to access both in urban and in rural areas.

Who consulted services, who didn't and why (in percentage of total included in the survey)

<table>
<tr><th></th><th>Dar %</th><th>Other urban %</th><th>Rural %</th><th>TZ Mainland %</th></tr>
<tr><td colspan="5">As proportion of all those reporting illness</td></tr>
<tr><td>Consulted any provider</td><td>80</td><td>76</td><td>67</td><td>69</td></tr>
<tr><td>Did not consult because no need</td><td>11</td><td>12</td><td>13</td><td>13</td></tr>
<tr><td>Did not consult due to cost</td><td>6</td><td>9</td><td>10</td><td>10</td></tr>
<tr><td>Did not consult due to distance</td><td>1</td><td>1</td><td>3</td><td>3</td></tr>
<tr><td>Did not consult – other reasons</td><td>1</td><td>2</td><td>6</td><td>6</td></tr>
<tr><td colspan="5">Reasons for not consulting</td></tr>
<tr><td>No need</td><td>58</td><td>50</td><td>43</td><td>44</td></tr>
<tr><td>Too expensive</td><td>35</td><td>39</td><td>32</td><td>33</td></tr>
<tr><td>Too far</td><td>7</td><td>3</td><td>11</td><td>10</td></tr>
</table>
</td></tr>
<tr><td>19</td><td>Access to care requiring hospital admission is a case in point. Because the distances and costs are so much greater than for primary care, it seems entirely probable that these do factor as deterrents for care seeking, and that the rural population, poorer groups and people living at great distance from hospital will be at a particular disadvantage. The data on consumption of hospital care support the contention that it exhibits much greater inequalities than access to primary care. Hospitalization and caesarean section show much greater inequalities than basic health services, and these inequalities do relate to distance.</td></tr>
<tr><td>19</td><td>Social discrimination by health workers e.g. of women below 20 years of age and less well educated women.</td></tr>
<tr><td>21</td><td>Our greatest challenge is covering hospital care for rural households as the CHF only covers care at primary level. Households facing catastrophic care needs – including care for mothers and children which cannot be provided at the level of the health care center – remain at risk. Catastrophic health care still impoverishes families (even non-poor families) or leaves them unable to attain urgent medical care.</td></tr>
<tr><td></td><td>Health seeking behaviour</td></tr>
<tr><td>12</td><td>Poor people are often forced to self-treatment, seek inefficient alternatives, or reporting much too late for care, use of traditional healers.
If people can afford treatment at all, government facilities are normally the only option.
The overall feeling. However, is that if money can be found it is best to spend it at mission facilities which are generally known for staff commitment and availability of drugs and tests, but perhaps most importantly for their willingness to defer treatment and start treatment if necessary.</td></tr>
</table>

19	The observed differences in consumption of health care seem to have only a little to do with availability, or even costs. Instead, the best predictor of health care utilization is the propensity to perceive illness in the first place. Regional variations are best explained by "demand-side" characteristics such as personal values ill health and what constitutes illness severe enough to warrant treatment.
20	Income level impacts the sequence by which the user decides to treat an illness. Some of the poor will use the traditional healer and others will use the rural health center. The very poor cannot afford to use either the traditional healer of health center. If very ill, the poor and very poor may be able to borrow money from wealthier family members.
	Implications of health care charges
1	Spending of the poorest quintile on medical care has increased from 1.7% (2001) to 3.2% (2005) of household income. Access of poor people to cash is extremely limited.
2	A previous report by MOH/London School of Economics (?) prior to the introduction of user fees pointed the reasons for introducing user fees. This report confirmed that lack of user fee system is disadvantageous to the vulnerable.
2	A study in 7 regions (Kilimajaro, Iringa, Ruvuma, Mbeya, Rukwa, Dodoma, Singida)is mentioned (no reference) which suggests an average of not more than 5% of people who reported lack of money as being the reason for non-treatment.
3	Most respondents (civil society organizations and local politicians) thought that cost sharing has a positive impact on quality of health services though with variations between the hospitals.
9	Arguing against many of the recent findings, .g that cost sharing is reducing equity in health access. Argues against withdrawing from the cost sharing initiative, but rather to deal with the issues which hinder its effectiveness (such as quality of care and ineffective exemption and waiver systems).
9	Many studies on the effectiveness of cost sharing done prematurely (within first 5 years of programme), whereas international experience shows that demand often declines immediately after introducing costs, but once the price shock effect has worn off.
9	Cost sharing system works, though with problems in the exemptions system.
11	Most studies focus on the most vulnerable group and may create a biased analysis of the situation.
12	Health care charges have placed an impossible financial burden on the poorest households; many fail to access primary care when they need it most and many more fail to obtain the necessary referral for more skilled care.
12	User fee are not the only charges; other costs include transport, bribes, payments for drugs and supplies, and time spent away from productive activities which is particularly critical for people living in poverty
12	People do not always know what they are supposed to pay; unofficial charges are still in place.
12	Many poor households have fallen deeper into poverty as they end up using their limited and critical assets to pay for treatment.
12	CHF is not necessarily benefiting the very poor. Many report, they are not able to afford the joining fees and therefore pay for treatment on a case-by-case basis, which can ultimately be more expensive.
12	In Nyanza Village, Meatu District, pregnant women end up paying a minimum of Tsh 7,700 for childbirth. As a result many women stay at home for deliveries. In Mpwapwa, pregnant women will only be assisted with deliveries at the health center if they carry supplies like gloves, razor blades etc. "They will harass you and ask to deliver on your own". Although there is little ambiguity in criteria for exemption, even a poor TB patient may be requested to pay 1,000 Tsh consultation fee before diagnosis.
14	Services provided free of charge do not particularly benefit the poor. Payments under the table of unknown proportion, delayed health care provision to the needy, waiting surgical lists, and out-of-stock essential life saving drugs have a far tallying price and costs to the sick and more so to the poor. The poor are worse off in non-CHF districts.
14	The real poor who cannot pay by wealth ranking techniques are known and exempted; but of poor households 2/3 can actually pay CHF prepayment fees.

29	Cost of treatment is third most acute household problem reported, affecting more than half of all households; affect female households more than male.
	Awareness and knowledge about exemptions and waivers
1	General understanding of the exemption and waiver (e/w) mechanisms: at health facility level highest on exemption for children under five and pregnant women; less on chronic diseases (TB, HIV/AIDS) followed by other diseases (Diabetes, Asthma, Hypertension). Emergency cases and prisoners generally understood as treated free of charge; but variations in understanding of the waiver status of poor and elderly people.
1	Knowledge about the e/w mechanism variable among the selected sample of health staff and community members. No systematic means of keeping health staff updated, however, several information channels are used and appear, when taken together, to be quite effective.
1	Average level of knowledge of community considerably lower than the health staff; no systematic means of communication information on e/w Most important channel of information is the point of registration at the health facility Information also on pin boards – but information at health facilities too late for getting necessary authorization from the community. Limited knowledge about the function of the Health Boards, the community representatives.
3	Most people understand the policy of exemptions. 84% of the patients interviewed are satisfied with the exemption system. 74% believed that the procedure are cumbersome.
3	Patients opinion: Most people understand the policy of exemptions 69% of patients were convinced that e/w are granted to those most in need against 13% who do not believe that they are granted to those most in need. Only 4% thought corruption as a problem. 74% of the patients indicated that procedures for processing exemptions are cumbersome. About 84% indicated satisfaction with the exemption system. Only 5.5% of the respondents showed complete dissatisfaction with the system.
12	A study in Korogwe District: There are serious gaps in information and access. 72% of the local community leaders felt that most were not aware of waivers; 61% of the exit patients interviewed were uncertain if the policy exists.
12	There is low uptake and lack of insistence on free services by the poor; primarily because they are not aware of their rights; a lack of clear criteria and policy guidelines for identifying people who are eligible for waivers has resulted into ad hoc decisions, without clear records or follow-up.
	Magnitude of exemptions and waivers at health facilities
1	Number and proportion of exemptions and waivers: in 2004 about 580,000 in City of Dar Es Salaam = 0.23 visits per capita; 1.4 million (40%) of health service contacts per year are exempted or waiver cases; value of exemption and waivers was at least 1 million USD (roughly 1,300 TsH per health service contact); however, high variation (possible reasons: different application of policy? geographic and economic differences).
1	The majority of exemption and waivers provided to children under five (70-80%), to pregnant women (10-20%), all other variable but below 5%; the poor below 1 %. Low level of waivers granted for the poor.
2	Under the current exemption system, in some facilities more than 50% of outpatients are exempted and in others the figure is as high as 80% as most of the patients are women and children under five years of age who are covered by the exemption policy.
3	Ruling out inefficiencies in the system, there are indications that in some health facilities visited, the exemptions and waivers might have been understated
9	The exemption system benefits children more than any other group (examples of 71% of exemptions for children under 5 and 26.5% for MCH services, with 1.7% for the poor.
11	Several years after implementation, the user fee system is seen to exclude the poor and most vulnerable, the main reason being the ineffectiveness of the exemption and waiver system.

11	In some facilities the exemption are 50% of users, in other facilities up to 80%, most of whom are women and children under 5.
12	Lindi Rural Study: only 49% of acute cases and 20% of admitted cases of under-five years old were exempted; findings also suggest that the least poor tend to benefit more form the scheme, in particular for chronic illness and admission: 23% of the least poor and 20% of the moderate were exempted, compared to only 12% of the poorest.
12	An assessment of existing practices related to e/w is not possible because hospitals do not generally keep accurate records of e/w granted
27	Exemption for under five (30%) accounted for 30% of patients who reported not paying for services while 6% reported to have been given exemptions by health facility workers. No exemption was reported to have been obtained through Ward/Village Government.
28	Percent of exemptions/Waivers for the needy and unable to pay in Igunga District (1999): 23 % of total population got got exemptions: out of these 98% were exempted children under five
	Problems with exemptions and waivers
1	One reason why reported rates of waivers for poor people is low or zero is that the reporting forms used by some health facilities do not contain cells for reporting these waiver categories.
1	Process of obtaining an exemption highly variable in terms of ease, timeliness, and consistency between the health facilities. Refusal to grant waiver for poor if relevant documentation is not presented; if documents not available, discretion is left to a senior member of staff. No criteria defined neither for health staff nor for community leaders! → limited consistency and barrier to access.
1	Facilities clearly attempt to implement e/w; however some factors beyond their control: e.g. resources for services are not available compromising quality of care for the exempted or waiver cases; insufficient drug kits, people have to buy at the pharmacies
2	The exemption /waiver system does not benefit the intended target group: Most of the studies done so far focus on the most vulnerable and this might create a biased analysis of the actual situation. The data available might not build a sound basis for policy change / action.
2	Exceptions and waivers have not ensured access to health services by the poor: Some health facilities are demanding payment. The waiver system does not benefit the target group.
3	The general feeling is that exemptions benefit those who qualify though they are not necessarily the ones who need most; The implication is that exemptions do not target the poor and emergency cases, as it should be in principle.
3	The e/w procedures have loopholes that allow the mis-use and sometimes abuse of the system
3	The exemption select correctly those who qualify for them though not necessarily those who need it most.
3	Public opinion (civil society organizations and local politicians): procedures for accessing e/w are not user friendly; but cumbersome and bureaucratic; Few cases of corruption in addition to the general feelings that e procedures have loopholes that allow misconduct. All agreed that e/w have to go to those who need it most.
9	More than 50% of patients in public hospitals get exemptions and waivers (40% noted later in the report).
9	The exemptions and waivers procedures have loopholes which allow misuse and sometimes abuse of the system. Exemptions select correctly those who qualify for them, though no necessarily those who need them most.
9	The problems of exemptions and waivers are practical rather than policy, whose solution is within the communities.

11	Exemptions and waivers have not ensured access to health services by the poor. Despite the policy on exemptions and waivers, stating the people and the services to be exempted, some facilities are demanding payment. The waiver system is not benefiting the target group of the poorest.
12	Exemptions, and waivers in particular, are not effective as a means of protecting vulnerable social groups and the poorest of the poor. Even if official fees are exempted or waived, the poor and vulnerable still end up having to pay for drugs, transport, some small charges for supplies, and bribes.
12	Exemptions and waivers are cumbersome and inefficient, has loopholes that allow for misuse and sometimes abuse of the system. A lack of clear criteria and policy guidelines for establishing people who are eligible for waivers result in individual ad hoc decisions, with no clear records of follow-up management. Poor people themselves are not routinely informed of the procedures for getting exemptions and/or waivers.
12	There is limited evidence of systematic implementation of the waiver policy; the lack of consistency is due in part to health service providers not following procedures that themselves are not clear.
12	At present there is no standardized waiver system in place; rather there is a great deal of personalized negotiation around payment in all facilities charging fees. The tasks then become open to interpretation and uneven application, and possible abuse. Regular patients and those who are known to staff are often more likely to gain deferment or waivers.
12	Exemptions, and in particular waivers are not systematically implemented and are not effective as means of protecting vulnerable social groups and the poorest of the poor. Even if official fees are exempted or waived, the poor and vulnerable still end up having to pay for drugs, transport, small charges (e.g. cards, materials) and bribes.
12	2002 Mbeya Study: No one in the patient or household interviews had used, or even attempted to use the waiver system or knew of anyone else who had done so.
12	In Hanang (CHF introduced) a list of names were identified by the community and submitted to the district council; but nobody from that list had been given waiver; the assessment concludes that policies in Hanang District are insufficient to protect the poor from the burden of health costs.
22	Policies are in place to promote equity in accessing health care, but reality still has a long way to go before reaching the ambiguous goals. Exemption schemes are far from being functional and there is evidence that the poor have difficulties in accessing health facilities.
27	Participants were aware of different groups that are entitle for exemption. However, it was reported that in some facilities pregnant women pay for the services.
27	Exemption policy is not yet clear to people. There seems to be two exemption policies, one for CHF scheme and another for user fees which are somehow confusing people. Majority of the respondents seemed to accept exemption for underfives although some of them had reservations. It is accepted that children exemption of under fives aim at promoting their health as a vulnerable group. However, given the proportion of under fives attending the health facilities (the proportion in the community) and the value that parents put on them when they get sick there is a need for a study to determine the impact of under five exemptions on CHF enrolment and if found significant mechanisms for compensating the scheme or service providers who attend them should be instituted. The exemption criteria on the payment of development levy can be considered as an option for exemption in CHF.
29	Nearly 75% of respondents thought that “people’s ability to pay for health services” has deteriorated during the last five years; less than 10% thought it has improved.
29	40% of respondents know people who have been refused treatment because of inability to pay – over about 25% know “a lot of people”. Female households more likely to report this.
29	75% of women report inability to pay consultation fee as reason for refusal 25% of all people report bribes, with over one third in DSM reporting

	Impact of e/w on revenue collection
1	Waiver and exemption is perceived as lost revenue for the facility/system; this is in fact largely true
3	Effectiveness of the exemptions in terms of protecting vulnerable social groups and its negative impact on the revenue collection process not known yet.
3	Opinion of hospital management teams: The management teams thought that cost sharing does not generate significant funds; however, there was a general agreement that hospitals can afford more with cost sharing revenue. Laboratory services were said to have improved both in the quality and utilization.
11	The exemption policy states that loss of revenue from exemptions should be compensated through budgetary provision. However, there is a gap between policy and practice. Compensation is ex-post and takes time. Meanwhile quality of care at facilities declines through lack of resources. The more exemptions a facility has, the inevitably the less revenue it generates.
12	A lack of funding to health facilities to compensate for loss in revenue due to exemption and waivers has a negative impact on the facilities performance and discourages facilities from granting of e/w.
	Identification of exemption and waivers
3	Hospital teams assessed people who cannot afford to pay. Negative effect on revenue collection mentioned. Hospital management thought that e/w are not at all difficult to process. The blames were on local leaders who are supposed to write letters that should introduce potential beneficiaries to the hospital management.
3	Hospital management agreed on the need to simplify the procedures for e/w by using Mtaa/Vitongoji leaders, village heads, and committees to identify the needy cases.
10	Exemptions for the poor who cannot afford to pay the CVHF contribution are granted by the Village Council and are not easily given so as not to discourage membership by payment. Most members of CHF schemes were non-poor households. Despite exemptions policy for the poor, only one individual was found to be an exempted member.
15	A national exemption policy has been established to be implemented by all the districts. The village level (community) governments are the ones to recommend who should/should not pay.
	Financial management and recording of exemptions and waivers
1	Financial procedures found to be appropriate – not too burdensome, but with a paper trail that promotes accountability and reduces possible frauds. Recording on e/w patient numbers and monetary values, however, highly variable. Several different forms, incompatible sets of data → reduction of completeness, comparability and reliability of data. But health staff did not complain about administrative load.
1	Only marginal additional costs of administering the exemptions and waivers in addition to the admin procedures for the cost sharing.
2	The exemption policy states that loss of revenue from exemptions should be compensated through budgetary provision. However, there is a gap between policy and practice. Compensation is ex post and takes time; meanwhile, quality of care at facilities declines due to shortage of resources → the more exemptions the facility has, the less revenue it generates.
2	The process for reimbursement for exemptions: currently the system takes too long that is why facilities are hesitant to honor them.
3	There is a potential conflict between the attempt to generate revenue and protection of the potentially vulnerable social groups.
3	When cost sharing was first introduced, hospitals used to prepare records on the values of exemptions with anticipation that the government would compensate them as per the policy guidelines. However, according to DMOs and RMOs, the government seems to have dishonored such arrangements and as a result public hospitals found it costly and useless to keep such records.

3	Estimated revenue loss from exemption and waivers: Four year average 1998/99 - 2001/02 (8 districts): large variations! Actual collection as a % of potential revenue: 33%-96% Estimated revenue loss by %: 4%-67% Contribution of cost sharing revenue to total hospital spending: 20% - 65% Possible reasons for variations; The more exemptions, the less income; the poorer the area, the less income; The more children attending the hospitals, the less income.
3	Exemptions are socially justified irrespectively of the revenue impact on cost sharing
3	Flawed procedures and practices in exemptions and waivers can be construed to cover misuse which, in turn, has negative implications in volume of revenue used for health care
3	Poor-performing hospitals are those which have granted more exemptions and waivers. In contrast, facilities which have granted the least exemptions and waivers appear to have collected relatively more revenue
8	Value for waivers/exemptions 30% of total revenue earned (1998); other losses 35% Other losses include: inefficiencies, possible fraud in the cost sharing programme, "corridor clinics', theft, money collected not appropriately accounted for.
14	The ones identified as poor will receive a CHF card paid by the community and get treatment throughout the year free of charge. For the purpose of financial management and accounting, the CHF cards for the indigent will be paid for by resources from the CHF account using the user fees. These cards will attract matching also from the Government grant for equity reasons.
	Related CHF issues
14	The CHF plans take care of the poor through heavily subsidized CHF membership and heavily subsidized user charges.
14	Those who cannot afford to pay will be identified by hamlet leaders: This group will receive a CHF card paid by the community and get treatment throughout the year free of charge.
14	Increased health system operational efficiency through the prepayment and transparent fee for users have for the first time made the drugs and supplies available.
14	The CHF experimentation is intended to narrow the financing gap at the local level, make drugs and medical supplies at local health care units available and place the management and decision making of the units to the local communities.
15	CHF is a pro poor scheme: The contribution level is calculated so as to ensure that the majority can contribute in order to avoid large scale exclusion from essential social services. Contributions might be made in installment on in one lump sum, for example at the time of selling farm produce.
27	At district level the major reasons for low enrolment were reported to be poverty 46% (57/123), lack of awareness on the benefits of CHF 38% (47/123) and inadequate services (17/123). About 32% (38/120) thought exemptions reduced rate of enrolment because it includes pregnant women and children that forms a large group of health services users. Political differences were reported to affect enrolment in Karatu (52%) and Urambo (24%) districts. From the exit interviews it was revealed that about 15% (20/130) of patients attending OPD were members of CHF. Those who had not joined gave various reasons such as lack of affordability (27%) lack of sensitization (12%) and shortage of drugs. Constraints for rolling out CHF were mentioned to be lack of commitment by leaders; lengthy bureaucracy partly due to lack of legal officers and lack of seriousness of district leaders in the introduction of CHF. At the district level constraints for CHF rolling out CHF included lack of understanding of potential benefits (22%), poverty (19%), lack of confidence that services will improve (12%), people used to free services (10%). Facilitating factors were said to include sensitization and education (56%), assured access to health services (15%) and lessons from Igunga (12%).
27	People complained of high CHF rates especially in areas where the premium were at Tsh 10,000. "The rates are so high for the majority of us, and this will cause some members to continue seeking treatment from the traditional healers'

	Community participation
12	Community participation is very limited across the sectors, not only health; in part due to lack of knowledge about rights and recent reforms; reliable mechanisms are not in place for discussing issues of concern at the village level and than raising these issues of concern to the district level for action.
27	Community involvement was a major concern. "We were not involved in setting the fee so the idea was just sold to us by the district leaders".
	Health Care Financing
21	In FY 05, Tanzania has $ 7.42 per capita for public expenditure on health (this includes on-budget development assistance). Public financing equals 10% of public (health?) expenditures. 47% of total health expenditure (2000) was spent by households (out-of-pocket payments). Often these go to traditional healers of poor-quality for-profit providers (evidence??)
24	Data show reversal of the fall in share of public health spending. However, the budgeted health sector share for FY05 had not gained its FY02 high of 11% of actual expenditure (including CFS), and that even falls short of the Abuja commitment of 15%.
31	NHIF enrolment: Actual by December 2005 principal members: 267,049 beneficiaries: 1,228,425 Expected by June 2006 principal members: 286,580 beneficiaries: 1,318,268 Projected for 2010: principal members: 445,000 beneficiaries: 2,100,000
23	CHF membership ranging from 7% in Singida Rural to 27% and 30% in Igunga and Hanang districts respectively (2001)
24	The introduction of the allocation formula for the OC component of the health block grant to councils has had a clear impact in favour of district rural councils, implying better targeting of government (and basket) funds towards more needy areas (given the known higher prevalence of poverty in such areas).
27	53 Councils are in various stages of implementation of CHF (2003) The challenge facing the districts which are fully implementing CHF is low enrolment of CHF members. To date, percentage of communities joining CHF range from 4% to 18%.
27	The existing pre-payment schemes especially CHF and NHIF are not clear especially in the rural areas. Some people (civil servants) are obliged to shift from CHF which is a voluntary scheme to NHIF which is compulsory. This has created confusion whereby the two schemes are seen as competitive rather than complementing.

B. Recommendations from literature research

Ref. No.	*Recommendation*
1	The public health system should make waivers more widely available and easy to obtain, in order to reduce spending of poor people on medical care
1	Further refine e/w policies: E/w should be better defined; the poor eligible should be further clarified; Definition of criteria; specification of free services for each group; set targets at ward level fro number of poor people who should be given waivers based on local poverty rates; examine whether the e/w categories chosen exclude any specific vulnerable group, such as HIV affected households or households with a high dependency ratio.
1	Communication of the new policy to health staff and community: Further training for staff on guidelines, especially for night staff often having the responsibility to grant waivers on the spot Training for community representatives to develop common understanding on e/w Strengthening social welfare units in hospitals and ensure its representation at lower level facilities Strengthen most potential communication channels Improve functioning Health Boards in terms of two-way flow information.
1	Ensure access to all free services for e/w categories: Increase budget for drug kits and/or prioritize among exempt cases Adopt the indent system for drug distribution tailored to community needs – capacity building required Reduce the red tape for poor people, waivers to come to them rather than poor have to seek for waiver Granting of waivers should not be left to health workers; in the absence of routine household data on income (e.g. tax forms), a community based solution is necessary not far removed from the concept of Tencell or Street Leader (??) being authorized to grant waivers – criteria needed see above Special identity card for the poor with photo attached for a longer period of time; at present, the letter from the community leader is only valid in one specific area.
1	Standardization of approach: Studies on inter-health facility differences in practices and outcomes related to e/w Regular feedback to health facilities, showing cross-facility comparison and requesting missing information Provide an unique template for recording on e/w and compiling summary for MMOH; standardize practices at least within each municipality but preferably at city level.
2	Blanket policies should be avoided. Instead, a mechanism should be put in place to enforce transparency and accountability as well as monitor and evaluate implementation of the system.
2	Prerequisites for user fees systems: Quality of care Qualified health workers available in under-served and remote areas Essential health care package available at primary level Access to health services widened through infrastructure improvements \including rural roads, public transport etc. A system to ensure transparency and accountability
2	There is the need to define ways to determine whether payment of user fees and not other problems e.g. wastage and misuse of resources and supplies is the cause of poor quality of care.
2	The process for reimbursement for exemptions needs to be improved and expedited so that exemptions do not create a resource gap in the facilities.
2	Exemptions lead to lees income at the facility level. There is need to carry out a cost-benefit analysis to determine the trade off between improved health financing and exclusion of the poor.
3	All facilities visited, most exemptions are granted to children below the age of 5 and to MHC services. This is regarded in the study as a very strong justification for continued existence of the practice of issuing exemptions and waivers.
3	Establishment of specialized hospital management unit for cost sharing and design incentive mechanisms for management of cost sharing that will among other reinforce an effective implementation of the policy for waivers and exemptions

3	Review the exemptions and waivers with the objective of making them more applicant friendly and operationally efficient and more focused on targeting the poorest households
3	Public sensitization on e/w
3	Simplification of the e/w application procedures More focused targeting on the side of the beneficiaries Major review of the e/w entitlements and the application processes
5	The potential for establishing a broad-based National Health Insurance Program down to the village level should be realistically discussed.
5	Cost sharing: The existing plans should be reviewed and modified to match the economic profiles of the districts and the needs of the people in their districts.
8	Registers in each hospital department should be summarized monthly and should show the value for paying and non-paying patients.
8	Staff should be deployed in critical areas: medical record department, accounts, social welfare
8	Effective linkage of the cost sharing programme with HMIS at hospital level.
8	Gradual periodic review of policy exemptions and waivers especially: hospital staff members, members of the armed forces and their dependants; other exempt categories should be reviewed form time to time to ensure that they are still necessary.
8	Training sessions for all hospitals and set revenue targets nation wide.
9	Involvement of communities in granting of exemptions and waivers
10	The need for broader risk pools for community health insurance schemes, along with greater involvement of communities
11	Need to carry out a cost benefit assessment to determine the trade off between improved health financing and exclusion of the poor
12	The key to success of an exemption and waiver system is its financing. Systems that have compensated providers for the revenue forgone from granting exemptions (Thailand, Indonesia, Cambodia) have been more successful than those which have expected the provider to absorb the costs of exemptions (Kenya).
12	Clear criteria for granting waivers is a prerequisite to reducing confusion and ambiguity among those responsible for managing the system and among potential recipients.
13	Presentation KfW: Output-based approach as waiver scheme to increase pro-poor coverage.
13	Health workers need to be reminded of exemption guidelines.
14	Need for poverty assessment criteria to rank the poor households in terms of their wealth index.
14	By mandating the households to contribute and empowering the communities will protect the poor households by placing the mandate to exempt the indigent at the local committee level and leadership. Who knows the poor at the local level better than the community and its leadership? By exempting poor households by the committee using their own local criteria of poverty guided by the support from the CHF …is the simplest and most transparent way of protecting the poor in the CHF programme.
19	Demand side is most important for effective health care. Improving access must therefore aim at encouraging people to recognize signs of illness and seek care promptly.
19	Reduce inequalities in treatment: availability of skilled personnel in the peripheral facilities, ensure that they are trained, equipped and supplied to be able to address their patients' needs in a comprehensive fashion.
19	Improving logistic of drug and medical supplies has direct relationship to removing financial barriers to effective treatment.
20	Improving the "Community Action Plan" which serves as a guide for deciding on health priorities and what health issues will be addressed with CHF.
24	Amore detailed evaluation of the CHF scheme's overall performance is long overdue, and should be undertaken before the next PER up-date (2006).
25	There is need to fully sensitize the community about the CHF and improve the quality of health service delivery.
26	" There should not be a policy for the poor and one for the rich. There should not be a health service for the poor and one and one for the rich either. The services should be the same and of similar quality for the poor and the better off. The difference should only be who pays and how much"
26	" The "hati punguzo" ITN voucher system is a good system BUT it is introducing a cost-sharing in the preventive services, which are the public goods. But it is an experience: let us see how it works

27	Exemption guidelines are neither well understood nor followed. There is need for comprehensive guidelines coupled with better methods for dissemination to grassroots level.
27	Since exemption mechanisms were seen to be inadequate there is need for prior action to strengthening the mechanism so as to ensure that the poor do not suffer from service exclusion.
30	If we feel the exemption mechanisms are not working then let us address that specific area and find more workable measures to protect the weakest amongst us and ensure that they, like all their fellow citizens have access to similar health care at the time of need.

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Health Focus ltd.	Dr. Michaela Mantel	Public Health	Tel Off. Potsdam: +49 331 200070 Tel. Off. Berlin: +49 30 44031951 Mobile Tanzania: +255 Mobile Germany: +40 1797486309 michaela.mantel@gmail.com mantel@health-focus.de

Field Visits

Iringa Region

Organisation	*Names of persons met*	*Designation or office*	*Telephone number Tanzania +255*
Regional Administration	Cecilia Shirima	RAS	0741 307485
	Dr. Ezekiel Mpuya	RMO	0744 312959
District Administration	Mr. Gabriel Fuime	DED	0744820???
	Robert Salum	DMO	0744 377176
	Solphen Njeleka	DHS (District Hospital Secretary)	0774 829921
Regional Hospital Management Team	A.M. Mhagama	Health Secretary	0744855169
	Dr. O. Gabone	Hospital D i/c	0744 287463
	G.M. Lugenge	Supplies Officer	0744 538239
	V. Mphum	Accountants Assistant	0744 533708
	H. Madefu	Medical Recorder	0744 674996
	Dr. James Tumaini	Dental Officer	0741 483773
	Dr. M. Grinciayi	AMO Obs/Gnaecology	0748 354790
	V. Lally	PNO Assistant Matron	0744 051557
	I. Mushi	Laboratory Technician	0748354938
	A. Sikulo	Psychiatric – Unit	0745-369173
	Dr. E. Mpuya	RMO	0744 312959
Idodi Rural Health Centre	Rogatus Mavika	CO i/c	
Patients	Shakila		
	Regina		
Idodi Community Members	Hendry Mgati	Ward Executive Officer (WEO	
	Felix Ripambila	Member	
	Mussa Kigelelo	Chairperson, CHF Member	
CHMT Iringa Rural	Blandina Mkumbwike	CBHCCO/Malaria IMC Coordinator	0744 -22263/0262700145
	Stanslaus Luzuki	District Pharmacist	0744 – 32 4937
	Mlay Reginald	Health Officer	0744 584489/262700120
	Aten Svelege	Cold Chain Operator	0745 88669/0262700120
	Edmunda Mosha	PNO	0744-806418
	Castory Kawono	District TB/Lep Coordinator	0744013717
	Solphen A.L. Njeleka	District Health Secretary	0744829921
	Chinangwa Aidan	District Health Officer	0744203111
	Jengela P.M.	DTLC	0744 548789
	M.A. Mwambwelwa	Chairman of District Health Board	0748 780089
	Robert Salum	DMO	0744 -377176
Kalenga Dispensary Committee	Augustina Lukosi	Disp. Committee member	
	Jafari Mnoja	Village Health Worker (VHW)	
	Syvanus Makinda	Disp Committee Member	
	Hamidah Nuru	VHW	
	Pelesi Ngakonda	Disp Committee Member	
	Charles Mashallo	Chairperson, Disp Committee	
	Blandina Kiyeyeu	Secretary, Disp. Committee	
Ilula Health Centre (Lutheran)	Dr. Mwakalebela	Med. Officer i/c	
	Mr. Alam Kikoti	Administrator	
	Mrs. Mida Msamba		

Morogoro Region

Organisation	*Names of persons met*	*Designation or office*	*Telephone number Tanzania +255*
Regional Administration	Hon. Stephen J. Mashishanga	Regional Commissioner	+255 232604227 +255 748799586 smashishanga@yahoo.co.uk
	Dr. Massi	RMO	massimmz@yahoo.co.uk Cell: +255 (0) 741670320 Tel Off: +255 (0) 233099
District Administration	Mr. Sapanjo	District Executive Officer	
	Dr. Harun M.S. Machibya	DMO	Te; Off: +255 234147 Mobile: +255 744462788 msafa@hahotmail.com
	Mr. Theosonius Lisonja	CDO	
CSSC Zonal Coordination	Dr. Kibosi	Diocesan Zonal Coordinator	
Regional Hospital Management Team	Mankambila	Health Secretary	0744 878365
	Malisa A.M	Reg. Pharmacist	0744 820378
	Dr. Ngarawa K.	Act. MO i/c	07415740398
	Dr. S. Mkambr i		0787143877
	Rose Sengo	NO	0741 388527
	Anna A.Ngatunga	PNO	0744 325618
	Joash A. Garcho	NO	0745 056137
	Lwambura L.T	Hospital Pharmacist	0744 658885
	H. Ngatolwa	Medical Social Welfare	0748 534138
	Tatu Kasuku	Matron (H)	0744 563336
	Anna Gutapaka		0744-817442
Council Health Board Morogoro Rural	G.S. Toru	Board Member	0748 246498
	B.M. Chonile	Chairman of the District Health Board	P.O.BOX 1880 TAWA
	E.G.Mlegu	Chairman of the District Health Board	0741 472463
	Dr. H. Machibya	DMO DC	0744 962788
Mkuyuni Dispensary Staff, Health Facility Committee and Village Government	Mohamed Korongo	Mjumbe	
	Mohamed Shomari	Mwenyekiti/Bodi	
	Mtola S. Mili	M/Kitongoji	
	Ali m. Ngemange	Mjumbe	
	Abdgu S. Sadala	M/Kitongoji	
	Ali Maumba	M/Kitongoji	
	Omari A. Gunewe	M/Kitongoji	
	Abdallah Ali Rutexua		
	Shaban Mafunda	M/kiti	
	Tabu M. Makumbea	M/Kitongoji	
	Abdallah A. Mngozi	Mjumbe	
	Mariam Bakari	Mjumbe	
	Maua M. Ngalawa	Mjumbe	
	Zaituni Mbega	Mjumbe	
	Ally R. Madenge	Mjumbe	
	M.T. Chacha	Mganga i/c	
	O.A. Budi	VEO	
	C.D. Matwarane	Afisa Tabibu	
	Kasole E. Maungo	Afisa Afya	
	Mawa Mzallah	Mjumbe	
	Tukae Tondolla	Mjumbe	
	Yolanda Ruguna	PHN	
	Mariam Mussa	A/Asst	
	Paula Nchimbi	N/M	

Organisation	*Names of persons met*	*Designation or office*	*Telephone number Tanzania +255*
	Ramadhani Mzee	Mjumbe	
	Siayo Rashid	Mjumbe	
	Sinayo Zohoro	Mjumbe	
	Rashid Tonola	M/kiti – Kijiji	
Mtumbuzi Dispensary Staff, Health Facility Committee and Village Government	Gilion Alphonse	MW/Kitongosi	
	Andrew Mloka Mluso	Mjumbe wa serekali kijiji	
	Editha John	Mjumbe wa serekali kijiji	
	Selina Raimondy	Mjumbe kamati ya zahanati)	
	Abedi H Chamame	M/kiti Kijiji	
	Ally Kassim Ally	Mjumbe wa serekali kijiji	
	Godfrey Pascal	Mjumbe wa bodi wa zahanati	
	Beatrice m Chomile	M/kiti wa Bodi wa Afya	
	Ally Lusewa	CO i/c	0748411774
	Godfrey L. Kameki	HO	
	Emma Magawa	M/Att	
	Asha Mkwachu	CO	0787285757
	Tabia Ramadhani	Lab Att	
	Lilian Haule	Midwife	0748497015
	Godfrey Kanick		023 2605629

Kisarawe District

Organisation	*Names of persons met*	*Designation or office*	*Telephone number Tanzania +255*
Council Health Management Team and District Hospital Management Team	Dr. Chacha	DMO	0741 464504
	Zahili Fadhili	District Pharmacist	0741 623672
	A.H. Mfinanga	Ag. District Lab Technician	0744 565619
	Mariam Mwilola	District Nursing Officer	0741 415768
	Mdangaya Ally	District Cold Chain Officer	0741 407200
	S.N. Tarimo	District Health Officer	0787 471760
	Dr. E.N. Helela	District Dental Officer	0744 668020
	Dr. E. Mazim	Medical Officer Incharge	0741 363474
	Happy Mziray	Matron	0741 755195
	Emerensiana Mtesigwa	DRCH	0748 864359
Masanganya Dispensary	Bernadetha Lugongo	Nursing Assistant	P.O.Box 28002 Kisarawe
	Maliki A. Muhomba	Nursing Assistant	Box 28002 Kisarawe
Mwanarumanga Dispensary	Yona Kabata	Clinical Officer	
	Juma Kifaru	Medical Records Management	
	Kimambo Gadieli	Health Assistant	
	Tatu Hebel	Nurse Assistant	
	Emanueli Gongi	Laboratory Attendant	
	Mwanahamisi A. Mgomba	PHN B	
	Dastan Zephania	Member of Health Centre Committee	

Tanga region

Name of health facility	District and Region	People met
Muheza District Designated Mission Hospital	Muheza Tanga	District Medical Officer, Mr H Mwalugaya; Hospital Medical In charge, Dr Rajabu Mallahiyo; Hospital Secretary, Mr Adam Lyatuu; Hospital accountant, Nestor T Mkoni; Hospital accounts clerk, Frank Mganga; Social welfare officer, selected patients, MCH and OPD Departments visited
Magila Dispensary	Muheza Tanga	Clinical Officer In charge, Mr Abdallah Hinte; Nurses
Mkuzi Health Centre	Muheza Tanga	Assistant Medical officer, Dr Grace Samba; Matron, CHF cashier and accounts clerk, Mkuzi village chairperson, Mr Mzee Jumbe W Bendera; Mkuzi village health committee chairperson, selected patients, MCH and OPD Departments visited
Mkanyageni Dispensary	Muheza Tanga	Clinical In charge, Nurses, CHF cashier accounts clerk, Ms Ashura Issa, selected patients
Bombo Tanga regional hospital	Tanga	Regional Medical Officer, Dr Baltazar J Ngoli; Medical In Charge, Dr Margareth E Mhando; Hospital welfare officer (Waivers unit), Ms Thereisa Godfrey; Hospital accountant, Ms Khalima Mwendo; Hospital Secretary, hospital chief nurse/matron/MCH services
Other/Cross cutting institutions	Muheza Tanga	District Executive Director, Mr Ephraim Williams; District CHF coordinator, District Social Welfare Officer, selected members of the district health board

Kilimanjaro region

District Medical Officer	Mwanga District Kilimanjaro	District Medical Officer, Dr Mhina
District Health Officer		District Health Officer
Usangi District Hospital	Mwanga Kilimanjaro	Medical In charge, Dr Braka I Mmari;, CHF cashier/accountant, Mrs Sauda Bakari Msofe; District Pharmacist, Mr Bajaya Amiri; social welfare officer, MCH and OPD Departments visited and interviewed
Ndanda Dispensary	Mwanga Kilimanjaro	Clinical Officer In Charge, Nurses, Mr Abdalla Shuhuli
Mwanga Health Centre	Mwanga Kilimanjaro	Clinical Officer In Charge, Nurses, Mr Aubrey John Ishasi
Mawenzi Regional Hospital	Kilimanjaro	Regional Medical Officer, Dr H Mbwana; Medical In Charge, Dr Saganda AB; Hospital Secretary, Mr LR Msamai; Hospital Social Welfare Officer, Ms R Olomi; Hospital Accountant, Mr B Muro
District Medical Officer	Moshi Kilimanjaro	District Medical Officer, Dr Ngomuo
Kyaseni Dispensary	Moshi Kilimanjaro	Clinical Officer In charge, Dr Yusoto Kwauu, and all other staff
Kibosho Mission Designated District Hospital	Moshi Kilimanjaro	Medical In Charge, Dr Sr Henrica; Hospital Accountant, Sr Hyacinta; Hospital secretary, Sr Avilla Marandu, Matron, selected patients
KCMC Referral Hospital	Moshi Kilimanjaro	Director Hospital services, Director of Finance, Others, Various Departments visited
Kibosho Barazani dispensary	Moshi Kilimanjaro	Clinical Officer In charge, all other staff; Mr Claude Peter Silayo
Cross cutting	Moshi Kilimanjaro	Selected people, focus group discussions, village government officers