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HEALTH

EQUITY IMPLICATIONS OF HEALTH SECTOR USER FEES IN TANZANIA

Do we retain the user fee or do we set the user f(r)ee?

ANALYSIS OF LITERATURE AND STAKEHOLDER VIEWS

Commissioned by Research for Poverty Alleviation (REPOA)

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FINAL REPORT

ETC Crystal
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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMO	Assistant Medical Officer
ANC	Ante Natal Care
CBHI	Community Based Health Insurance
CCM	Chama Cha Mapinduzi
CHER	Coalition for Health And Education Rights
CHF	Community Health Fund
CHMT	Community Health Management Team
CHSB	Council Health Service Board
CSO	Civil Society Organisation
CSSC(1)	Christian Social Services Commission
CSSC(2)	Council Social Service Commission
CWIQ	Core Welfare Indicator Questionnaire
DANIDA	Danish International Development Assistance
DC	District Council
DDH	Designated District Hospitals
DED	District Executive Director
DFID	Department For International Development
DPG	Development Partner Group
DPO	District Planning Officer
DRDP	District Rural Development Programme
DRF	Drug Revolving Fund
EDI	Economic Development Initiatives
ELCT	Evangelical Lutheran Church of Tanzania
ERAF	Equitable Resource Allocation Formula
FBO	Faith Based Organisation
FGD	Focus Group Discussion
FTE	Full Time Employees
FY	Financial Year
GNI	Gross National Income
GOT	Government of Tanzania
GTZ	German Technical Cooperation
HERA	Health Research for Action
HF	Health Facilities
HIV	Human Immune-deficiency Virus
HMIS	Health Management Information System
HMT	Hospital Management Team
HSF	Health Sector Fund
HSPS	Health Sector Programme Support
HSR	Health Sector Reform
IEC	Information Education Communication
IMCI	Integrated Management of Childhood illnesses
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPAR	Institute of Policy Analysis & Research
LGA	Local Government Authority
LGRP	Local Government Reform Programme
MC	Municipal Council
MCH	Mother and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MOEC	Ministry of Education and Culture
MOH	Ministry of Health
MOU	Memorandum Of Understanding
MPH	Master in Public Health
NGO	Non Governmental Organisation
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research

NPES	National Poverty Eradication Strategy
OC	Other Charges
OPD	Out Patient Department
PEDP	Primary Education Development Program
PER	Public Expenditure Review
PHC	Primary Health Care
PLWHA	People Living with HIV and AIDS
PORALG	President's Office, Regional Administration and Local Government
POW	Plan of Work
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
R&AWG	Research and Analysis Working Group
RE	Resource Envelope
REPOA	Research for Poverty Alleviation
RMO	Regional Medical Officer
SCF	Save the Children Fund
SDC	Swiss Agency for Development and Cooperation
SIP	Sector Improvement Programme
SWAp	Sector-Wide Approach
TA	Town Authorities
TAS	Tanzania Assistance Strategy
TB	Tuberculosis
TC	Town Council
TEHIP	Tanzania Essential Health Intervention Project
TGNP	Tanzania Gender Networking Project
TOR	Terms of Reference
Tshs	Tanzania Shillings
TzPPA	Tanzania Participatory Poverty Assessment
U5MR	Under Five Mortality Rate
UNCESCR	United Nations Committee on Economic, Social and Cultural Rights
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNICEF	United Nations International Children's Emergency Fund
VA	Voluntary Agencies
VPO	Vice President Office
VSSC	Village Social Service Commission
WB	World Bank
WDC	Ward Development Committee
WDP	Women's Dignity Project
WHC	Ward Health Committee
WHO	World Health Organisation
WTP	Willingness to Pay

EXECUTIVE SUMMARY

1. Background

Early 2004, Research for Poverty Alleviation (REPOA) commissioned ETC Crystal to examine the equity implications of health sector user fees in Tanzania, with particular reference to proposed and actual charges at dispensary and health centre level. This year, Tanzania will review its Poverty Reduction Strategy. With the findings of the user fee study, REPOA aims at making a valuable contribution to the review process and provide country-specific insight into one of the most debated issues in health financing.

2. Methodology

The focus and design of the study was formulated in close cooperation with the Research and Analysis Working Group of REPOA. The strategies for data collection comprised: (1) a comprehensive literature analysis literature, (2) semi-structured interviews with resource persons from the government of Tanzania, multi- and bilateral donors, research institutes and NGOs in Dar Es Salaam, and (3) a case study in Kagera Region, including both document analysis and semi-structured interviews with resource persons from the MOH, NGOs, FBOs, health workers and health care consumers from vulnerable and poor population groups. The study team developed multiple tools for data collection and analysis including: (1) a data matrix for categorisation and identification of key issues, (2) guidelines for the interviews in Dar Es Salaam, (3) guidelines for data collection and interviews in Kagera Region, and (4) a tool for the analysis of poverty reduction strategy documents. A total number of 170 user fee-related documents were assessed, including those covering the experience from neighbouring countries. Seventy-nine resource persons participated in the study.

3. Main findings and recommendations

1. *Resources generated by user fees and their use at hospital, district council and PHC levels.* The study team found that reliable, transparent user fee income data for district, hospital and PHC level were difficult to obtain. Based on what information is available, the team concludes that revenues raised from user fees at the hospital level have been lower than what has been projected. Furthermore, the data reflect huge variations between facilities and a decline in the revenues from cost sharing. The reasons of the reported decline are unclear. The data reflecting the contribution of user fees and CHF to the health budget at district council level show huge variations as well. The reported user fee income proportion for the district health budget was on average 10.5%. The study team could not establish how the income from cost sharing and the CHF was re-distributed by the council to PHC facilities or priority areas. A worrying finding was that some councils did not spend all health resources in the health sector. The study team observes an urgent need for: (1) more accurate and comprehensive record keeping at local council level, and (2) more costing and tracking studies to obtain a better insight into cost sharing and expenditures and to adequately inform policy making.

2. *Contribution of user fees and CHFs to the health resource envelope.* The study team concludes that the national projections of the cost sharing schemes do not reflect an accurate picture, since the data are based on the inaccurate financial data received from the districts. It is likely that the actual and projected data on user fees, CHFs and HSF are underestimations of the real income collected at the different facility levels. This means that the MOH faces a loss of income that cannot be redistributed to the health sector. It also implies that people (both wealthy and poor) are likely pay more than what is officially reported. The actual potential and use of the non-reported user fees are not known. The total contribution of the cost sharing schemes (excluding NHIF) to the national health resource envelope for FY03/04 is 1.67 Billion Tshs. This equals a contribution of 0.6% to the overall budget for the health sector. In total, this is US$ 1.56 million. Given the size of the total health budget (US$ 260 million), it can be concluded that the *officially* reported user fees contribute a small proportion only. The actual revenue generated does not meet the initial expectations.

3. *Contribution of revenues generated to improved services*. The study team found limited positive evidence that user fees in Tanzania have in general achieved their original objectives of sustainability, drug availability, quality of care, equity and access for the poor. More specifically,

the study team found that government-run PHC facilities appeared to face severe shortages of drugs and supplies. In addition, user fees were not always retained at PHC level, but deposited in the HSF account which mainly benefits the purchase of supplies for the district hospital. Positive results were seen for reinvestment of CHF funds. In total, 50% of the health workers and patients reported improvements in drugs availability, diagnostic facilities and maintenance. However, equity criteria for the distribution of available resources from the user fee income to PHC level are not systematically followed.

4. *Impact of user fees on access to health services*. The study team concludes that presently, the user fees in Tanzania are regressive and contribute to substantial exclusion, self exclusion and increased marginalisation. The team has collected evidence which shows that user fees have disproportionally affected access to health care for poor and vulnerable population groups, more specifically: (1) pregnant women from poor households, (2) under-five children from poor households, (3) orphans and especially double orphans, (4) widows, (5) people older than 60 years, (6) people with disabilities, and (7) AIDS patients.

5. *Further extension of fees to dispensary and health centre level*. Also at the PHC level, the study team found that fees have negatively impacted the use of health care by the rural poor population, particularly women and children. Given the importance of the public PHC facilities for poor people (government health centres are the main choice for out-patient care for the poor), the study team expects that the further extension of user fees to PHC level without effective exemption and waiver mechanisms will contribute to further exclusion and self-exclusion.

6. *Effectiveness of exemption and waiver mechanisms.* The study team identifies the ineffectiveness of the present exemption and waiver mechanisms as the core problem in the user fee debate in Tanzania. A functional exemption and waiver system is actually non-existent putting vulnerable and poor people at risk by practically denying them access to public health services. This applies both to (1) the exemption and waiver system in health facilities and (2) the exemption mechanisms instituted for the CHFs. In both situations, poor people just do not receive the exemptions to which they are entitled to! Revenue collection appears to prevail over protecting the poor and vulnerable. Some hospitals have even tried to hide the waivers in their statistics in order to have, on paper, a better performance with their user fee income. The study team recommends that, should the government of Tanzania decide to maintain its user fee policy, priority is given to the design of an effective exemption and waiver system combined with: (1) sufficient resources to compensate for the unknown money lost (since it not recorded properly), and (2) a serious effort to make it work. However, there is substantial evidence that exemption and waiver systems do not guarantee increased access to health services for poor people unless major adjustments in the design, implementation and funding for adequate exemption and waiver systems take place. In the light of recent developments in Uganda and Kenya, it seems a much more realistic approach to compare the costs of (1) the suspension of user fees at PHC level against the required costs for (2) improved exemption and waiver systems or (3) improved NSHIF approaches in the contest of abolishment of fees and to opt for the most pro-poor and cost-effective approach within the shortest possible time frame.

7. *The potential and impact of Community Health Funds.* The introduction of the CHF has not provided the expected benefits for poor people. There are a number of constraints the study team thinks should be urgently addressed, including the delays in the introduction of the CHFs and the weak management at the district and lower levels. More importantly, the study team found that poor people often cannot afford to pay the CHF premium because it is too high and has to be paid at once. If membership of the CHF becomes compulsory and poor people are not effectively exempted from paying CHF premiums and co-payments, the impact of the CHF can be disastrous and lead to double exclusion of poor people. Another issue of concern is related to the link between user fees and the CHF. According to the CHF Act, the user fees paid at public health centres and dispensaries form a source of income to the CHF. The premium paid to the CHF will receive WB matching funds, putting pressure on the PHC facilities to raise income through user fees. This indicates a complicated dilemma since it means that if user fees will be suspended or abolished at PHC level, the CHFs will not be able to take off as planned and will not receive part of their required resources. This points to the need to assess the mix of financing mechanisms and their interactions, rather than look at them as stand-alone policies.

Tanzania has opted for a system of multiple risk-pooling schemes for the health sector. There is an urgent need to review the ongoing processes and assess their impact on the overall health system and the vulnerable members of the population.

8. *Scenarios*. Reviewing the available literature, the study team observes that the abolition of user fees for education in Tanzania, and for health in South Africa and Uganda, has had impressive results in terms of attendance and access. Recently, Kenya also decided to abolish user fees for health. However, when reviewing the stakeholder's attitudes towards abolition, the study team concludes that the necessary support for such a decision seems to lacking in Tanzania at present. The study shows that Tanzania is at a cross road. Tanzania can opt for two strategic directions. One strategy can be to continue on the road of the multiple risk pooling strategies. The other strategy can be to follow the abolishment of user fees at either (1) all levels or (2) at PHC levels. Both strategies will require substantial support from external donors and will require major adjustments in the current funding mechanisms. However, given the negative equity implications for poor people with the multiple risk pooling systems and the complicated, time consuming, costly and unreliable administration that is required for user fee systems and CHF, evidence indicates that it seems a more pro-poor and pragmatic strategy to abolish the user fees for poor people either (1) temporarily till improved exemption and waiver systems have been designed and introduced or (2) as long as the poverty situation in Tanzania requires. In case Tanzania will opt for the continuation of a multiple risk pooling system, then a number of key conditions will have to be met in order to ensure access to health services for poor people. It will be crucial to assess the mix of financing mechanisms and their interactions rather than look at them as stand-alone policies.

   Considering the severe poverty situation in Tanzania, it is concerning to find that many stakeholders continue promoting and supporting user fees in the absence of effective exemption and waiver systems. This does not correspond with the commitment to reducing poverty in Tanzania as articulated in the PRS. Consequently, immediate political action is required. Abolition of user fees can be considered as a pro-poor option to reduce exclusion and self-exclusion among the poor and vulnerable. The studies illustrate, that the abolition of fees needs to be combined with considerable efforts in other areas, such as changed levels of funding (internally and externally), improvements in the allocation and disbursement of funds, improved human resource development, improved incentive schemes for health workers and improved quality of services. This indicates the importance of a broad, strong political support and donor support.

9. The developments in Uganda and Kenya might have created a momentum for Tanzania to re-think the current multiple risk pooling strategies in the context of the PRS Review and to opt for more pro-poor health strategies. It should be noted that in the current political situation strengthening the existing exemption and waiver systems seems to be the most preferred scenario at this moment. However, in the light of all the constraints mentioned and in the context of positive developments in Uganda and recent decisions taken in Kenya, the study team would like to recommend to include the suspension of user fees at PHC level in the next PRS document for Tanzania as a real pro-poor health strategy for Tanzania. The study team considers the Poverty Reduction Strategy Review Process as an excellent opportunity to lobby the government and the development partners on these issues, and to demand that a specific Plan of Action is included in the second Poverty Reduction Strategy Paper. The study team hopes that the findings of this study will contribute in such a positive and constructive way to the Tanzania PRS Review Process.

The outcomes of this study confirm that in Tanzania, user fees are an issue to be carefully (re)considered when designing national pro-poor health policies in Poverty Reduction Strategies. Considering the severe poverty situation in Tanzania, it is concerning to find that many stakeholders continue promoting and supporting user fees in the absence of effective exemption and waiver systems. This does not correspond with the government's commitment to reduce poverty in Tanzania. Consequently, immediate political action is required.

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Many resource persons contributed to this study on Equity Implications of the Health Sector User Fees in Tanzania. People from a wide range of organisations availed documents, website and email numbers and reserved ample time to meet with the members of the study team. We have included the names of all resource persons in Annex 6. We would like to express our deep appreciation for all the support and guidance we received throughout the study period.

We first of all would like to thank the resource persons in the Netherlands and England who were instrumental to direct the study team to relevant documents. We especially would like to thank resource persons from Wemos and from Medact.

In Tanzania, resource persons based in Kagera Region, Dar es Salaam and Dodoma provided valuable information. We would like to thank the resource persons in Kagera Region for their participation in the study. We are especially thankful to the Kagera Regional Medical Officer (RMO) who availed one of his senior staff members, Dr. Tiimanywa Lutaremwa (MPH), for data collection in Bukoba District. We are also thankful to the offices of the District Rural Development Programme (DRDP) and the Kagera Health Sector Reform Programme for availing various study documents. Lastly we would like to thank the health workers from the Ministry of Health (MOH), Faith Based Organisations (FBOs), Non Governmental Organisations (NGOs) and private clinics for their participation in the study. Especially the participation of guardians, orphans, people living with HIV and AIDS (PLWHA) and persons with a disability was highly valued.

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We sincerely hope that the findings of this study will contribute in a positive way to the Tanzanian Poverty Strategy Review Process 2004.

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I INTRODUCTION

1.1 Background to the study

The Research and Analysis Working Group (R&AWG) of Research for Poverty Alleviation (REPOA) commissioned the public health consultancy group ETC Crystal to carry out an in-depth analysis of the Equity Implications of the Health Sector User Fees in Tanzania. The study was carried out in the period 3rd March to the 5th June 2004 by Ms. Leontien Laterveer, Mr. Michael Munga and Ms. Patricia Schwerzel. The Terms of Reference (TOR) was the guiding document for the study (see Annex I).

1.2 Purpose and objectives of the analysis

With the findings of the analysis, REPOA aims at making a meaningful contribution to the Poverty Reduction Strategy (PRS) Review Process taking place this year in Tanzania. The main purpose of the analysis was to examine the equity implications of the user fee system in Tanzania with particular reference to proposed and actual charges at Primary Health Care (PHC) facilities.[1] The analysis aimed to address one of the guiding PRS questions in relation to health:

> *"The Government should consider suspending cost sharing for basic health services at least until the time when an effective system of exemptions for the poor is in place. In preparing for this, a cost-benefit assessment should be undertaken to determine how much is gained by fees as compared to how much is lost by excluding the poor."* (Statement made during a Poverty Reduction workshop, 2003)

The main objective of the analysis was to examine how much is gained by the user fees in the health sector as compared to the impact of fees on the access of poor people to health care services, especially at the primary level of care. The analysis examined the following critical issues:

1. The impact of user fees in the overall health sector and more specifically in relation to (1) their contribution to the overall resource envelop, (2) resources generated and used at facility level, (3) contribution of generated revenue to improved services, (4) transaction costs and administration requirements, (5) payment of "unofficial fees" by the poor, (6) local ownership, accountability and provider responsiveness, (7) access to services for the poor, and (8) effectiveness of exemption and waiver mechanisms.
2. The potential impacts of further extension of user fees to the dispensary and health centre level in relation to the issues mentioned under 1.
3. Options that exist for revising the current user fee system to achieve greater equity and effectiveness.

1.3 Equity definition, research questions and methodology

Working definition of Equity

In the literature a wide range of definitions of equity[2] can be found. The study team opted for a working definition which is much in line with the priorities mentioned in the TOR and by the members of R&AWG:

> *Equity means that everyone should, in practice, and not just in theory, be able to access and use appropriate health services. Health services should not only be for the dominant population group. This implies equitable access and use, given that some people will need more health care than others. It also means that we should seek to minimize inequalities in health outcomes. The main elements of a just health care system can be listed as universal access, access to responsive care and fairness in financing* (Healy and Mckee, 2004).

[1] PHC facilities include Health Centers and Dispensaries

[2] A distinction must be made between equity and *equality*. Whereas equity deals with fairness, equality is concerned with equal shares (Carr-Hill 1994:1190; Donaldson & Gerard 1993:73; Wagstaff, Van Doorslaer & Paci 1991:145; in Laterveer, 2001).

Research Questions
The following research questions were identified:

- What is the background/context of user fees systems and what are critical issues for poor people?
- Are poor people/specific categories of people excluded from public health services, private health services or both due to costs and other barriers?
- How do the costs of health care services influence people's trade-offs? Do they force poor families to make trade-offs that could drive them further into poverty?
- Are Exemption and Waiver systems enabling access to health services for the poor and if not, what are the main reasons?
- How can the negative impacts of cost-sharing (exclusion of the poor) be mitigated while recognizing the financial requirements and constraints in Tanzania?
- What are the various scenarios for improving access for the poor, including revising the current fee structure?
- What are the options, the costs and the benefits (for whom?) if fees will be reduced or abolished at a certain level? How much is lost at different levels?

Methodology
The methodology included different strategies to ensure sufficient collection of secondary and primary data (see also Inception Report (Schwerzel, 2004)).[3]

- An extensive literature search of (1) leading publications in the fields of poverty analysis and equity in health, (2) Poverty Reduction Strategies, (3) National Policies, (4) Research studies, (5) Scientific papers and (6) Grey Documents (see list of consulted documents).
- In-depth interviews with resource persons and key-stakeholders from (1) Government Departments, (2) Donor Agencies involved in the Health Sector, (3) Research Institutes and (4) NGOs.
- A Situation Analysis in Kagera Region[4] including (1) document analysis and (2) interviews with resource persons representing the MOH, NGOs, FBOs, health workers and vulnerable groups. The findings from Kagera Region are based on different sources of information. A first source was the Rural Kagera Core Welfare Indicator Questionnaire (CWIQ) Survey[5] (DRDP, 2004). A second source was the study on Health Care Financing Options in Kagera Region (Mubyzazi et al, 2002). A third source of data was generated by the study team in Bukoba District. In total 59 resource persons[6] participated in a small-scale assessment.

1.4 Structure of the report

Chapter 2 starts off with a brief introduction to the overall user fee debate and alternative financing approaches. A more extensive review of documented evidence on user fees, exemption and waiver systems and their (potential) achievements has been included in Technical Paper Part 1. As from chapter 3, the focus is on Tanzania, starting with an analysis of the poverty and health situation. This includes an assessment of Tanzania's Poverty Reduction Strategy. Chapter 4 sketches the Tanzania health strategy framework, zooming in on health sector financing. This is worked out in more detail in chapter 5, which describes the contribution of user fees and community health funds to the national resource envelope. The impact of user fees, exemptions, waivers and community health funds in Tanzania are described in chapter 6. This is based on the outcomes of the Kagera study that was conducted for the purpose of this paper, on stakeholders' views and on other available studies. Chapter 7 presents the conclusions.

[3] In total 170 documents were assessed and 79 resource persons participated in the study.
[4] Kagera Region is one of the National Health Sector Reform pilot Regions in Tanzania. Alternative forms of health financing have been one of the areas for further research.
[5] CWIQ is an off-the-shelf survey package developed by the World Bank to produce standardised monitoring indicators of welfare. A total of 2,250 households participated in Kagera.
[6] (1) 19 Health workers from Government Health Facilities (HF), Faith-based HF, NGO managed HF and private clinics; (2) 11 NGOs; (3) Community Health Fund staff; (4) 4 Guardians of orphans; (5) 4 orphans; (6) 10 HIV positive clients; (7) 8 persons with a disability; (8) 1 Government Social Welfare Officer.

II LITERATURE REVIEW

2.1 Introduction to the overall user fee debate

Background
The user fee debate is full of controversies. The alleged positive and negative impacts of user fees on efficiency, equity, quality and sustainability have led to heated debates among health sector stakeholders. Almost without exception, the donor community strongly supported the cost-sharing approach to education and health progressively introduced in the 1980s and 1990s. The IMF and WB have traditionally promoted user fees, although their official policy is more careful nowadays. They considered charges at the point of use needed to deter frivolous use and to help bring money into cash-strapped health systems (Rowson, 2004). Toward the late 1990s, however, other donors started to change their position regarding the desirability of user fees. This trend is confirmed by Bennet and Gilson (2001) and the WHO World Health Report 2000. They conclude that "the focus of the international debate is on the need to move away from excessive reliance on out-of-pocket payment as a source of health financing towards a system which incorporates a greater element of risk pooling (for example, through health insurance) and thus affords greater protection for the poor.

Commonly used systems
Health care systems, particularly those in developing countries, typically depend on a mix of financing mechanisms rather than only one. The principal mechanisms are: (1) tax-based financing, (2) social insurance financing, (3) private insurance, (4) user fees and (5) community-based health insurance. It is common for different population segments to be covered by different types of financing mechanism. The degree to which the financing system as a whole is pro-poor depends on how the different mechanisms interact (Bennet & Gilson, 2001). Two broad models of user fee systems have been adopted in African countries: (1) the 'standard model' and (2) the 'Bamako Initiative model' (Nolan and Turbat, 1995; in Gilson, 1997) (See Technical Paper Part 1). There is a wide range of different types of user fee payment systems: flat fee or differentiated fee; fee per episode or fee per item of service; prepayment or payment at time of use (Price, 2002). In addition to formal user fees, informal charges are common practice (Nyonator and Kutzin, 1999).

The reviewed literature mentions several main and derivative objectives for introducing user fees in the health sector. They are classified (see table 2.1) in three main categories.[7]

Table 2.1: Objectives for introducing user fees in the health sector

Enhancing efficiency	▪ The introduction of price signals through user fees can strengthen the appropriate use of the referral system by patients, facilitate the reallocation of resources to cost-effective primary care, and rationalize utilization and 'frivolous' consumption of health services.
Enhancing sustainability	▪ Raising revenue to replace or supplement government funds is mentioned as the dominant objective. There is a desire for 'system sustainability' (a broader concept than 'financial sustainability') as the underlying rationale.
Enhancing equity	▪ User fees can avoid the provision of subsidies to those who can afford to pay, and in doing so free up funds to pay all or part of the costs for those less or unable to pay. If resources generated through user fees are allocated to improve coverage and quality of care[8], user fees are said to disproportionally benefit the poor by increasing their demand and utilization of health services.

Source: Newbrander & Sacca, 1996; Gilson, 1997; Wilkinson et al, 2001; Bonu et al, 2002; Kivumbi & Kintu, 2002; IPAR, 2003; Price, 2002; Bijlmakers, 2003; Ridde, 2003.

2.2 Documented implications of user fees

The study team identified the most relevant documented evidence on the implications of user fees. For more background information the Addis Ababa Consensus on Principles on Cost Sharing in Education

[7] Some authors mention enhancing quality as an additional objective. In our view, however, it is more appropriate to consider improved quality as being instrumental to enhancing sustainability, efficiency and most notably equity. We therefore do not mention it separately (see also Bijlmakers, 2003).
[8] The reviewed literature mentions different strategies for such quality improvement: either directly or indirectly aimed at health services. Kipp et al (2001) report on the implementation of user fees as a staff incentive system (i.e. top up low salaries), which led health workers to offer improved services. They note that they found no other published information on using cost-sharing revenues in such a way.

and Health in Sub-Sahara Africa (Addis Ababa 20 June 1997) has been included in the Technical Paper Part 4. The following overview of key findings follows Gilson (1997; citing various authors)[9] and has been supplemented with observations from the literature review.

Efficiency implications of user fees

Fee systems appear to represent weak mechanisms for improving the efficiency of utilization, and may rather promote inefficiencies in provider behaviour (see Table 2.2).

Table 2.2: Efficiency implications of user fees	
Provider behavior	▪ Fees have been shown to encourage inefficient provider behaviour when the resulting revenue is retained at the point of collection (supplier-induced demand)
Utilisation	▪ As the travel and time costs of seeking care are usually high, there is unlikely to be any unnecessary utilization ('frivolous' consumption). Fees may encourage more efficient utilization patterns if: (1) they are graduated by level of the system, (2) a by-pass fee is introduced in areas where the primary care network is adequate and referred patients are exempted at higher levels of the system, (3) they are associated with quality improvements which promote utilization at the primary level. A lack of co-ordination within a fee system may encourage greater use of less cost-effective care when lower levels of the health system charge higher fees than higher levels.

Source: Various authors; in Gilson, 1997[10]; Nyonator & Kutzin, 1999[11]; Bonu et al, 2003

Sustainability implications of user fees

Revenue generation from any fee system is unlikely to be adequate in addressing the large and growing gap causing nationwide quality shortfalls that exist in many African countries. Fees need to be complemented by a broader range of actions if they are to enhance the sustainability of health systems (Gilson, 1997; Bennet & Gilson, 1997). Table 2.3 presents the main findings for sustainability.

Table 2.3 Sustainability implications of user fees	
Revenue generation at national level	▪ National user fee systems have generated an average of around 5% of total recurrent health system expenditures, gross of administrative costs (this proportion is also mentioned by WHO). In countries with low average household incomes, it is probably not possible to raise more than 10-20% of service delivery costs. Evidence also demonstrates that revenue levels vary over time; they increase due to improved implementation practices, but fall in periods of inflation, war and economic recession.
Revenue at facility level	▪ Fees may generate considerable proportions of the total non-salary recurrent expenditure within lower level, lower cost health facilities.
Substitution	▪ User fees are said to have been used to cover administrative costs instead of being translated into direct improvements in services at the local level; and to substitute funding from the central ministry instead of raising additional revenue.
System sustainability	▪ The impact of user fees on overall system sustainability is not well-known due to a lack of studies, but the available evidence suggests that their contribution is limited.

Source: Various authors; in Gilson, 1997; 50 Years Is Enough Network; see also Nyonator & Kutzin, 1999; Bennet & Gilson, 2001.

Equity implications of user fees

Equity implications of user fees are related to both (in)adequate management systems and to the direct effect user fees have on people in need of health care service. The problems of implementation are likely to *prevent* the potential equity benefits of fee-plus-quality-improvements being realized in practice. Instead, fees have the potential to worsen existing inequities (Gilson, 1997). More recent studies confirm this conclusion. In Guinea and Indonesia, the main reason given by the poor for not seeking care at government facilities was the cost of treatment. The poorer the patients, the more respondents in that category cited costs as a reason for seeking care from alternative sources. In Ecuador, 54% of the poorest group said they were unable to seek care because of lack of money. In Kenya, it was found that sometimes the poor pay even more for health services than the non-poor (Newbrander, Collins and Gilson, 2002). An overview of documented equity implications of user fees

[9] These findings in Gilson (1997) cover Africa as a continent.

[10] This poses a dilemma, however, because the impact of user fees is reported to improve if the revenues generated are used at the facility/level where they have been collected.

[11] Since fee levels are determined by individual facilities, there may be no differential between health centre and hospital charges for the same service, giving the patient no incentive to use the health centres. Indeed, given the dependence of all facilities on user fee income, hospitals have a strong incentive to compete for primary care patients, and they are in a strong position to do so, given the difference in human resources (i.e. the presence of doctors at hospitals) between the facilities (Nyonator & Kutzin, 1999; for Ghana).

have been highlighted in Technical Paper Part 1 and includes; (1) utilization and exclusion, (2) regressive outcomes of user fees on specific groups, (3) trade-offs at household level, (4) nature of payment scheme, (5) barriers other then user fees, (6) safety nets, (7) quality, (8) potential of fees at primary level, (9) adequacy of revenue generated, (10) management, (11) transparency and (12) community involvement.

2.3 Documentation on exemption and waiver systems

Exemptions and waivers are so-called 'safety nets' which aim to protect the vulnerable and poor from the adverse impact of user fees. Most of the reviewed literature expresses a strong concern that safety nets tend to protect the poor insufficiently from the adverse impacts of user fees. Case studies in Kenya indicate that in 1999 waivers rarely exceeded 2 persons per month while 42% of the population was living below the poverty line. It was also found that 80% of inpatients and 86% of outpatients were not aware of waivers and exemptions (Owino, 1998 and 1999). Evidence from other studies indicates both leakage of benefits to ineligible households and inadequate support to the primary intended beneficiaries (under coverage). This is often related to the existence of complex, unworkable and inconsistent exemption mechanisms that require too much information and are therefore costly to administer; lack of public funding to pay for waivers and exemptions; the lack of guidance on financial management and control practices; and weak administrative systems. Income criteria as a reason for a waiver are difficult to apply since many poor people work in the informal sector while fees and income eligibility thresholds are not adjusted to changing circumstances (Newbrander & Sacca, 1996; Gilson, 1997; Owino, 1998; Price, 2002; Kivumbi & Kintu, 2002, IPAR, 2003; Bitran et al, 2003).

According to UNICEF and Bitran (2003), the performance of exemption and waiver systems is seldom evaluated. This is considered as a major weakness as the consequences cannot be assessed and policies cannot be adjusted. Main constraints include; (1) exemption schemes are implemented in informal and ad hoc ways; (2) exemptions based on the ability to pay are extremely uncommon in practice; (3) decisions to exempt are often left to the discretion of local service providers; (4) absence of specialized staff hampers the effectiveness of the waiver procedure; (5) there can be a negative attitude of health staff towards policies for protecting the poor as waivers mean less income and more work; (6) the distribution of cards for a waiver or exemption are often cumbersome and lead to high administrative costs, delay and retention of cards, (7) financial incentives or staff performance are linked to successfully collecting fees; (8) the characteristics of the poor are generally not defined in a clear fashion. The lack of clear identification criteria seems to be a major problem; (9) poor people do not know about exemptions or do not bother because of administrative barriers; and (10) exemption schemes can be stigmatising and dehumanising.

Positive experiences that improved equity allocations of health services for poor people were found in Cambodja were an Equity Fund (EF) of the National Hospital financed the cost of health services (consultation and medicines) at no charge or reduced prices to the poor. A key factor of the EF that was beneficial to the poor was the payment of health providers for the services delivered. This made health providers indifferent towards treating regularly paying patients and EF beneficiaries. Other best practises have been included in Technical Paper Part 1.

2.4 Documented findings on Community Health Funds

Community Health Funds and limited understanding of interaction with other health care financing schemes

Community Health Funds (CHFs) are a form of community-based health insurance. Community Health Funds (CHFs) or Community-Based Health Insurance schemes (CBHI) are often mentioned as 'the solution' for the problems generated by user fees. CBHI schemes, where they have been operated successfully, have offered benefits to the poor. However, the very poor require special arrangements to enable them to access benefits under the scheme (e.g. subsidies from government or higher income scheme members); few schemes have effectively implemented these arrangements. A recent paper (Bennett 2004:147-157), emphasizes that there is actually very limited understanding of how CBHI schemes interact with other elements of a health care financing scheme. Sofar there has only been marginal analysis of the impact of the CBHI scheme on the population at large and the possible effects of the schemes beyond their members. There are virtually no studies that have discussed CBHI schemes from a system-wide perspective. CBHI schemes cover a bewildering variety of benefit

packages and formal coordination between CBHI schemes and government financing schemes appears to be limited (Bennett, 2004).

Differences in design of CBHI schemes
CBHI schemes differ markedly in terms of their ownership structures, benefit package composition and membership. Some countries have multiple risk-pooling schemes, meaning that a CBHI scheme runs parallel with other social security schemes and different CHFs in other districts. However, there is very little empirical evidence about the consequences of the multiple risk pools in developing country contexts. There is evidence that members and health workers "shift" between different schemes to obtain the best coverage and benefits. There is sofar limited understanding on the impact of multiple risk pools on financial sustainability and how the mix of payment systems used by such schemes affects outcomes and whether the outcomes will be acceptable (Bennet, 2004).

Beneficial for the poor?
The design and coverage of the CBHI scheme (less or more pro-poor) will determine the preferred option by communities. A pro-poor approach is if CBHI schemes will cover the payment of co-payments. Some studies have indicated that it is desirable for poorer people to joint CBHI schemes since it seems likely that this will promote access to basic services, but according to Bennet it is not clear that this is the best strategy to promote the progressive distribution of subsidies. A high membership amongst very poor households in CBHI schemes might be counter to equity goals if the Government operates a parallel system of programmes to provide free health care services for elderly, school children and the poorest households. A main concern is what will happen to non-members since it is unlikely that there will other safety nets for those who do not (or cannot) join the CBHI scheme. It is possible that non-members might actually be made worse off by a CBHI scheme than before (e.g. by increase in prices for non-members, preferential access for members, increased Government funding to CBHI schemes). There is therefore a great need for further research to enhance the understanding of the linkage between the CBHI schemes and health system wide goals (Bennett, 2004).

2.5 Documentation on abolition of user fees

Abolition of user fees for Primary Education in Tanzania
Most governments and donors have favoured the concept of cost-sharing in the health and education sectors as an appropriate strategy. It was believed that it was the only financially-viable alternative and that it would enhance parent ownership of their children's education. In recent years, this concept has become subject of serious scrutiny and re-thinking. As a result, some countries have abolished user fees for education (Tanzania) and health (Uganda and Kenya).

A clear pro-poor policy has been adopted in Tanzania with the elimination of the Enrolment Fee for Primary Education in 2001. The deterioration of educational outcomes in the 1990s[12] was related to a combination of rising costs and a declining quality and returns of education. Although people already had to contribute to the costs of education, a primary school enrolment fee of Tshs. 2,000/= was formally introduced in 1995. The fees were particular regressive for poor people and as a result children were kept out of school. Since the university education remained free of charge, the government expenditure was highly regressive since the highest income quintile received more than twice the share of the overall public expenditure on education received by the lowest quintile (Terme, 2002:1-6). Social discontent, the PRSP process, activism of civil society organisations (CSOs) in Tanzania and the North, and the turn-around of the Tanzanian government and the donor community were crucial to gain support for the elimination of the enrolment fee.

In formal policy documents (2000), the Government still considered cost-sharing as an essential component of primary education expansion but when it became clear that the donor community was willing to support the elimination of user fees for primary education, the government of Tanzania announced in 2000 in its PRSP the abolition of primary school fees in order to ensure that children, particularly from poor families, would have access to primary education. The Primary Education Development Programme (PEDP) was prepared and was supported with a US$ 150 million World Bank project loan. The financing gap was estimated at US$ 450 for a period of three years and was

[12] A decline in gross enrollment in primary education from 100% in 1980 to 82% in 1993 and increased illiteracy between 1986 and 1992 increased from 10 to 16%.

met with donor support. After the abolishment of the enrolment fee and the introduction of legal measures, enrolment rates in primary schools indeed increased dramatically.[13] The CHER considered Tanzania 'an example of what can be achieved where donors provide coherent support to a national strategy' (CHER, 2002).

Abolition of user fees in the health sector of Uganda
Recent studies of Deininger et al (2004), Burnham et al (2004) and Yates (2004) contribute to the emerging literature on the impact of the abolition of user fees in Uganda. Uganda introduced cost sharing in public facilities shortly after the decentralisation in 1993. The intention was to lessen the impact of irregular payment of low health worker salaries, to alleviate drug shortages and to strengthen community management of facilities (Burnham et al 2004:188). Studies pointed to the adverse impact of the user fees on the population and concluded that cost sharing was leading to unnecessary suffering and even death. Poor health indicators and poor utilisation rates supported this (Yates 2004:3).

With the election campaign of 2001, cost sharing was abolished in the public sector and fees were stopped in March 2001 (with exception of private wings in hospitals). Abolition of cost sharing aimed at improving access to health services for the poor. It has been estimated that the abolition of user fees was only US$ 6 million in lost revenue. To compensate for the loss of cost-sharing revenue and potential consequence of drug availability, the MOH introduced a supplemental buffer fund of US$ 5.5 million from the World Bank supported District Health Services Project (DHSP). This represented an increase of 22% to the MOH drug budget for 2001 (Burnham et al 2004:188). Furthermore, the mode of health financing shifted to budget funding. Since July 2001, the Government budget for health has been the primary financing mechanism and the doubling of the budget has provided the MOH with the required resources (resources now accounting for 54% of the resource envelope for health).

The policy change has been combined with (1) improved allocations for District PHC funding, (2) a more appropriate balance between inputs (drugs, human resources and infrastructure), (3) massive increase in basic inputs (per capita drug funding up 50%, PHC workers and training of nursing assistants), (3) increased allocation of PHC funding to the neediest districts in order to ensure improved equity, and (4) rapid disbursements of PHC budgets and (5) increased funding to the private health sector (Yates 2004: slide 12-16). Although health services were decentralized to Districts, it is important to note that the central government re-centralised the payment of health workers because of the irregular payments by local governments in order to support the policy change (Burnham et al 2004:190-191).

The impact of the abolition of the user fees has been impressive. Attendance rates increased in the first 12 months after the abolishment of the user fees. The mean number of monthly new visits for all people increased with 53.3%. The increase in visits by children aged under 5 years was 27.3% and the monthly immunizations for children under 5 years increased with 17.2% (although they were already free before the abolishment of user fees). Monthly antenatal visits increased by 25.3% (Burnham 2004:188-189). There is also evidence of a clear reduction in the incidence of morbidity after the abolition of user fees. The probability of falling sick decreased 1.5% for adults and 3% for children. The abolition of user fees did provide social benefits that were commensurate to the cost in terms of foregone revenue (Deininger et al 2004:2, 14 and 18). In 2003/2004, outpatient attendance had gone up with 90% compared to 1999/2000, DPT3 immunisation rates were up to 105%, the utilisation rates of public health centres increased by 77% in 2 years and increased attendance was reported in the private sector as well (demonstrating real rises in health care consumption). The findings in Uganda are in contrast with the decline in utilisation of private services not in South Africa (Burnham 2004: 188-189 and Yates 2004: slide 18-22 and Deininger et al 2004:2, 14 and 18).

It is concluded that the abolition of user fees significantly improved access for the poor especially for those whose health spending (at household level) has become significantly lower after the policy change as compared to the situation before. The share of sick households who reported not to have utilized health services due to high costs, decreased from about 50% in 1999 to 35% in 2002. This was particularly pronounced in the poorest region of Uganda. The abolition of user fees was more effective in reaching the poor than the policy of exemptions. Poor people have benefited

[13] Gross enrollment reached 100.4% in 2002 compared to 77.6% in 1990; net enrollment increased from 58.8% in 1990 to 85% in 2002 (progress report 2001/02). Aggregate data for the poor is not provided.

disproportionately, with the lowest income quintile capturing 50% from this policy change (Deininger et al 2004:12 and 18 and Yates 2004: slide 22-24 and page 3).

Concerns and areas for attention haven been pointed out as well. It was found that the abolition of user fees did not improve the situation for orphans, who were 3.8% more likely to be affected by sickness after the reforms. This indicates that the impact of abolition of user fees has not been uniform across the population and implies hat specific measures are needed for vulnerable groups. Health workers (41%) have indicated that they felt they had a more negative attitude towards their work after cost sharing ended. This was related to lack of funds to purchase additional drugs (29%) and to pay support (non-skilled) staff (40%) which was not on the central payroll. Some supplies had reduced and cleanliness and maintenance of health facilities had worsened substantially after the abolishment of user fees. The Health Unit Management Committees (HUMC) largely have stopped meeting after cost sharing ceased. They may have seen their job mainly as managing cost sharing funds. There is a concern that the accountability to the community by health workers and health facilities will be reduced. Although health workers seem to continue fulfilling professional responsibilities despite the loss of income from the cost sharing revenue, they may in the long term shift to their private clinics to compensate the loss of income and shorten the opening hours of government clinics (Burnham et al 2004: 189-194). It is emphasised that in order to maintain the gains of the policy change, it will be critical to ensure the quality of services in public health facilities (with essential inputs and incentive schemes for health workers) (Deininger et al, 2004:18-19).

It has been argued that the positive results are fragile in the sense that the difficulties of the public sector with respect to drug supplies make the services vulnerable when emergency buffer funds become exhausted. Yates has expressed concerns that the allocations for the health sector might be affected by constraints (e.g. reduced levels of aid flows, views of development partners, sector ceilings and sector competition) but emphasizes that for the achievement of the health Millennium Development Goals (MDGs), the health budget should increase rapidly (absorption capacity is sufficient and a bigger health budget will result in higher outputs) (Yates 2004: 32-27).

Abolition of userfees in Kenya
Very recently (1st July 2004), Kenya introduced the abolishment of user fees in public dispensaries and health centres. This is not as extensive as in Uganda where hospitals were included as well. With this initiative Kenya hopes to improve access to medical care for approximately 9 million people who live in absolute poverty (Press release, June 2004). Kenya also hopes to reverse the reverse the health statistics especially for children under the age of five years and pregnant women. The Government has set aside US $ 51.5 million to implement the free medical care programme in 2004/5. The abolition of user fees will be combined with a mandatory membership in a National Social Health Insurance Fund for all employed Kenyans. The Kenyan approach is considered as an important pro-poor initiative which could set an example for Tanzania as well (at least very worthwhile to explore further). Close monitoring of the impact of the Kenyan scheme will therefore provide more insight about the relative costs and benefits with respect to services which are of benefit to the poorest people.

III POVERTY AND HEALTH IN TANZANIA

3.1 Demography, poverty and health indicators

Demography and income poverty trends
Tanzania is located in East Africa and is considered to be one of the poorest countries in the world.[14] In 2002, the Gross National Income (GNI) per capita was US$ 280. It has been estimated that over half the population in Tanzania lives below the poverty line, defined in Tanzania as US$ 0.65 per day. As many as 40% lives in abject poverty, that is, in a situation where their income is insufficient to buy food to cover minimum nutritional needs (MOH/SDC, PER 2001:14). The population is estimated at 35 million people (World Development Report 2004). Over half the population is under 18 years of age, and almost one-third of the population falls into the age group 10-19 years (Evans et al, 2001:157). There has been very limited improvement in the income poverty status of the Tanzanian households over the 1990s. This is especially the case for urban areas other than Dar es Salaam and for rural areas. This is of great concern since it is highly unlikely that the PRS target of halving basic needs poverty will be achieved (Poverty and Human Development Report 2002:7-8).

Health Indicators: "Being sick means trouble" (Resource person Kagera Region)
The last decade of the 20th century has seen Tanzania experience a reduction in some of the key health indicators, including its ranking in the Human Development Index of the United Nations, dropping from 126 in 1992 to 156 in 1997. Poor health in Tanzania has been frequently identified as one of the key contributors to poverty (MOH/SDC, PER 2001:7).The standard health indicators have been extracted from National Country Profiles (see also Annex 5). Table 3.1 presents trends and statistics.

Table 3.1: Tanzania Health Statistics 1990-2002

Health Statistics	1990	1995	2000	2001	2002	Over 12 years
Life expectancy at birth (years)	50.1		44.4	43.7	43.1	Reduced
Fertility Rate (birth per women					5	-
Infant Mortality Rate (IMR) (per 1,000 live births)	102		104	104	104	Stagnant
Under 5 Mortality Rate (U5MR)	163		165	165	165	Stagnant
Child immunization, measles (% under 12 months)	80		78	83	89	Improved
Prevalence of Child Malnutrition % of under-five children	29			29		Stagnant
Maternal Mortality Rate (MMR) (per 100,000 live births		1,100				-
Births attended by skilled health staff (%)	44		35			Worsened
Prevalence of HIV (female, % ages 15-24)			8.1	8.1		Stagnant
Incidence of Tuberculosis (TB) (per 100,000 people)			359.1			-
Access to an improved water source			68			-

Source: Human Development Report 2004, World Bank (WB) 2003, Millennium Development Goals Tanzania 2002

Epidemiological profile
The 1995 Burden of Disease study found that 70% of life years lost is due to 10 diseases that can be controlled through effective preventive and promotive measures. Health facility data confirm that malaria is the leading cause of mortality for all age groups in the country. The leading 5 killer diseases among the population aged 5 years and above in 1999 were malaria (22%), clinical AIDS (17%), tuberculosis (9%), pneumonia (6.5%) and anaemia (5.5%). HIV prevalence among the population aged 15-49 is estimated at 9.4% (though infection rates in some urban areas are as high as 24%). Patients with HIV/AIDS related illnesses occupy approximately 50% of hospital beds (MOH/SDC, PER 2001:7).

The human face of the health indicators
Many Tanzanian households are affected by ill-health. The Tanzanian Participatory Poverty Assessment (TzPPA) shows just how many people have to deal with an illness year in and year out (see table 3.2).

[14] Tanzania ranks 156th of the 174 countries listed on the UNDP Human Development Index.

Table 3.2: People affected by a disease in a specific year of period 2000-2003 (in order of numbers of people)	
▪ 8,640,000 people with iodine deficiency[15] ▪ 4,073,992 people treated for malaria ▪ 3,456,000 people are disabled[16] ▪ 2,229,770 people living with the HIV virus ▪ 1.928,000 orphans (43%-66% caused by HIV/AIDS)	▪ 1,477,795 people with acute respiratory infections ▪ 641,745 people treated for diarrhoeal diseases ▪ 255,000 women with acute obstetric complications ▪ 70,000 to 80,000 children die of malaria each year

Source: TzPPA 2003:91-131

Health and poverty

Poverty affects the health status of people in Tanzania. The infant and under-five mortality rates serve as a proxy for the overall level of welfare in a country. Infant and under-five mortality has not declined over the 1990s, mostly due to HIV/AIDS, gender and urban-rural disparities.[17] Children from the richest households are 1.5 times more likely to have received all relevant immunisations than children from the poorest households (Poverty and Human Development Report 2002:27-29).Table 3.3 reflects differences between the poorest and richest households (TzPPA 2003:116).

Table 3.3: Risk and well-being of young children in Tanzania by household economic status, 2000		
Health status under-five children	Poorest 20% of households	Wealthiest 20% of households
Immunisation coverage (BCG, Polio, DPT, Measles)	57.3%	82.5%
Stunted (height for age)	50.5%	28.9%
Underweight (weight for age)	11.6%	2.8%

Source: TzPPA 2003:116

The proportion of births attended by a skilled health worker is commonly used as an indicator for maternal mortality. In 1996, only 27% of the births in the poorest quintile were attended by a medically trained person compared to 81% in the richest quintile. The overall trend shows a worrying decline from 44% in 1991/92 to 36% in 1999. Again there is a great urban-rural disparity (Poverty and Human Development Report 2002:32). Urban-rural disparities are also seen with the spread of HIV/AIDS. Adult infection rates are 20-24% in urban areas and 7-10% in rural areas.

3.2 PRSP focus and health related targets

PRSP Focus and health related targets

The Tanzania Poverty Reduction Strategy Paper (PRSP) was finalized and endorsed in late 2000. In 2001 and 2003, the Government prepared two subsequent progress reports.[18] The PRSP was framed within already existing development strategies (such as Vision 2025, the National Poverty Eradication Strategy and the Tanzania Assistance Strategy) and elaborated on ongoing policy formulation and reform processes (see also Technical Paper Part 2). The focus of Tanzania's PRSP is on three key strategies: (1) reducing income poverty, (2) improving human capabilities, survival and social well-being (i.e. non-income poverty), and (3) containing extreme vulnerability among the poor. The education sector is one of the first sectors which show real results of the PRS. A significant increase[19] in enrolment figures has been seen since the year 2000 (Poverty and Human Development Report 2002:17-19).

The PRSP for Tanzania identifies 11 health related targets (see Technical Paper Part 3). The worrying health trends leads to the prediction that only one of the PRS targets will be met in time unless major breakthroughs can be made in containing (1) the spread of HIV/AIDS, (2) malaria and other infectious

[15] Cause of goitre in 24% of the school age children and mild metal impairment, deafness and/or dwarfism in others.

[16] This is approximately divided into 28% physical impaired, 27% visually impaired, 20% deaf, 8% mentally impaired, 4% multiple impairments, 13% other impairments (TzPPA 2003:93).

[17] Infant and Under-five mortality rates are significantly higher for boys than for girls and rural areas report a higher infant mortality rate (Poverty and Human Development Report 2002).

[18] It is important to include these reports in the PRSP analysis since they contain some more specific strategies that still had to be formulated at the point of PRSP completion.

[19] The increases in the last two years are by far the largest for more than a decade

diseases, (3) reducing malnutrition and (4) achieving a drastic reduction of income poverty (Human Development Report 2002:34 and Poverty and Human Development Report 2002:105). Tanzania has also committed itself to achieving the Millennium Development Goals (MDGs). It is foreseen, however, that the worrying health trends will also negatively affect the achievement of the health related MDGs number 4, 5 and 6 (see annex 5).

3.3 The position of health in the PRSP

Health addressed in the PRSP

The study team analysed key health related issues in the Tanzanian PRSP by making use of a self-designed assessment tool (Annex 4; based on Laterveer et al, 2003) and an analysis carried out by the Word Health Organisation (WHO 2003). Table 3.4 presents the outcomes of these analyses.

Table 3.4: Health as addressed by the PRSP of Tanzania
1. Health is an important component of the Tanzanian PRSP. The paper identifies 'disease' as one of the three national 'development problems'. It recognizes the particular role of health in the context of poverty reduction, by identifying it as one of the priority sectors for improving human capabilities, survival and social well-being.
2. The health sector strategy proposed by the PRSP is rather disease-oriented, with less attention for examining or addressing underlying health system weaknesses. The focus is mainly on reducing infant and child mortality rates and the burden of communicable diseases, especially HIV/AIDS and malaria. Improving health services provision, especially primary health care, and boosting health awareness, particularly on nutrition and HIV/AIDS, are also mentioned. This indicates an implicit pro-poor approach. However, the difficulties of achieving the set targets in the poorest areas and groups are not discussed.
3. The PRSP and the progress reports indicate a lack of poverty-related health data, despite the commendable efforts of the government to obtain such information. Studies to analyze and describe the distribution of the burden of disease across the population, the prevailing health system constraints and the impact of health services, particularly in relation to the poor, are not mentioned. The focus is mainly on the general population.
4. The PRSP does include a number of specific concerns expressed by the poor: (1) limited access to quality health services, causing (deeper) poverty, (2) the unsatisfactory level of service provision, especially in the rural (poorest) areas, and (3) their limited involvement in designing health plans and programs. Poor people also expressed their concern about the low standard of health education. The PRSP acknowledges only some of the raised concerns, notably the poor condition of health facilities and the low quality of services.
5. Reducing vulnerability is part of both the PRSP and progress reports. According to the PRSP, 'many communities are forced to deal with a growing number of AIDS victims and orphans, the handicapped, the very old and refugees, and there is a growing need for safety-nets'. The PRSP and progress reports do not explicitly address the position of women (gender), the disabled, and/or HIV/AIDS clients in relation to health. Addressing extreme vulnerability is said to be a part of future poverty reduction policies.

Analysis based on Tanzanian PRSP and PRSP related documents

Financial barriers to health for the poor addressed in the PRSP?

The study team also assessed what is stated on cost-sharing, user fees and the impact of user fees in the PRSP and the progress reports. The key findings are presented in Table 3.5.

Table 3.5: To what extent are financial barriers to health addressed in the PRSP?
1. The PRSP states the commitment to increase health spending.
2. The PRSP does not explicitly mention cost-sharing or user fees in relation to health, while doing so extensively for education (i.e. it announces the abolition of user fees) The rationale for different user fees strategies for the education and health sectors is not explained.
3. The progress (01/02) report does explicitly address cost-sharing. It reports the introduction of the Drug Revolving Fund (DRF) in all district hospitals; the introduction of Community Health Funds (CHF) in nearly 40 districts; and the operational National Health Insurance Fund (NHIF) enrolling all civil servants.
4. The progress report concludes that 'the introduction of health care financing options including CHF and user fees have improved availability, access, provision and use of services by beneficiaries as drugs are now available in health facilities all the time.' The report does not explain the policy rationale for the continuation and/or further introduction of user fees in the health sector. Neither does it distinct between user fees for public and private services, nor explains at what service levels user fees are charged.
5. The PRSP and the progress reports do not discuss financial and non-financial barriers for the poor to access health services; or examine which specific groups do not have access. They do not propose measures to protect the poor against possible adverse impacts of user fees, such as exclusion, or reduced (financial or geographical) access or use (i.e. equity, which is not mentioned in the documents). They do not mention waiver and exemption schemes or pay attention to implementing or strengthening existing schemes. They do not report on the impact of user fees in the health sector (other than for drugs), in general or in relation to the poor. The same can be said for the CHF.

Analysis based on Tanzanian PRSP and PRSP related documents

3.4 Critical views towards PRSP pro-poor health strategies

Several health sector stakeholders have examined the guiding poverty reduction strategy questions in relation to health (see e.g. WB, 2001; WHO, 2001; Dodd and Hinshelwood, 2002; Walford, 2002; Laterveer et al, 2003; Verheul and Cooper, 2001; Verheul and Rowson, 2001; Rowson, 2004). Some of these studies have also assessed the extent to which PRSP countries propose appropriate strategies that meet the specific health needs of the poor and the vulnerable. The views expressed in table 3.6 apply to PRSPs in general, but also hold true for the Tanzanian PRSP.

Table 3.6: Critical views towards "pro-poor" PRSP health strategies (in general and for Tanzania)
1. The pro-poor content of health policies is unclear (Laterveer et al, 2003; Dodd and Hinshelwood, 2002; Verheul and Rowson, 2001). The extent to which PRSPs take a systematic approach to defining the health needs of the poor continues to be weak. PRSPs should be more explicit and specific in the formulation of their health policies, particularly in how they intend to serve and target the poor (Laterveer et al, 2003).
2. PRSPs are insufficiently analytical and evidence-based in the formulation of their health and poverty reduction strategies, although progress can be observed. There is a need to strengthen the link between health and poverty research on the one hand, and PRSP policy making on the other. Monitoring and evaluation mechanisms that capture equity performance and ensure that the voices of the poor are heard should be developed (Laterveer et al, 2003; Laterveer, 2003).
3. Many interim and full PRSPs include elements of cost-sharing, including for basic health services. Financial barriers are discussed by some PRSPs, but they are rarely dealt with in detail (Verheul and Rowson, 2001; Verheul and Cooper, 2001; Dodd and Hinshelwood, 2002; Laterveer et al, 2003). Dodd and Hinshelwood (2002) conclude that "the problems associated with fee exemption schemes, and the impoverishing costs of catastrophic illness – both issues extremely pertinent to improving the health of the poor – are rarely mentioned".
4. PRSPs fail to tackle the adverse impacts of user fees. Most PRSPs do not go beyond proposing exemption schemes to protect access for (categories among) the poor and vulnerable, and do not discuss them in detail (Verheul and Rowson, 2001). Governments should revisit their user fee policies in view of poverty reduction and develop a long term financing scheme based on risk-pooling between the sick and healthy and risk-sharing between the rich and poor (ibid.). The most equitable and feasible option for low-income countries are tax-based financing systems, supported by external aid, as recommended by WHO.[20] Donors should refrain from imposing user fees on developing countries (Verheul and Rowson, 2001). A similar point is made by Verheul and Cooper (2001) who argue that the abolition of user fees for health services is not an issue on the health policy agenda; and that this could be tackled in the PRSP-process.

Systematic studies regarding the attention for of equity implications of user fees in PRSPs (in general and in Tanzania) have not been undertaken yet. Consequently, it is not clear whether the PRSP process has brought (or will bring) about a change in existing opinions on user fee related policies.

[20] The WHO considers tax-based systems, supported by external aid, the most equitable and feasible option for low-income countries.

VI HEALTH SECTOR STRATEGIES TANZANIA

4.1 Health delivery network

Tanzania has a five tier (formal) health care system.[21] The Essential Health Care Package in Tanzania is guiding the service provision at different levels in the health care system. The Government is the major provider of health services being the owner of 36% of the hospitals, 82% of the health centres and 58% of the dispensaries. The quality of services is severely affected by the under-distribution of qualified staff to the remote rural areas. The total workforce of active health workers seriously declined since 1994/1995 from 67,000 to 54,000 in 2003 (Kurowski et al, 2003). The human resource requirements were estimated to be 40% higher then the human resource availability. This implies an absolute gap of 20,000 Full Time Employees (FTEs). It is projected that this number will almost double to 40,000 in 2007, and triple to 60,000 in 2015. This projection is deeply concerning given (1) the current disease patterns and (2) a rising demand for health services.

4.2 Background to Health Sector Reforms

Health Sector Reform Strategies
From 1990 onwards, Tanzania re-examined its approach towards the health sector and initiated the development of Health Sector Reforms (HSR). The HSR aimed to address structural problems within the health system itself (see Technical Paper Part 2). The focus of the current health reforms are the eight strategies presented in table 4.1 (MOH/SDC 2001:9-10).

Table 4.1: Health Sector Reform Strategies 1999-2002	
1. Improvement of district health services. 2. Improvement of secondary and tertiary health services. 3. Strengthening the role of the Ministry of Health. 4. Development of human resources.	5. Reinforcement of the central support system. 6. Exploring various options for health financing. 7. Increased participation of private/public mix. 8. Establishment of effective relationship between Ministry of Health and donors.

Source: Danida HSPS II, 2001

Government policy situation
The HSR also take place in the context of other reform programmes. Tanzania is currently undergoing a major transformation through the Local Government Reform Programme (LGRP).[22] The LGRP aims at increased responsibility and transfer of funds from central level to district level for all development sectors. There is still limited coherence between the LGRP and the Sectoral Reform Programmes (such as health). This has already hampered effective district planning and has affected the allocation of funds to districts and non-governmental development actors (and hence the implementation of essential development interventions) (Schwerzel et al, 2003).

Sector Wide Approach
During the period 1996-1999, the Sector Improvement Programme (SIP) prepared the framework for a Sector Wide Approach (SWAp) in the Health Sector. An outline for joint funding mechanisms was developed and stakeholders[23] agreed upon the arrangements for administration, management, financing, procurement and monitoring (also known as the basket fund or joint disbursement mechanism). A set of indicators has been developed to monitor the performance of the public health sector (including the financial performance) (Technical Paper Part 2).

[21] The lowest level is the dispensary in which curative and preventive ambulatory services are provided. The next level is the health centre where more complicated cases can be treated and patients can be admitted. The first line hospital (or district hospital) provides basic surgical, medical, obstetric and paediatric care. The dispensaries, health centres and first line hospital together comprise the primary health care system or district health system. The regional hospitals provide specialist care and the national hospitals have an important role as teaching hospitals.
[22] The LGRP is one of the seven components under the Civil Reform Programme.
[23] Stakeholders are at this moment: the Government of Tanzania, the Swiss Agency for Development Co-operation (SDC), the Danish International development Agency (DANIDA), the Norwegian Agency for Development (NORAD), the World Bank, Ireland Aid and the Netherlands Government. DFID has moved on to budget support and is no longer a member of the basket fund.

4.3 Health Sector Financing

Stakeholders
The main stakeholders in financing the health care system in Tanzania are the Central Government through the Ministry of Health, the Regional Administration and Local Government, the District and Urban Councils, development partners, and members of the local community. The resources are distributed to the Ministry of Health Departments, Referral Hospitals, Health Training Institutions, Regional Hospitals, District Hospitals (including DDHs and VAs), Health Centres, Dispensaries and all preventive activities required to improve health.

Public Expenditure Review
The Public Expenditure Review (PER) in Tanzania is the key tool for the Ministry of Finance to review and decide on inter-sectoral allocations. The aim is to ensure that spending priorities match the priorities as stated in the PRSP and the Sector Strategies. The draft PER 2004 reflects the total *public* health expenditure for the Financial Year (FY) 2003-2004[24]. The basket fund provides since FY 1999/00 three types of funding; (1) recurrent Ministry of Health activities, (2) Ministry of Health development projects, and (3) recurrent expenditure at council level (MOH/SDS 2001). Externally funded activities are traditionally recorded in the Development Budget rather then in the Recurrent Budget. However, in Tanzania donor-funded programme expenditure increasingly supplements the recurrent budget. This is based on the recognition that recurrent spending is necessary to ensure a minimum level of service delivery (Draft PER 2004:11). In addition to the basket fund, donors contribute direct funding to health interventions (off budget expenditure). The total health expenditure in FY 03/04 was estimated to be Tshs. 271.66 Billion (US$ 260 Million). Table 4.2 provides an overview of the public health spending (resource envelop) by funding type for the FYs 1998/1999 to 2003/4.

Table 4.2: Actual Public Health Spending by funding type (Billion Shillings), Tanzania

Funding type	**98/99**	**99/00**	**00/01**	**01/02**	**02/03**	**03/04**
Recurrent funds (MOH, Region, LGA)	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**	**(Budget)**
Domestic	62.18	57.98	74.90	95.91	109.47	150.69
Foreign	-	1.36	10.63	21.57	32.27	17.28
Total	**62.18**	**59.34**	**85.53**	**117.47**	**141.75**	**167.97**
Developm. funds (MOH, Region, LGA)						
Domestic	0.92	2.80	5.13	5.04	6.11	6.61
Foreign	17.01	9.34	12.61	18.82	27.78	26.42
Total	**17.94**	**12.03**	**17.74**	**23.86**	**33.89**	**33.03**
Total on budget	**80.11**	**71.38**	**103.27**	**141.33**	**175.64**	**201.00**
Off budget expenditure						
Domestic funds (Cost sharing)	*1.09*	*1.49*	*1.86*	*1,24*	*1.67*	*1.67*
Foreign funds	42.76	60.04	75.00	79.37	59.11	68.99
Total off budget	**43.85**	**61.53**	**76.86**	**80.61**	**60.77**	**70.66**
Grand total	**123.96**	**123.91**	**180.13**	**221.94**	**236.41**	**271.66**

Source: Draft Health PER Update 2004

The table shows that total health spending shows an upward trend since FYs 98/00. A major change is the inclusion of the contribution of the National Health Insurance Fund (NHIF) in the recurrent budget and actual expenditure from FY 01/02 onwards. This includes the employee and employer contributions for the civil servants. This represents in FY04 in total 3.4% (Tshs. 6.6 billion) of the health sector budget. Another change for FY04 is the switch from DFID to channel the health funds from the basket funding mechanisms to budget funding. This explains the reduced foreign funding level in FY04. It is expected that the FY05 will show an increase of basket funding due to the WB funds for the new Health Sector Development Programme (including matching grants for the Community Health Fund). The table also reflects the off-budget funds which continue to be a large proportion of the total health expenditure. This shows the domestic contributions made by the cost-sharing schemes (excluding NHIF), and donor funds that are not captured by government systems (and is likely to be underreported). Important to note is that the cost-sharing schemes only contribute 2.4% of the total projected off-budget resources (Draft PER 2004).

[24] It should be realized that in Tanzania no comprehensive study on *all* sources of health sector finance is readily available. Little is known about the overall income and expenditure patterns in the private sector (apart from the grants through the MOH). It is estimated that the NGO sector (including FBOs) contribute 7% of the total health expenditure but this fact is not well established.

Pro-poor observations

Tanzania has undertaken important measures to strengthen its pro-poor financing strategies in the health sector. Various documents reflect existing pro-poor expenditure mechanisms (REPOA 2001, MOH/SDC2001, MOH/DFID 2002, Poverty and Human Development Report, PER 2004; see table 4.3). Resource allocations may be considered to be pro-poor if they put priority on addressing the burden of diseases which disproportionately affect poor people[25] and an increased provision of essential medical supplies and drugs (the latter is covered in the budget under the heading Other Charges (OC)) (Poverty Human Development Report 2002:80). The new Equitable Resource Allocation Formula (ERAF) takes the pro-poor allocations into consideration as well. The ERAF aims to redirect resources towards the poor, the rural areas and priorities of the health sector. This is a clear pro-poor approach which is in line with PRS objectives and the National Health Policy 2002.

Table 4.3: Documented Pro-poor expenditure mechanisms

Increase in Other Charges	▪ There is an increasing share of OC expenditure from FY 97/98 to FY 01/02; (1) 35% to 62% for the MOH administration, (2) 31% tot 50% for hospitals, (3) 36% to 54% for preventive services (including dispensaries and health centres and (4) 33% to 53% in total government recurrent expenditure.
Increased distribution of funds to local councils	▪ An increased distribution of allocation to local councils implies that services come closer to the people. The OC share to local councils increased between FY98/99 and FY 0/02 from 5.8% to 58%. ▪ The overall block grants for health (Personal Emoluments and OC) to the LGA are the primary source of revenue at LGA level. Allocation to Region and LGS between FY01 and FY04 remained however fairly static.
Increased public health budget	▪ An increased public health budget for district-based health services is seen between FY97/97 to FY01/02 from 52% to 58%.
New allocation formulae for LGAs to achieve a more equitable distribution of resources to district level	▪ A new formula for allocation of LGA resources has been developed[26]. This includes an allocation based on: 1. Population (70%) based on 2002 Census data. This reflects the importance of the individual as main client-recipient of health care services 2. Mileage (10%). Mileage travelled by health sector vehicles within the district, in order to reflect the higher costs of service delivery in rural areas and scarcely populated areas. 3. Poverty (10%). This uses the basic needs poverty line weighed for council population. 4. Under-five mortality (10%). This indicator was selected since it reflects better the major causes of the disease of burden, including HIV/AIDS. The allocation will be based on the Census 2002 data for each district.

Source: REPOA 2001, MOH/SDC2001, MOH/DFID 2002, Poverty and Human Development Report, PER 2004

Concerning observations

Although there are important pro-poor strategies underway in Tanzania, there are still major concerns that require pro-longed attention. Various concerns are highlighted below.

- Tanzania had in FY 99/00 a sizeable financing gap of US$ 3.48 per capita in the public health sector[27]. The current gap is Tshs 218 billion (US$ 6 per capita). The Development Partner Group (DPG) has recently raised a concern that with the large funding gap and the insufficient size of the current resource envelope the identified PRSP and MDG health targets can absolutely not be met (DPG April 2004).
- The share of the Health sector in the Government Budget is declining. The overall GOT budget figures for health show a continuous drop in the proportion of budget funds allocated to health from 15% in 1996/97 to 10.4% in FY03. It is projected that this will be reduced further to 9% in FY04 (PER 2004). This downward trend was critically reviewed by the donor community as this seems incompatible with addressing key priority areas of the PRSP (DPG 2004).

[25] This would imply an increased allocation towards preventive care and to district-based health services that are easily accessible to the majority of poor people in the rural areas.

[26] The arrhythmic calculation will be: C= (P*0.7*F) + (W*0.1*F) + (M*0.1*F) + (B*0.1*F): C=Total grant allocation to eligible council, P=Population index, M=Mileage index, W=Population-weighted poverty index, B=population weighted U5M index as proxy of burden of diseases, F=Total basket fund. For each of the 4 indicators, an index for each council has been calculated to estimate the adequate allocation to the councils.

[27] This is based on the World Bank figure of US$ 12, which is an estimate of the requirements needed to fund a minimum health package.

- Under expenditure has been identified as a constraint. The budget performance in FY03 showed that the total expenditure was 89.9% (10.1% below the planned budgets). There is clearly room for improved budget performance and absorption capacity of available funding at different levels in the health system (PER 2004).
- Funds do not always reach the intended beneficiaries. Although the allocation of health funds to the district councils has increased, widespread leakages of OC funds have been reported. The leakages include (1) a higher allocation of funds to administration and transport instead of medical equipment, utilities and training, (2) lack of transparency regarding the disbursements and allocation of funds to dispensaries and health centres. This has contributed to a reduced amount of funding and per capita expenditure actually used in the delivery of services (Poverty and Human Development Report 2002:82).

V COST SHARING STRATEGIES TANZANIA

5.1 User fees

History and rationale for introducing user fees
Already in 1988, the GOT planned to introduce a user fee for every patient seeking a consult in a public health unit. This initial idea was not pursued at that time since it was not clear what the revenue potential and cost sharing impact would be (Mushi, 1996:3). Cost-sharing was already common practice in the FBO health services but not in the public sector. During the 1980s and early 1990s, arguments against free public health services gained strength. Several studies argued that free public health services suffered from misuse and inefficiency. It was felt that the introduction of a small user fee would eliminate or at least minimize these problems (Msambichaka et al 2003:1). Early 1990s, the GOT reviewed its public health sector financing policy with the objective of introducing reforms that (1) would rationalize utilisation of public health facilities and (2) would mobilize additional resources for enhancing services in the Health sector. In 1992, a GOT comprehensive assessment concluded that the introduction of user fees would not deter people's accessing to public health services. In view of these findings, the GOT proceeded with the development of a cost *sharing* implementation programme. The overall rationale for the introduction of user fees in Tanzania centred around two main ideas; (1) The need to mobilize additional resources for enhancing services in the Health sector and (2) to complement government budgetary allocations (see Technical Paper Part 3)

Protection of vulnerable and groups
In July 1993, user fees were introduced for Grade one and Grade two services[28] in public health facilities (Technical Paper Part 3). In January 1994, user fees were introduced for Grade three services in public hospitals (Msambichaka et al 2003:1). The revised user fee scheme of 1996 indicates that user fees for grade I, II and III medical services were differentiated and did not aim at full cost recovery but at cost sharing

The protection of vulnerable and poor people was from the onset of the programme a major concern. For this reason, an exemption and waiver system was included in the user fee system. According to the cost sharing operationalisation manual for Tanzania, an exemption is a statutory entitlement to free public services, which is granted to individuals that automatically fall under the categories specified in the manual. Exemptions are to be extended to (1) children of five years and below, (2) MCH services including immunizations, and (3) patients with TB, Leprosy, Paralysis, Typhoid, Cancer, AIDS, and long-term mental disorders. Epidemics (e.g. Cholera, Meningitis, and Plague) are exempted as well. A waiver is granted to patients who do not automatically qualify for the statutory exemption but who are in need of an exemption as they are classified as "unable to pay". People eligible for waivers include the elderly and other people "as might be decided by the hospital management" (Munga, 2004 and Mamdani 2003:6).

Documented position of the GOT towards user fees in recent years
Different documents reflect that the GOT has consistently been in favor of the user fee policy and its institutionalized protection mechanisms since the introduction of user fees in 1993. This is reflected in recent studies (PPC and Ministry of Finance 2001 and Rwechungura, 2003). However, the MOH also realized that the user fee policy did not protect the poorest groups sufficiently. For this reason the MOH commissioned a study in 2003 with the purpose to assess the impact of exemptions and waivers on the cost sharing revenue in public health facilities. The study concluded that cost sharing is still considered as a complementary source of revenue that should be strengthened in all public hospitals. The recommendations pointed to the need (1) to strengthen the management of the cost sharing programme, (2) to design incentives that will re-enforce collection of revenue and proper expenditure of the revenue, (3) for an effective policy on exemptions and waivers, (4) to re-design the statutory exemptions with the aim to target the poorest households and (5) to design strategies to alleviate the lost revenues due to exemptions (not indicated how) (Msambichaka et al 2003:28-29).

[28] Grade one and two refer to first and second class services in Referral and Regional hospitals. This includes daily costs for medical services, food and admission charges. Grade three services are also charged at District level and in special clinics and include out-patient and in-patient services. The fees are charged for admission but exclude drugs, laboratory tests and other tests (Mushi, 1996:4 and User Fee Policy, 1996).

5.2 Community Health Fund

Community Health Fund (CHF) Concept
In 1994/5 the GOT collaborated with the WB's International Development Association and other donors to design a new approach to improve the financial sustainability in the health sector and to increase access to health services. The CHF was identified as one mechanism to achieve these objectives. In Tanzania, the CHF is a pre-payment insurance scheme for rural people. It is based on the concept of risk sharing, whereby "those who get sick will benefit from a fund where patients' contributions are greater than the outflow of funds". The CHF scheme is also designed to empower communities in health care decisions and promoting cost sharing with a strong local participation (Baraldes et al, 2003:8). Each household[29] can participate in the CHF scheme by purchasing a health card at a flat rate. There are variations in the CHF premiums but on average a premium of Tshs. 10,000 has to be paid by a household. The card entitles the households to a basic package of curative and preventive health services throughout the year. Households that do not participate in the CHF scheme will still be required to pay a user fee at the health facilities at the point of use. For those who cannot afford the CHF, the District can decide on exemption criteria (e.g. not able to pay, disability, elderly over 60 years), and can authorise the community to make exemptions. The contributions from the households are pooled at district level (Baraldes et al, 2003). According to the CHF Act, user fees paid at public health centres and dispensaries can also form a source of income to the CHF (CHF Act 2001:68). The idea is that communities through the established government structures (at district, ward and village level) can decide on the use of the CHF resources.[30] Evaluations have shown that the benefits of the CHF have included the continuous availability of drugs and medical supplies, rehabilitation of medical facilities and improved morale among health workers (MOH/SDC, 2001).

The Community Health Fund (CHF) operates under the Community Health Fund Act 2001. The CHF is therefore an endorsed legal entity and a formal designed financing scheme under the responsibility of the MOH and PORALG. The key elements of the CHF are presented in Technical Paper Part 3. According to the original design, by the end of 2003 all 113 districts in Tanzania would have an operational CHF and 60% of all households in each district would become a CHF member (Baraldes et al, 2003:8). In April 2003, however, only 14 Councils had an operational CHF and 39 districts had passed the preparatory stages for the implementation of a Council Health Service Board and required committees within the districts (MOH, 2003:I). At this stage the donor community is not very much involved in the CHF developments. The main donors that currently support the CHFs are the WB with matching grants for premiums and GTZ (technical assistance). The WB matching grant support will continue up to 2008. It is unclear what will happen afterwards.

5.3 National Health Insurance Fund

Another health financing initiative, which has been developed, is the National Health Insurance Scheme (NHIF). Implementation started in 2001. The actual expenditure of the NHIF is still low since the fund is still in its infancy. Initially the NHIF will include central government employees, followed by local government employees, and finally all formal sector employees. This assumption points to a beneficiary group which does not include the poorest people (PER (draft) update 2004:44). In the context of this study, the NHIF will not be highlighted further (see also Technical Paper Part 3). However, it is important to note that the recent abolishment of user fees in Kenya have been linked to a mandatory contribution by employees to a National Social Health Insurance Fund (which is a follow-up system of the Kenyan NHIF).

5.4 Contribution of user fees and CHF to the health resource envelope

Contribution of user fees at District Council level
Huge variations have also been reported in the registration of the income from user fees and CHFs at District level. The MOH/DFID PER 2002 Update estimated the overall reported income to the health sector at council level from cost sharing and CHF in 18 Councils for the year 2000. On average, the

[29] A household means (1) a mother, father and children under 18 years (2) a member of 18 years or more with children under the age of 18 years, or (3) an institution (criteria not clear).
[30] Based on a District Health Plan; drugs, hospital equipment, rehabilitation and/or maintenance of health facility, furniture and equipment for the facility, materials and supplies for facility use, uniforms for nurses, top-up and/or double-shift allowances for clinical staff and nurses, travel and per diem expenses incurred by staff.

reported income proportion for the health sector was 10.5% but variations were reported between 1% and 22%. The average income per capita from cost sharing across the Councils was Tshs. 105/= varying between Tshs. 5/= per capita in Mufindi Council and Tshs.305/= per capita in Muheza Council. Three Councils reported the proportion of the overall funds for health collected through the CHF. This was respectively 2%, 5% and 13% with an average of Tshs. 53/= per capita collected in 2000. There was no information available on how the income from cost sharing and CHF was re-distributed by the Council to PHC facilities or priority areas. The vast majority of the overall health funds were allocated towards recurrent costs. Personnel Emoluments, Drugs and Medical Supplies consumed 82% of total expenditures.

Contribution of user fees to the resource envelope at national level

The MOH/SDC PER Update 2001 analysed the locally generated funds and was able to make a distinction between data available on the Community Health Funds operating in primary health centres and the cost sharing Health Services Fund (HSF) operating in hospitals. Data for the years FY02 to FY04 were projected data. At that time, it was expected that the revenue gained from these sources would increase over the medium term. A conservative projected estimate was made (Table 5.1), based on the patterns observed in FYs 1997/98 – 2000/01 (doubling of CHF money year per year, and multiplication of 1.5 year per year for the hospital cost sharing schemes). The study team used the data to estimate the contribution of the Health Services Fund (HSF) and CHF to the National Resource Envelope (RE) for Health. It was estimated that the 2003/04 projected contributions of the HSF and CHF would respectively be 4% and 0.7% of the resource envelop.

Table 5.1: Health Resource Envelope and locally generated funds (Billion Shillings), Tanzania

	2000/01	2001/02	2002/03	2003/04
Health Services Fund (HSF) Hospital	2,752,800,000	4,129,200,000	6,193,800,000	9,290,700,000
Community Health Fund – PHC	207,200,000	414,400,000	828,800,000	1,657,600,000
Total	**2,960,000,000**	**4,543,600,000**	**7,022,600,000**	**10,948,300,000**
Proposed funding ceilings for the health sector, 2001/02 – 2003/04				
	2000/01	**2001/02**	**2002/03**	**2003/04**
Grand Total Resource Envelope Health	**180,347,442,232**	**182,506,819,160**	**202,449,584,160**	**224,599,724,598**
Percentage of HSF-Hospital	**1.13%**	**1.7%**	**2.6%**	**4%**
Percentage of CHF-PHC	**0.09%**	**0.175%**	**0.35%**	**0.7%**

Source: Extracted from MOH/SDC PER 2001.

From the various studies it is clear that the available data on user fees, CHFs and National Health Service Fund are unreliable. It has become evident that contributions of the various schemes are underreported due to weak management and administration of funds.

Overall conclusion

The overall conclusion of the MOH/DFID PER 2002 Update was that there is a great need for more accurate and comprehensive record keeping at local council level. The study concluded that the findings pointed to a great need for more costing and tracking studies to obtain a better picture on cost sharing and expenditures (MOH/DFID, 2002:29-44). Even more concerning is that the findings from the PER studies (2001 and 2002) imply that the MOH should actually have a higher income from the user fees than what is currently reported. This means that the MOH has a loss of income that cannot be re-distributed in the health sector. In addition, it is most likely that people (both rich and poor) probably pay much more for health services than what is officially reported. These assumptions are concerning since it is difficult (1) to establish precisely the total amount of the non-reported income and its potential contribution to the resource envelope for the health sector, (2) to know how exactly the non-reported income is used at different levels and (3) to know what people actually have to pay for health services at different levels. In relation to the latter, it was estimated with the FY04 income data from cost sharing schemes (1.67 Billion Tshs.), that with a population of 35,000,000 people in Tanzania, each person has to pay at least Tshs. 47,71/= per person per year to maintain the official reported level of cost sharing income. This does not seem a realistic figure given the fact that so many people indicate that the costs of health services are not affordable! This clearly must indicate that the available figures do not predict the actual equity implications of the user fees on poor people in terms of level of payments and can therefore not really be used for realistic policy formulation.

VI IMPACT OF USER FEES IN TANZANIA

6.1 User Fee charges

Actual charges and proposed charges at PHC level
It was difficult to obtain differentiated quantitative data on the actual user fees currently charged in the public and private sector (non-profit and for-profit) at health centre and dispensary level. Costing studies (HERA, 1999) reflect the actual costs of health services at health centre and dispensary level and relate this to the required income for health facilities at PHC level, but do not indicate the actual fees charged. According to MOH representatives in Kagera Region, the PHC facilities are suggested to follow the formal user fee charges given for District hospitals.

The Health and Education Financial Tracking Study (1999) found that non-governmental health facilities in most cases charge higher user fees than government facilities. This was also confirmed in Kagera Region (see Technical Paper Part 5). Information that is available on user charges in the public facilities never includes the additional costs that people have to incur for transport, purchase of drugs or items that are supposed to be free of charge, unofficial fees, etc. Table 6.1 indicates that people often have to incur substantial extra costs on top of the formal user fee charges.

Table 6.1: User fee charged in different public health facilities, 2003

Source of Care	Formal User fee charged	Excluding costs for;
GOT-HC 1	▪ Registration costs Tshs. 100/=	▪ Medicine which are not available in the HC ▪ Medicine available in the HC ▪ Transport costs from home and 2nd visit to collect lab results ▪ Food in case of admission ▪ Long waiting time if you do not have money ▪ Referral costs to Hospital (Tshs 8,000/=)
GOT-HC 2	▪ ANC card Tshs. 500/=	▪ Syringe, Tshs 200/= ▪ Gloves, Tshs 2,000/= ▪ 'Thank you' for staff, Tshs. 5,000/= ▪ Transport costs
GOT-dispensary	▪ Registration Fee Tshs. 50/=	▪ Medicine which are not available ▪ Transport cost from home

Extracted from SDC 2003:31-33 and TzPPA 2003:98

Huge variations in charges to be paid have been noted. The MOH/DFID PER Update 2002 mentioned that for hospitals where user fee income was reported, the overall average annual user fee per person was Tshs. 130/=.[31] There was, however, a wide variation, from an average of Tshs. 12/= per person in Mafinga District Hospital to Tshs. 994/= per person in Amana District Hospital. This indicates that it is difficult to establish precisely what people actually pay for the costs of health services both for formal charges, informal charges and additional costs if the required services cannot be obtained at one health facility during one visit.

Differentiated use of public and private health facilities by the poor and rich people
Although there is huge variation in the reported individual user fee charges, it was clear from different studies that the lower charges in the public health facilities are preferred by both the poorer and richer segment of the population. The Human Resources Development Survey (WB, 1993/94) found that Government health centres were the main choice for *out-patient* care for the poorest. Approximately 70% of the sick individuals in the poorest 20% of households sought treatment firstly at government health facilities. Furthermore, a more recent study confirmed that the poorest 20% of households depended on government health centres and dispensaries twice as often as the richest 20%. It was also found that in terms of *in-patient* care, wealthier individuals were more often likely to use government hospitals and consume a greater relative share of all services than the poor (MOH/SDC, 2001). This seems to point to an unequal access to in-patient care for the poorest people. The Policy and Service Satisfaction Survey (PSSS) 2003 confirms that this trend is still there. In 2003, two-third of the rural households used government dispensaries and health centres for most treatment and only

[31] Assuming that every person in the catchment population made one visit to the main hospital during the year 2000 and made a user fee contribution. The average fee for this visit was calculated to allow for comparison (MOH/DFID 2002:39). From the available data it couldn't be established whether fully exempted clients were included in the average figures.

14% resorted to private (non-profit and profit) in first instance. In urban areas a similar trend was observed (PSSS 2003:24).

Use of income from user fees
Documents do not reflect a differentiated and representative overview of the use of user fee income per level for public dispensaries and health centres. It is therefore difficult to come to conclusions regarding the actual use of the income of user fees by health staff working in public dispensaries and health centres and the contribution of user fees to improved quality of health services. Detailed costing studies (HERA 1999:74-129) looked in particular at the supply side rather than at the demand side of the health services. However, due to the lack of transparency in the management of the district health budget, it was not possible to obtain a good insight into the actual use of the health budget at PHC facility level (In 1999, the health centres had not introduced cost recovery yet). The Health and Education Financial Tracking Study (1999) found that government facilities which did charge user fees did not retain them; collections were deposited by the DMO into the Health Services Fund Account which is mainly used to purchase medical supplies for the District Hospital (and not the PHC facilities). The study also found that the distribution of medical supplies benefited hospitals more than health centres and dispensaries. Equity criteria for the distribution of available resources to the PHC level were not followed systematically. A study in 2000 found that Government-run PHC facilities appeared to suffer from severe shortages of antibiotics, antacids and anti-diarrhoeal drugs. The study confirmed findings of earlier studies that allocations of supplies did not appear to be closely related to the patient attendance and activities of the health facilities (MOH/SDC 2001).

In addition, it was very difficult to find evidence whether (1) increased availability of drugs is in fact a result of user fees at different levels and (2) user fees themselves have contributed to increased ownership and accountability of health workers. The overall impression is that availability of drugs is more related to the allocations from the National Resource envelope than to income from the user fee collection.

6.2 Consequences of user fee charges for poor and vulnerable people

Critical issues
The introduction of cost sharing in 1993/4 into the public health care system has put professional health care beyond the reach of many (TzPPA 2003:97-98). Critical issues for poor people have been highlighted in various studies. A prevailing view is that the introduction of the user fees has disproportionately affected the use of services by the poor and vulnerable groups and constitutes a barrier for the poor. This is often not well reflected in studies reflecting on the positive results of the user fees, since available data fail to capture the experiences of people who fail to access care in health facilities (Mamdani 2003:3-7, Dercon 2000:19). In the PSSS 2003, the cost of health treatment was reported as the third most acute household problem, affecting over 50% of all households. Dar es Salaam households complained more about the costs than those in other urban areas and rural areas. Time and distance to the health facility constitute a major problem for one-third of rural households and for less then one-fifth in urban settings. People reported to live even 45 km. from a health centre. Distance, poor roads, the lack of suitable transport for the sick and persons with disabilities is the second most cited obstacle to health care. In the last ten years the mean distance to primary health facilities decreased from 4.4 to 3.9 km. However, nearly a half million households remain more then 20 km. from the nearest health facility. The real distance is often far greater if treatment is limited by the quality of the nearby services (e.g. poorly trained staff, ill-equipped facilities, lack of pharmaceuticals). The availability of drugs was reported as a major problem by nearly two-fifths of the households and one-third complained about the long waiting time before they received assistance. Female headed households identified these problems slightly more often than male-headed households.

Nearly three-quarters of the respondents thought that the ability of people to pay for health services had deteriorated during the last five years. Only less than 10% thought that this ability had improved. Two-fifths of the respondents reported that they knew people who had been refused treatment because of their inability to pay, especially for drugs and supplies. In Dodoma, 75% of the respondents reported that they had been refused treatment because they could not pay the required charges. Female headed households reported this constraint more often than men. A quarter of the respondents reported unofficial payments to health workers. This was particular common in Dar es Salaam. In urban areas, more men reported this constraint while in rural areas this was the reverse.

An indication of actual charges and additional costs to be paid by people in public PHC facilities is provided in Table 6.1. The table shows that the additional costs to be paid can be even 15 to 80 times more (or higher) than the formal fee implies! Poor people in a Lushoto health facility paid for an episode of illness on average 80% for drugs and other fees, 10% on transport, food and accommodation and 10% on informal charges (Mamdami, 2003). In the PSSS, people expressed views on improvements and detoriation of costs and services. While 19% thought that the cost of treatment had declined, 39% thought it had increased. While the availability of drugs increased for nearly 30%, it deteriorated for 23% of the respondents (PSSS 2003:24-27, TzPPA 2003:97-98, SDC 2003:31-33, Mamdami 2003:8-10; Msuya, 2003; Munga, 2003; Khan, 2003; Ewald et al, 2004). People's ability to pay is not only determined by treatment costs but also depends on inflexible payment modalities. Traditional healers are in that sense much more flexible than health facilities (Muela et al 2000:301). It has been estimated that in hospitals and dispensaries, 70% and 40% of the clients respectively, have difficulty to make the full payment for health services provided (Dercon 2000:56).

Coping mechanisms

The Tanzania Participatory Poverty Assessment (TzPPA 2003) provides a bleak overview of how poor people cope with the inability to afford the user fee charges (see table 6.2).

Table 6.2: Coping mechanisms related to inability to pay user fee charges

▪ In 2001, a survey reported that 58.7% felt that they should have consulted a health care provider but did not do so because it was too expensive.	▪ People cope with a disease, malnutrition or injury by learning to live with even less by cutting back on essential costs as medication, food and clean water.
▪ The Tshs 500/ fee for consultation is beyond the meagre means of people, especially for women and children who lack decision-making power over the expenditure of household assets.	▪ In order to pay people resort to desperate measures. (reduce eating, selling of productive assets, taking out a loan). This can lead to a poverty trap which can not be escaped without external assistance.
▪ Substantial treatment causes even a bigger problem.	▪ People resort to self-diagnosis and medicate traditional or commercial remedies.
▪ People are forced to bribe (especially in dispensaries and clinics) as a pre-condition to receiving services. The official charges constitute just one part of what is really paid. The official fee can be 35% of the total costs while the bribe can constitute 65% of the total costs (based on available figures).	▪ Stigmatising diseases such as sexually transmitted infections, HIV and AIDS fistulae, incontinence, and disabilities often lead to humiliation, abuse, neglect and social exclusion. This contributes to the inability to work for an extended period of time. Combined with inability to pay user fees often contributes to seeking delayed treatment which becomes more costly.

Source: TzPPA 2003: 97-98

Poverty-ill health circle

Many households have been directly impoverished by illness (SDC, 2003:1). The poverty-ill health circle includes different phases; (1) People in poor households are more likely the others to become ill, (2) When illness strikes, poor households lose the labour power of family members, (3) Many poor households are forced to cope by selling off productive assets while social exclusion makes the outcomes uncertain, and (4) The loss of productive assets and skills contributes to long-term poverty. This limits the capacity of poor households to safeguard their health. This process has become visible among people who have become affected by HIV/AIDS in Tanzania. Financing the drugs needed for the treatment of opportunistic infections can devastate household resources because of the high costs and recurrent nature of the illness (a single course of drugs may cost between Tshs 26,000-Tshs 40,000). People with HIV/AIDS are supposed to be exempted from cost sharing in public health care facilities but this rarely occurs in practice (TzPPA 2003:97-98).

6.3 Findings from Kagera Region

Summary of critical issues

The study team carried out data collection in Kagera Region. The findings have been included in the Technical Paper Part 6. In Kagera Region, people systematically indicate that they cannot afford to pay the current user fees and that they have, as a consequence, to resort to alternative and even humiliating strategies in order to obtain at least some kind of health service. On average this is the case for 30% of the population in Kagera Region. The majority of the households (74%) do not have access to a health facility, while the costs of transport to a health facility are considered as one of the

most important barriers to access health services. Other barriers to access to health services are; (1) Employment status, (2) being a pregnant women in a poor household, (3) being younger than five years, (4) being older than 60 years, (4) being HIV positive, (5) having a disability and (6) being a widow. The shortage and attitude of health staff, the reduced quality of services and the limited availability of drugs in the public health facilities are additional barriers.

At the same time, the public health facilities face the burden of having to treat the poorest patients because the private-for-profit and the faith-based health facilities do not – and cannot accommodate them. Especially, the FBOs have become less pro-poor while the assumption among many people is that a faith-based approach should still function as a *shock absorber* for the poor. Respondents even considered the private sector as being non-ethical because of their charges. The situation in the private sector is caused by (1) the need to generate own resources for the running costs, (2) the need to charge higher user fees, (3) the absence of a functional exemption and waiver system or pro-poor approach in the private health facilities, and (4) a tendency to *push* poor patients into the public health sector by the private sector. It becomes clear that the private sector in this sense contributes to the problems that are experienced by the public health sector. If the FBOs and the private-for-profit health facilities would develop a more distinct pro-poor approach, they would actually contribute to a more equitable access to health for the poorest people. The poorest people are now forced to bypass a private health facility even if this facility is nearby home. This leads to higher (transport) costs and delayed treatment. The need to generate income is understandable since the FBOs and the NGOs are confronted with reduced donor funding and the pressure to become more sustainable (thus to generate more income), but this has a direct negative effect on the poorest project beneficiaries. This is often not realized and discussed sufficiently between the major stakeholders in health.

Even though the exemption and waiver systems are either not clear, not well understood or not transparent, still people see them as a last resort for the poor. It is felt that the poorest people have a bigger chance to obtain a waiver in the public sector and it is even considered as a better solution than a CHF. The overall opinion about the CHF is positive since it is understood as a pro-poor solution. However, there is a clear indication that the poorest groups are not able to afford the CHF premiums. Unless the premiums systems are either (1) revised to accommodate the poorest people or (2) are paid for by others (on behalf of the poorest people), poor people will still continue to depend on the out-of pocket payments at the point of delivery. As the Kagera analysis shows, this excludes at the moment already a substantial number of people, particularly from vulnerable population groups, from access to health services. It can therefore be concluded that the potential impact of the proposed introduction of user fees at the PHC level will be disastrous for many people and will push people further into poverty.

6.4 Critical views regarding the impact of the user fees, exemptions and waivers

Impact of the user fees in the overall health system
Despite the intentions of the MOH to guarantee equity, universal access and affordability in the health sector, major concerns have been raised by researchers about the tremendous negative impact of user fees on the poorest people in Tanzania. Some studies have also reflected positive contributions of user fees towards (1) improved quality of health services, (2) increased availability of drugs, (3) increased maintenance of health facilities, and (4) increased contribution of user fees to the recurrent budget and non-wage budget for the health sector (Rwechungura 2003, Msambichaka 2003, MOH 1999). Mackintosh and Tibandebage (2001) report that some very poor people did experience inclusion and decent treatment from some health care facilities in Tanzania. However, Mackintosh and Tibandebage (2000) also found evidence of regressive outcomes of user fees with substantial exclusion and self-exclusion in Tanzania, and of impoverishment from struggling to pay formal and informal health care charges. Mackintosh and Tibandebage (2001) furthermore report that some experiences from exclusion from government hospitals in Tanzania have led to death.[32] A growing number of documents point to the negative impact of the user fee system on poor people in Tanzania. The major points of discussion are presented in Table 6.3.

[32] The other literature included limited specific evidence on increased morbidity and mortality.

Table 6.3: Critical observations regarding the impact of the user fee system in Tanzania
▪ The ineffectiveness of the exemption mechanisms is a key problem and not just the user charges. Exemptions are unable to direct subsidies adequately to the neediest due to the absence of proper exemption incentive structures.
▪ Unofficial payments combined with poorly functioning exemption mechanisms are highly critical and powerful in excluding the poor and other vulnerable population groups.
▪ User fee systems, waiver and exemption systems are differently applied throughout the country. Evidence shows that exemptions have benefited the better off more than the poor, resulting in more inequities instead of improvements. ▪ User fees place a heavy burden on the poorest households which have very little income flexibility. Fees in PHC services have resulted in negative effects on the rural, poor population particularly women and children. This has contributed to increased morbidity and mortality among women and children. ▪ User fees have increased exclusion and marginalisation of the poor and other vulnerable populations in Tanzania.
▪ It is questioned to what extent did user charges actually have, or did not have, a bearing on quality improvements, improved coverage and equity. Authors wonder whether "the revenue raising rationale" as proposed by the proponents of the policy still valid in the light of user fees contributing to excluding poor and vulnerable populations from accessing and utilizing health care services. ▪ It is felt that the contribution of user fees (2%) to the health recurrent budget cannot reasonably justify the welfare losses the fees are causing. There is no rationale for its continued existence. User fees act in opposition to all efforts geared toward alleviating poverty.
▪ Authors indicate that there is no evidence of a 'clear' concern in the MOH on how to reverse the situation towards a positive direction. This is reflected by the failure or rather negligence of the government to appreciate the potential inequities that can be caused by implementing user fee policy. This has resulted in the absence of clear and workable strategies to correct inequities created or exacerbated by the implementation of the policy

Source: Mubyazi et al, 2000; UNICEF, 2002; URT 2002; Tibandebage and Mackintosh, 2002; Msambichaka et al, 2003; Wyss, 2003; Mamdami and Bangser, 2004; Mushi, 2004; SCF, 2004.

Potential impact of user fees at PHC level

A recent study was conducted to obtain ex-ante insight into the potential implications of user fees at PHC level. Since 1998, user fees have also been introduced in lower-level facilities (health centres and health dispensaries) in combination with CHFs. Bonu et al (2003) recently published a study that assessed the potential regressiveness of this policy. The study assessed Willingness to Pay (WTP) for a health care visit to a lower level facility irrespective of the *ownership* of the facility. The findings therefore include the public and private health facilities (Bonu et al 2003:377-380). In the 36 districts where cost-sharing has been introduced between late 1998 and the end of 2002 in the form of CHFs and user fees, the annual *membership fee for each household* varies from Tshs. 5000 to 10,000 (US$5–10). The *user fees for non-members* vary from Tshs. 1000 to Tshs. 1500 (1US$ = Tshs. 960 in 2003) *per visit*, including the cost of medicines and laboratory diagnostics. However, the median WTP for a visit to a lower-level health facility among the poorest 40% is only Tshs. 100 (Tshs. 251 at 2003 prices), while for the richest 60% it is Tshs. 1000 (Tshs. 2510 at 2003 prices) *when* the quality of the services meets their expectations.

The study emphasizes that there is a high demand for high-quality services at the lower-level health facilities in Tanzania. Earlier studies in Tanzania have noted extensive bypassing of lower-level health facilities.[33] It has been assumed that the bypassing of lower-level public health facilities may be mainly due to poor quality of health services. Despite this assumption, the study found that it is in particular the user fees that pose a main barrier for poor people to utilize health services at PHC level. The study found that the current fee levels being introduced will adversely affect the utilisation of services, especially among the poorest 40%. Almost 20% of the respondents in the poorest quintile refused to pay anything even when the quality of health services met their expectations. The study therefore questions the conclusions derived from earlier studies that user fees may promote equity by improving the quality of care, which in turn will encourage utilization among the poor. This might not be the case if people in the poorest quintile are still not able to pay for improved health services.

Inability to pay for health services at PHC level by the poorest people implies that people have to depend on free health services in the public facilities and otherwise may resort to self-care once cost-sharing is introduced. The study confirmed that women, the poor and people aged 46 years were found to resort to self-care. It was found that female respondents were willing to pay significantly lower

[33] This has been raised as a concern since the bypassing of lower-level facilities increases the burden on the tertiary hospitals and reduces the efficiency of the health system by increasing per unit cost of service delivery.

amounts than the male respondents. It was found that user fees may result in lower utilization of services by women including institutional delivery care. This is supported by the declining trends in delivery care utilization in Tanzania between 1992 and 1999 following the introduction of user fees in higher-level facilities in 1993.[34] Similar to declining institutional delivery observed among poor women after the introduction of user fees in higher level facilities, adverse effects might also be observed in primary health care for the poor on the introduction of CHFs and user fees in lower-levels facilities, unless accompanied by effective exemption and waiver policies. The elderly population may also be more adversely affected by the implementation of (uniform) user fees. Almost 17% of respondents older than 46 years were not willing to pay anything for a health care visit.

The need for effective exemption policies for disadvantaged groups in Tanzania is evident from the study. The authors conclude that (uniform) user fees can be regressive in terms of disproportionally greater negative effects on utilization of health care by the poor compared to the rich. The findings of this study are relevant to the ongoing efforts of the Tanzanian government to introduce cost-sharing in lower-level facilities.

Impact of exemption and waivers

The impact of exemption and waivers in Tanzania clearly is an under-researched area. The study by Msambichaka et al (2003) in that sense is an important study. The Msambichaka study reflects that a poor performance or a negative growth in revenue collection is related to the number of exemptions and waivers granted by a hospital. The growth in exemptions and waivers pull down the revenue collection. It was also found that the registration of exemptions and waivers does not clearly appear in the statistics and can be mixed up. It was found that waivers (e.g. for accidents) could be re-classified into exemptions in order to reduce the number of waivers in the statistics. There was evidence that waivers constitute an insignificant proportion of the total exemptions. This might be done as a strategy to cover mis-use of the system and raise the volume of revenue collections in the statistics. This implies that the data on hospital revenue collection can be flawed by inadequate registration of the exemption and waiver system. It also implies that the hospitals are not eager to face a down-ward pressure on their budgets.

The hospitals included in the study indicated that many patients apply for an exemption (at the same time this can also mean a waiver, since the terms are often mixed up) and indicated that the administration procedures are in itself not difficult to process. Hospital statistics indicated that most exemptions were provided as statutory exemptions (following the guidelines) to children under five years and women. Hospitals confirmed that (1) exemptions were provided to those who qualified but did not always need it the most and (2) waivers did not target the poor and emergency cases as it should be done. The study reflects that the processing of exemption and waiver systems is not user friendly but cumbersome and bureaucratic. The study emphasised that exemptions and waivers are socially justified irrespective of the revenue impact on cost sharing. The study recommended that there is a need to retain the exemptions and waivers in hospitals but emphasised that the procedures should become more simplified, user friendly, applicant friendly and time efficient. At the same time incentives should be designed with a three-fold purpose; (1) to reinforce collection of revenue, (2) proper expenditure and (3) effective implementation of the policy for exemptions and waivers. The loss of revenue should be compensated by government resources. The procedures should also target better the entitled beneficiaries and the poorest households since the procedures and entitlements are not well known (Msambichaka et al 2003:13-29).

The study of Mamdani (2003) confirms the findings above but also cites other studies. The study emphasises that there are examples of providing exemptions and waivers to vulnerable and poor people by the FBOs and the rural government dispensaries and health centres. They continue to serve as a safety net for the poorest people. The study, however, also points out that there is substantial evidence of exclusion of patients who are not able to pay a formal fee or a bribe. Respondents indicated that they did not use or attempt to use the waiver system. Many people simply do not believe that as a poor person they are entitled and will be granted a waiver. For this reason poor people refrain to go government facilities but try to obtain a partial waiver or partial treatment in FBO facilities. Those who cannot pay simply stay at home and remain untreated.

[34] The decline being more prominent among the poorest quintile of women (between 1992 and 1999 the proportion of deliveries in the public facilities declined from 36% to 23% among women in the poorest quintile).

All in all, there is limited evidence of systematic implementation of the waiver policy or beneficial impact of this policy on poor people and of insistence on free services by the poor themselves. A critical issue in this is the absence of a standardised procedure for the identification of the poorest in a community. Poor people continue therefore to negotiate for their right on a waiver or an exemption (Mamdani 2003: 12-15).

6.5 Impact of Community Health Funds

CHF Positive findings
The study of Chee et al (2002) in Hanang District of Tanzania, provides valuable insides about the function of the CHF. A main conclusion of the study was that "While the central government and basket funds provide the large majority of the total Hanang district budget, the CHF funds do make a significant contribution to the overall budget". Total CHF funds constituted 10% of the 2001 budget through the end of October – CHF membership and user fees accounted for 8% and the matching grant 2% of this budget. While the total contribution from CHF membership and user fees is significant, user fees contribute the majority of funds, and continue to grow as a share of total funds collected, from 20% of fees collected in 1999 to 77% in 2001. While the CHF membership fees account for a small portion of the total fees collected, CHF member utilization accounts for a significant portion of total utilization (38-88%)." However, a range of concerns and constraints have been pointed out as well.

CHF concerns and constraints

Linkage CHF and user fee policy unclear. The introduction of the CHF brings in a whole new dimension to the user fee discussion in Tanzania. Through the introduction of the CHF, districts will actually have to deal with varieties of user fee systems and exemption and waiver systems. While the current user fee system and exemption and waiver system still has to be followed in Referral, Regional and District hospitals, every CHF (per district) can autonomously decide on their own criteria and reasons for exemptions (based on community discussions). At this stage there seems to be no guideline in place how the CHFs have to deal with or have to integrate the formal exemption and waiver systems. It has been reported that CHFs do not follow the formal exemption and waiver policies.

Double exclusion and adverse incentives. The income from user fees raised in public health centres and dispensaries is supposed to form a source of income for the CHF. This will undoubtedly put more pressure on the public PHC facilities to raise more income through the user fees. In this context, it can be assumed that the introduction of user fees at PHC level is probably driven by the fact that user fees at this level will have to form a source of income for the CHFs. This development might lead to a *double exclusion* for poor people who (1) cannot afford the user fees at any level but (2) can also not afford the CHF premiums. Another side of the coin is that if (1) the income of user fees cannot be retained at PHC facilities (for quality improvement) and (2) the CHF funds are not adequately used for quality improvement in PHC facilities, health workers might not have an incentive to collect fees. On the contrary, there is however a clear incentive to raise as much income from CHF premiums as possible since the WB funds will match the premiums of the CHF. This implies that it is not attractive at all for CHFs to provide many exemptions for CHF premiums since this will reduce their potential income from the matching funds. Combined with the fact that the CHFs have to identify alternative means to compensate for the money lost through exemptions, one can assume that the CHFs will most likely (1) not be very eager to provide exemptions to the poorest people and (2) not be eager to utilise CHF resources to pay the CHF premiums or user fees for poor or vulnerable people.

A recent evaluation of CHFs in Tanzania shows very low membership levels. CHF contributions through pre-payment cards have not exceeded 30% of the households and are stagnant or declining over time (Chee et al, 2002; in Bonu et al, 2003). Bonu et al (2003) relate the poor performance of CHFs to a lack of desired quality of care. According to Bonu et al (2003), higher participation in a cost-sharing scheme is contingent on availability of desired quality of care.[35] Those who register initially into a cost-sharing scheme may drop out quickly if the quality of care does not reach prior

[35] According to Price (2002), "numerous studies have aimed to show that quality is more important than price. Increase quality outweighs the negative effects of user charges, and when charges are introduced, clients come to expect quality services, that are tailored to client's needs."

expectations. It appears that those who ultimately remain in a pre-paid cost-sharing scheme like the CHF are determined by 'adverse selection', where people with greater health needs remain in the CHF despite other disincentives – like poor quality – to avoid high health care costs under the alternative fees for services. Bonu et al (2003) conclude that their findings suggest that the current CHF and user fee schemes in lower-level health facilities in Tanzania need to design effective built-in mechanisms to protect women, the poor and elderly populations from adverse effects. Similar to declining institutional delivery rates observed among poor women after the introduction of user fees in higher level facilities, adverse effects might also be observed in primary health care for the poor on the introduction of CHFs and user fees in lower-level facilities, unless accompanied by effective exemption and waiver policies. Table 6.4 provides an overview of main findings shows that the implementation of CHFs, while a positive development, is not without problems.

Table 6.4: Documented CHF findings in Tanzania	
Low CHF implementation and enrolment	▪ The roll-out of CHFs to districts has been severely delayed and seems stagnant. ▪ The CHF enrolment is below the target of 60% of the district households. The enrolment ranges between 3-28% with the majority of districts reporting 5% (as such contributions have also remained low). Reason for the low enrolment seems to be that households have to pay the premium of Tshs. 10,000/= at once. The composition of members is a mix of less well off and wealthy, leaning to the well off, educated and middle class since civil servants were required to join as well. The poorest households do not join. The CHF in this form leads to exclusion of the poor.
Management	▪ Districts are not clear on CHF management. Political interference affects CHF implementation. District leaders do not fully support the CHF system. Starting up fund seems inadequate. Obtaining WB matching grant is time-consuming. ▪ Effective implementation of payment schemes requires a strong decentralised management structure. Mismanagement of CHF funds occurred with 27% of CHF implementers. Financial management systems at WHC and HF level are poor. Delays have occurred in the utilisation of collected funds due to delays in compiling plans to fit in with the district planning cycle.
Affordability and willingness to pay	▪ Communities have little participation in the CHF management and fee setting. The concept of insurance is not well understood. Awareness on benefits is low (38%). WHC plans for CHF face delayed approval and bureaucracy. ▪ It is estimated that 65% of the households have an annual income of less then Tshs.50, 000/= per year in districts where CHFs are established. On average, 27.5% indicate they would not be able to afford the premium of a CHF card. ▪ Districts report that 82% of the people are willing to pay Tshs. 3,000/= and 62% is willing to pay Tshs. 5,000/= for a CHF card. ▪ Availability of medical supplies and quality improvement are considered as essential for willingness to pay a user fee or CHF premium. In total 50% of patients and health workers reported HF improvements (drugs, diagnostic facilities, maintenance) after CHF introduction.
Exemptions	▪ Communities are not well aware on the exemption criteria and exemption procedures. By CHFs. Exemption guidelines are neither well understood nor followed by CHFs. ▪ Protection of the poor is not guaranteed in the CHF. A planned scheme to provide selected households with free CHF cards has not been implemented in the 18 months after the CHF take-off. Together with non-functioning user fee exemption and waiver mechanisms, the poor are not protected from the burden of the health care costs.

Source: Chee et al, 2002, Hutton 2003, Baraldes, et al, 2003, MOH 2003, Bonu, et al, 2003

6.6 Stakeholder Views

6.6.1 General observations from the interviews

Rationale and achievements of user fee policy objectives

There was general consensus among the interviewed stakeholders on the main reasons why user fees were introduced in Tanzania: revenue raising, enhancing equity, reducing frivolous consumption and improving quality of care. Few interviewees associated user fees with poverty reduction as a rationale for their introduction. Stakeholders' responses indicate that they find it very difficult to give a correct, conclusive statement on the extent to which user fees have achieved their objectives. Due to inadequate financial management systems, there is likely to be a gross over- or understatement of the actual contribution from user charges. However, most respondents agreed that user fees have contributed significantly to quality improvements in some specific areas, such as the availability of drugs. However, this was more based on their personal impression then on reliable data.

User fee policy
Stakeholders mostly recommended a phased approach to introducing user fees, starting with the higher levels of health care and gradually going down to PHC levels. As such, they seem to agree with the approach taken by the Tanzanian government. They did explicitly note, however, that the Tanzanian approach has created many loopholes for excluding the poor from using health care. The present user fee policy, the exemptions in particular, tends to benefit the better off more than the poor and vulnerable people. Regarding whether it is reasonable to abolish fees, most stakeholders shared the view that there is a need to strengthen exemption and waiver mechanisms for protecting the poor rather than abolishing fees. The following strategies were mentioned:

- Improving accountability among health workers, the primary implementers of the user fee policy.
- Improving transparency to all stakeholders, i.e. collect and disseminate information on what is actually collected, how is it being spent, how the exemption system operates, and what the exemption criteria are (these should be clear and unambiguous).
- Making community members responsible for deciding who is eligible for exemptions instead of relying on professional, technical criteria.
- Establishing a well-targeted fee structure and insurance system in line with the exemption system.

Poverty Reduction Strategy
Most resource persons recommended that in the second PRS, the Tanzanian government should further strengthen its commitment to increased funding to the health and education sectors, so as to create a sustainable infrastructure for improving people's health and education levels which are important tools in the fight against poverty.

6.6.2 Ministry of Health views

The MOH resource persons indicated that the first PRS did not sufficiently involve poor people in the process and had not been as successful as expected because of a technocratic top-down approach. It was felt that even at district level there was a disconnection with the priorities of communities. The priorities for poor people were for example not sufficiently reflected in district council plans. However, although shortcomings in the PRS process were acknowledged, the MOH resource persons unanimously supported Tanzania's present user fee policy. They pointed in particular to positive impacts in terms of poverty reduction, quality improvements (particularly for drug supplies), revenue generation, the reduction of informal charges and increased consumer's choice. They qualified the design and intention of the user fee policy as pro-poor because those who cannot afford to pay are under special exemptions arrangements.

Despite their support to the user fee policy, most resource persons, some more explicit than others, recognized that the present exemption policy is not functional. Corruption, mismanagement of funds and inconsistent ways of implementing exemptions have all contributed to exclusion and further impoverishment of the poor, the intended primary beneficiaries. The need to follow MOH guidelines as a strategy to address these problems and the importance of improving health workers morale were emphasised.

Resource persons differed in their opinions on the best cost sharing scenario for Tanzania. One resource person considered the Community Health Fund "the saviour to not only the poor, but to the overall health system" and preferred the continuation of the present situation, in which fees are charged in the hospitals and a binding CHF is implemented at lower level health facilities. If was felt that the severe delay of the introduction of CHFs in other districts was related to the time consuming process for CHF registration at district level (establishment of District Health Boards, need for legal constitution) and the limited follow-up of districts to follow-up with the PORALG the CHF application and establishment of the compulsory by law for binding citizen to the CHF for each district.

Another resource person felt that the CHF, complemented with other health financing mechanisms such as user fees taxation and NHIF, would be the best solution to address the health needs of the poor, and to help Tanzania rescue those resources that were wasted under previous policies. In addition, this resource person mentioned the need to generate domestic instead of donor resources to bridge the health financing gap. A third resource person, however, proposed to charge fees at all levels (further extension), while improving the existing exemption policies: "This is a pro-poor approach of financing health services because those who are not ready to pay for health services at the point of

use will be required by law to be members of the CHF. And there are already exemptions mechanisms which need to be improved."

MOH resource persons felt that in the historical context of Tanzania where health care services used to be free and the quality of services fully deteriorated, the experience had been that:

> *" free services equals no services at all"*

Resource persons indicated that many people still had a vivid memory of the major constraints related to free health services. The MOH resource persons therefore felt great reluctance to consider the abolishment of user fees for health as a viable option. It was felt that this would not contribute to poverty reduction because of its negative impacts on important PRS elements such as ownership and participation. It was felt in relation these views that "Tanzania can not afford to abolish user charges as a strategic move towards alleviating poverty"

> *"What has happened in Uganda immediately after the abolition of fees are positive changes that can politically be sustained on a short term basis. In a long run, they are going to face the same problems that justified their decision to institute user fees as a health financing strategy"*

6.6.3 Donor views

Most representatives from the donor sector found the trade-off between user fee revenue generation and its equity implications complicated. In this context, they referred to the lack of reliable information. It was felt that poor record keeping and financial management make it difficult to obtain an impartial insight into the contribution of user fees to the health budget. Similarly, the equity implications cannot be assessed due to the lack of information on who and how many people are entitled to exemptions and waivers and actually receive them. However, there was a common agreement that user fees in health may have added an additional burden to the already existing barriers to accessing and utilizing PHC. Like the government resource persons, the donors emphasised that protection mechanisms against the ill-effects of user fees should be strengthened to ensure that their implementation produces more equity than what is currently seen.

Most donor representatives supported user contributions to health as an additional source to complement government and donor funds. One person stated to consider the abolishment of fees a further dependency on donor financing, a situation which compromises sustainability. At the same time, the donor representatives emphasized the need to conduct studies (not just willingness to pay studies) to generate information that can be used to establish a register of the socio-economic status of individuals or population groups. This register should be updated over time to make sure that those able or unable to pay are known by the policy implementers. This should be accompanied by training health workers in correctly applying exemption and waiver criteria. Attention should also be given to adequately remunerating health workers so as to reduce the incentive to take bribes and to offer waivers and exemptions to ineligible clients. In the respondents' opinion, these strategies could substantially alleviate the negative effects of user fees.

6.6.4 Views from non governmental organisations

Similar to the previous stakeholder groups, NGO resource persons considered Tanzania's user fee policy as such not bad. Their concerns were related to the (f)actual implementation of the policy. Resource persons argued that the planned goals have not been achieved and that the exemption mechanisms are not properly functioning. Little money has been collected from user fees and it is not clear whether the money has been used according to the original objectives. Moreover, user fees have added an exclusion potential to the already existing factors that hamper access and use of services by the poor. Governance and accountability regarding the collection and management of funds also raised concerns among this stakeholder group.

Contrary to the previous groups, the resource persons did consider the abolishment of user fees as a feasible alternative. However, they caution that unless proper incentives are established, unofficial payments may replace official fees and exclusion of the poor and vulnerable will continue. Similar to the other groups, they pointed to the need to collect data and analysed how much money is actually obtained from fees and how it is spent. In terms of a pro-poor health financing policy, resource

persons suggested to design a policy that ensures that poor people are not priced out of the health care system, combined with a policy to allocate more funds to a basic package of quality health services that can be accessed by especially the poor.

In relation to the next PRS, the respondents were of the opinion that the position that user fees, CHF and alternative complementary financing mechanisms should be taken on board and should be effectively strengthened as part of the long-term strategy of using the health sector as a tool to fight poverty. Mechanisms should be designed to ensure that the next PRS is implemented in a selective manner, meaning that those who are able to pay do so and those unable to pay are actually exempted. The respondents did not find the achievements of the PRS over the last three years encouraging, particularly in relation to health. In their opinion, the health chapter had not been adequately mainstreamed in the PRS process. It was felt that the government commitment to financing health services is proportionally declining as compared to donor funding, which is increasing. More in general, the PRS is largely donor-driven around specific project and programmes, which are unfortunately not properly coordinated.

6.7 Lesson learned and policy recommendations from literature review

6.7.1 User fee systems

General key lessons
Over the past years, authors have summarized the lessons learned from the implementation of user fee systems and various safety nets. The recommendations predominantly relate to strengthening existing user fee systems. The study team has included detailed overviews of reference material in the Technical Paper (Part 5). Bennet and Gilson (2001) have identified the following key lessons;

- It does not make sense to assess whether or not a single financing mechanism is pro-poor; such an assessment must be carried out with respect to the complete mix of financing mechanisms and their interaction with resource allocation approaches and organisational contexts.
- User fees and community-based health insurance are unlikely to be equitable or sustainable if they are the prime source of health finance. In order to protect the interests of the poor they should be viewed only as a means to 'top-up' other financing systems (such as tax revenues and social health insurance).
- Although a financing system may in design be pro-poor, it is important to think about whether or not it is feasible to implement this design. In practice political pressures may prevent shifts in resource allocations to the poor, and limited government capacity may hinder the effective implementation of exemption schemes to protect the poor, or may prevent the promised gains in quality of care from actually materializing.
- Poor people's access to health care is often constrained by low quality care, high transport costs, long waiting times and inconvenient opening hours. Financial reforms, which deliver improvements in these dimensions of quality at a moderate price, particularly in relation to hospital care, will probably benefit the poor.
- The effective development and implementation of pro-poor financing policies is never a once-only action, but always the result of a sustained approach that allows adaptation over time in response to experience and changing circumstances. Within such an approach, it is essential that as much attention is given to strategies that build and maintain support for the policies over time, as to technical adaptations of policy design.

Inventory of lessons learned: four core sets.
In 1997, Gilson identified four core sets of lessons learned (see for the elaborate version Technical Paper Part 5). They are still valid since other authors confirm this set and come up with similar recommendations (also in more recent publications) (see e.g. Kipp et al, 2001; Nyonator & Kutzin, 1999; Newbrander & Sacca, 1996; Bennet & Gilson, 2001). Key questions and main lessons learned are:

1. *What are key bottlenecks to the effective implementation of user fees and safety nets*? (1) Weak design of user fee systems, (2) weak capacity for local level financial management and fee system implementation, (3) weak supporting systems, and (4) contextual constraints.
2. *Where and when to implement user fees*? (1) Fee implementation should focus on the hospital level and should be associated with risk-sharing mechanisms and exemptions, and (2) fees should

be part of a wider health care financing strategy rather than as central or only mechanism for addressing resource constraints.

3. *How to enhance the impact of user fees on their objectives*? User fees should be: (1) part of a broader health sector policy, (2) initiated within a coherent financing framework, (3) supported by complementary government policies that promote sustainability and address underlying health system weaknesses, and (4) built on various aspects of contextual support.
4. *How to strengthen the process of implementation*? Addressing the known problems of effective user fee policy implementation requires: (1) consideration of the overall process of policy development and implementation, (2) consideration of contextual factors, and (3) comprehensive rather than selective processes of reform. Possible stages in such a process are described in Technical Paper Part 5. Key strategies include: (1) advocacy before, during and after implementation, (2) information strategies, (3) quality improvements prior to implementation, (4) involvement of a wide range of actors, and (5) gradual and differentiated (at different levels) implementation. Necessary conditions are: (1) strong and consistent leadership of Ministry of Health, (2) capturing and use of relevant information, and (3) development and maintenance of consensus.

6.7.2 Exemption and waiver systems

Guidelines for the design of successful user fee-waiver systems

Based on the analysis of various country studies, Bitran and Giedion (2003) formulated a range of practical guidelines with the purpose to contribute to the design of successful user-fee waiver systems. Countries that carefully designed and implemented their waiver systems have had much greater success in terms of benefits incidence than those countries that took a more improvised approach. The key to successful user-fee waiver systems for the poor in some countries – Thailand and Indonesia – included (1) timely compensation to providers for revenue forgone from granting exemptions, (2) widespread dissemination of information to potential beneficiaries about waiver availability and procedures, (3) non-fee support to poor patients for costs of food and transportation (as in Cambodia), and (4) clear criteria for the granting of waivers (Bitran et al, 2003). The following guidelines are recommended:

- An explicit national policy on waivers and exemptions should be in place, which includes guidelines for facilities, clear definitions of target beneficiaries and identification criteria that are easily verifiable. The use of the income criterion alone for eligibility determination is questioned. Case information points to a need to complement the income criterion with other information, or to use other, more observable poverty proxies instead. The poverty definition ought to respond to local circumstances and must be adapted to the specific cultural context.
- Key to the success of waivers and exemptions systems is the sufficient and timely financial compensation of providers (instead of expecting them to absorb the cost). It is unreasonable to expect that underpaid health staff that are responsible for, and have the ability to charge user fees, will act in accordance with general equity principles by providing appropriate levels of exemptions. A well-performing system of waivers and exemptions in government health facilities must be in harmony with institutional and individual staff objectives. More specifically, government funds or external funding from donors or lenders are required to grant providers with the appropriate and minimum financial incentive to exempt the poor.
- Compensated user-fee revenue should reach health facilities promptly (timeliness of compensation). Where compensation exists, it must be timely; otherwise the cost of delayed reimbursement may be transferred by the provider to the poor, in the form of higher fees or lower (or fewer) exemptions. Policies seeking to improve the protection of the poor should therefore seek to streamline any bureaucracy involved in the reimbursement of facilities for exemptions granted. Reimbursement procedures may be timelier in various ways (e.g. the regular allocation of compensation funds from the central level to regional health authorities, or to regional funds, may make compensation more opportune and predictable; or, in the absence of a decentralization framework, monthly budgets sent from the central level to facilities may include an “exemptions allowance” equal to the monthly target for that facility, with any (relatively smaller) adjustments for differences between actual and budgeted exemptions being made later).
- In the absence of effective performance monitoring and evaluation systems, it is not possible to measure performance of waivers and exemptions and to take any required corrective measures. Regular monitoring of pro-poor protection systems should at a minimum, through routine facility recording and via periodic household surveys: (1) Record exemptions and waivers granted, (2) When using individual targeting, establish a data base containing basic information on

beneficiaries such as identity number, name, age, sex and geographic location, (3) compare actual exemption and waiver levels with targets and (4) estimate coverage and leakage of protection mechanisms.

- Fee levels and income-eligibility thresholds need to be adjusted and updated periodically. Otherwise, countries may inadvertently hinder access to medical care or induce facilities to adopt their own fee schedules. There is no single answer to who should be responsible for the exemption process, but those determining eligibility should be aware of the selection criteria; be adequately trained; and be fully informed about the constraints governing the waivers process. Providers need clear written guidelines about how waivers and exemptions should work, with enough flexibility to allow for regional or local variation if necessary.
- The poor should not only be waived for user fees but also be reimbursed for their access costs to health care beyond fees, such as transportation, lodging, food costs and opportunity cost.
- Disseminating pro-poor protection policies and mechanisms. Under-coverage will be a constant problem when the poor do not know they are eligible for free or subsidized care and when health facilities are not aware of whom to exempt or waive. Likewise, the population should be informed about the existence of certain exempted services.

6.7.3 Community Health Funds

Both Chee et al (2002) and Shaw (2002) have provided recommendations to strengthen the design and implementation of CHFs. They include short-term and long-term recommendations.

Table 6.5: Short-term and long-term recommendations to strengthen CHFs

Short-term	Long-term
▪ There should be an affordable prepayment membership fee. The benefit package and entitlements should be attractive. ▪ There should be a choice of different providers close to the vicinity of CHF members. ▪ There should be reimbursement to the CHF for exemptions provided to poor people. ▪ Effective social mobilisation should increase the CHF membership.	▪ Strengthening capacity of the DHMT required ensuring improved supervision and technical support of the CHF. Overall education and promotion is needed to increase understanding of the benefits and management of the CHF. More effort is required to involve district and community leaders in promoting and managing the CHF.
▪ The goal of the CHF should not be focused solely on maximizing enrolment rates, but rather on improving overall management.	▪ Analysis of the financial impact of covering hospital-based services is needed to ensure that hospital care does not deplete CHF funds.
▪ Procedures for utilizing funds collected in wards without health facilities should be developed. It is also important to determine how those WHCs will participate in oversight of CHF funds and health services.	▪ Implementation of an exemption policy is required to ensure that the poor are not excluded from accessing services.
▪ Procedures for record-keeping should be improved to ensure that funds are properly accounted for and deposited. In addition, training should be provided to staff to ensure that they understand the procedures.	▪ Strengthening the WHCs is required so that they can more actively oversee the CHF. Developing mechanisms to encourage community participation in managing the CHF would also be useful.

Source: Extracted from Chee et al, 2002 and Shaw, 2002

6.7.4 Overall conclusion

Conclusion

The overview of lessons learned and practical guidelines shows that there is sufficient experience and information available to come to the design of successful pro-poor health financing strategies. Tanzania has identified a health financing system that currently consists of a mix of strategies; (1) user fees at different levels but still predominantly at hospital level, (2) exemption and waiver systems for vulnerable and poor people, (3) public and private CHF strategies, and more recently (4) an insurance scheme for civil servants. In that sense, Tanzania has adopted a multiple risk pool approach.

We have seen that important health financing approaches have been put in place over the past years. We also must acknowledge that major constraints are being experienced with the actual implementation of the various strategies (despite their good intentions and assumptions). It has become evident that the current user-fee waiver ands CHF system has a tremendous negative impact

on the access to health services for poor people. It has been estimated that in some areas poor people and specific categories (e.g. women, orphans, disabled) may constitute 30-40% of a District population. If Tanzania is truly committed to poverty reduction, as articulated in its PRS, it will be crucial to include effective pro-poor health financing strategies in the next PRSP. This will without doubt lessen the daily burdens and concerns of poor people.

VII CONCLUSIONS

Poverty and health
More than half of the population (17,500,000 people) in Tanzania lives below the poverty line. As many as 40% lives in abject poverty. Health indicators reflect that the since 1990, life expectancy has reduced; Infant Mortality Rates, Under 5 Mortality Rates, prevalence of child malnutrition and prevalence of HIV among women are stagnant; and that the number of births attended by skilled health staff has declined. Many Tanzanian households are affected by ill-health. Patients with HIV/AIDS related illnesses occupy approximately 50% of the hospital beds. HIV/AIDS, gender, urban-rural disparities and poverty strongly affect positive health outcomes. The immunisation rate of under-five children in the poorest 20% of the households is 25% lower than in the wealthiest 20% and stunting among the children in the poorest households is 22% higher. Only 27% of births in the poorest quintile are attended by a medically trained person compared to 81% in the wealthiest quintile. There is an urgent need to undertake appropriate measures in order to reverse the impact of poverty on the health status of the poor.

PRSP
While the PRSP is *the* document to design such measures and to address poverty and health related issues, it must be concluded that this is not adequately taken up yet. The PRSP takes a pro-poor approach in some areas, but does not sufficiently discuss the difficulties of achieving the set health targets in the poorest regions and among the poorest population groups. The PRSP and progress reports indicate a lack of country-specific, poverty-related health data. They do not discuss financial and non-financial barriers for the poor to access health services, they do not sufficiently report on the impact of user fees, and they fail to propose measures to adequately protect the poor against the possible adverse impacts of user fees, such as exclusion or reduced access. It is concluded that the PRSP is not yet sufficiently analytical and evidence-based in the formulation of its health and poverty reduction strategies, and as a result fails to adequately address the negative impact of user fees.

Health sector strategies
It is concluded that Tanzania has come a long way with the implementation of its health sector strategies. Since the 1990s, Health Sector Reforms and SWAp have been put in place to ensure well coordinated, joint funding mechanisms and performance monitoring systems for the public health sector. This has generated a wealth of information and valuable insight in the progress of the health sector.

Health delivery network
Health services in Tanzania are provided by the public sector, the private non-profit sector and the private for profit sector. This substantial network of facilities does not imply that people have equal and adequate access to quality health services. Quality of care is severely affected by the under-distribution of qualified staff to the remote and rural areas. There is an absolute gap of 20,000 full time health workers. It expected that this will triple to 60,000 in 2015. It can be concluded that improved quality of health services cannot be achieved if no adequate measures are taken. It is evident given the current situation that the PRS and MDG objectives cannot be achieved.

Public health spending and pro-poor initiatives
Tanzania has undertaken important measures to strengthen its pro-poor financing in the health sector. Positive developments include an increase in OC expenditure (e.g. medical supplies and drugs) for the MOH administration, for hospitals, for preventive services and for the total government recurrent expenditure. The increased distribution of allocations to local councils and the overall block grants for health to LGA level (almost 20% increase in FY04) shows evidence of the government's commitment to devolution. An important strategy is the new Equitable Resource Allocation Formula (ERAF) which aims to redirect resources towards the poor. This indicates that the government is undertaking serious pro-poor efforts.

Public health spending and concerning developments
However, given the sizeable financing gap, it is doubtful whether the formulated health strategies can be achieved and the quality of health services can be improved. Under-expenditure has been identified as a major constraint and available funds do not always reach the intended beneficiaries. Widespread leakages of OC funds include (1) fewer allocations of funds to dispensaries and health centres than planned, and (2) a lack of transparency regarding the disbursements and allocation of

funds to dispensaries and health centres. This clearly is *not* a pro-poor development since it severely affects the people who require health services at PHC level. This observation implies that even if public expenditure at central level is pro-poor, the leakages of funds *within* the districts can counteract this initiative. This means that massive efforts for improved accountability should be directed to the district level in order to ensure that funds reach the intended beneficiaries. While the share of the health sector in the government budget is declining, the proportion of foreign funds has gone up. This trend has been strongly criticized by the donors, who have questioned the true commitment of Tanzania to the PRSP objectives. The reasons for the declining GOT commitment to health did not become clear in this study, but it certainly is a trend that should be reversed.

Contribution of the user fees and CHF to the health resource envelop
Reliable and transparent user fee income data for district, hospital and PHC level in the health system are difficult to obtain. The available data are merely indicative for what is happening at the different levels. Revenues raised from user fees at the hospital level have been low compared to what has been projected. Data reflect huge variations and a decline in cost sharing revenues. The reasons of the reported decline are unclear. The data reflecting the contribution of the user fees and CHF to the health budget at District Council level shows huge variations as well. The reported user fee income proportion for the District Health Budget was on average 10.5% but variations between 1% and 22% were reported. It could not be established how the income from cost sharing and the CHF was re-distributed by the council to PHC facilities or priority areas. It was furthermore found that a number of councils do not spend all the health resources in the health sector! It is clear that there is an urgent need for (1) more accurate and comprehensive record keeping at local council level, and (2) more costing and tracking studies to obtain a better picture on cost sharing and expenditures.

It is concluded that the national projections of the cost sharing schemes do not reflect an accurate picture since the data are based on the financial data received from the districts. It can be assumed that the actual and projected data on user fees, CHFs and HSF are under-estimations of the real income collected at different levels. This means that the MOH should actually receive a higher income and faces a loss of income that cannot be re-distributed into the health sector. On the other hand, it implies that people (both wealthy and poor) probably pay more than what is officially reported. The actual potential and use of the non-reported user fees are not known. Hence, it is not unclear what people actually pay for the health services they receive.

The total contribution of the cost sharing schemes (excluding NHIF) to the national health resource envelope for FY03/04 is 1.67 Billion Tshs. This equals a contribution of only 0.6% to the overall budget for the health sector. In total, this is US$ 1.56 million (and on average US$ 13,805 per district). It was established that this amount would be the lost revenue if user fees would be abolished in the health sector. This is a much lower amount than the amount of lost revenue lost in Uganda (US$ 6 Million), while Tanzania has a larger population. Given the size of the total health budget (US$ 260 million), it can be concluded that the *officially* reported user fees contribute only a small proportion to the overall health sector resource envelope in Tanzania. The actual revenue generated does not meet the initial expectations. There is limited positive evidence indicating that user fees in Tanzania have achieved their original objectives of sustainability, drug availability, quality of care, equity and access for the poor.

Contribution of revenues to the quality of services at PHC level
It can be concluded that the reviewed documents do not reflect a differentiated and representative overview of the contribution of user fee income to improved quality of services in health centres and dispensaries. User fees were not systematically collected in all PHC facilities since 1999. Some areas are known to have refrained from introducing user fees at this level. Available data are not transparent. It was observed that government-run PHC facilities appeared to face severe shortages of drugs and supplies. User fees were not always retained at PHC level but deposited in the HSF account which mainly benefits the purchase of supplies for the District hospital instead of PHC facilities. Positive results were seen with the re-investment of CHF funds. In total, 50% of the health workers and patients reported improvements in the health facility (drugs availability, diagnostic facilities and maintenance). However, it can be concluded that equity criteria for the distribution of available resources from the user fee income to PHC level are not systematically followed.

Importance of the public PHC facilities for poor people
It is clear that government health centres are the main choice for *out-patient* care for the poorest people (for 70% in the poorest 20% of households). In 2003, two-third of the rural households used government dispensaries and health centres for most treatment. Only 14% of the rural households resorted to the private facilities in first instance. There is unequal access for the poor in terms of *in-patient* hospital care. Wealthier individuals consume a greater relative share of all services. Given the importance of the public PHC facilities for poor people, it can be concluded that further extension of user fees to PHC level without effective exemption and waiver mechanisms for vulnerable and poor will contribute to further exclusion.

Impact of user fees
User fees have disproportionally affected the access to health services for vulnerable and poor people. In Tanzania, user fees are regressive and contribute to substantial exclusion, self exclusion and increased marginalisation. Fees at PHC level have contributed to negative effects on the rural poor population, particularly among women and children. The main barriers forming a deterrent to use among poor people include: (1) the real costs of health treatment (formal, informal and additional charges), time and real distance to a health facility where quality services can be obtained, (2) reduced ability to afford health services, (3) refusal of treatment if people cannot pay (especially for women), and (4) inflexible modes of payment. People report to have resorted to desperate measures in order pay for health services.

Not only poor people are excluded from adequate access to health services. This is also the case for specific categories of vulnerable people. Categories of people that experience consistent (self) exclusion are: (1) pregnant women from poor households, (2) under-five children from poor households, (3) orphans and especially double orphans, (4) widows, (5) people older than 60 years, (6) people with disabilities, and (7) AIDS patients. It is evident that many households have been pushed further into poverty by illness and the depletion of resources. It can be concluded that extension of user fees to PHC level will further aggravate the exclusion of poor people. As such, user fees act in opposition to all efforts geared towards alleviating poverty.

Exemption and waiver systems
It is concluded that the ineffectiveness of exemption and waiver mechanisms is a *core* problem in the user fee discussion. A functional exemption and waiver system is actually non-existent putting vulnerable and poor people at risk by practically denying them access to public health services. This applies both to (1) the exemption and waiver system in health facilities and (2) the exemption mechanisms instituted for the CHFs. In both situations, poor people just do not receive the exemptions to which they are entitled to! As a result, the majority of the poor people are not granted an exemption for the payment of a user fee or a CHF premium and hence have no access to basic public health services. The private sector (non-profit and profit) does not follow an exemption and waiver system and request higher (official) user fees then the public sector. As a consequence the private sector contributes to increased demand for services in the public sector.

From the onset of the introduction of user fees in 1993, the GOT had a clear intention not to compromise its traditional strategies of equity, universal access and affordability. However, this has clearly not been achieved with the current exemption and waiver systems. A key conclusion from this study is therefore that the current user fee policy should not be extended to the level of health centres and dispensaries. It would be too easy to say that the user fee policy can only be extended, unless and until a parallel, effective and affordable exemption and waiver system to ascertain access to health services by the poor people is in place. There is substantial evidence that exemption and waiver systems do not guarantee increased access to health services for poor people unless major adjustments in the design, implementation and funding for adequate exemption and waiver systems take place. In the light of recent developments in Uganda and Kenya, it seems a much more realistic approach to compare the costs of (1) the suspension of user fees at PHC level against the required costs for (2) improved exemption and waiver systems or (3) improved NSHIF approaches in the contest of abolishment of fees and to opt for the most pro-poor and cost-effective approach within the shortest possible time frame.

CHF

It can be concluded that the introduction of the CHF has not provided the expected benefits for poor people. Severe delays have been experienced with the introduction of the CHFs. The management of the CHFs at district level is still weak and financial management at a lower level is even weaker. According to the CHF Act, the user fees paid at public health centres and dispensaries should form a source of income to the CHF. The premium paid to the CHF will receive WB matching funds. This fact puts more pressure on the PHC facilities to raise income through the user fees. It can therefore be assumed that the introduction of user fees at PHC level is driven by the fact that user fees *have* to form a source of income for the CHFs. This shows a very complicated dilemma since this means that if user fees will be suspended or abolished at PHC level, the CHFs will not be able to take off as planned and will not receive part of their required resources! However, it has become evident that poor people can *not* afford the CHF membership.

It has become clear that the introduction of the CHF has brought in a whole new dimension to the user fee discussion. However, the actual benefits for poor people are unknown at this stage. The CHF can provide exemptions to poor people but does not do this sufficiently. It can be assumed that if poor people are not exempted from the payment of the CHF premium and co-payments (and still existing user fees), the impact of the CHF will be disastrous. There are signs that double exclusion and adverse incentives among health workers will affect the successful implementation of the CHFs in Tanzania. If the CHF is continued to be considered as the panacea for poor people, then poor people will either have to get a lower premium or, will have to receive a free membership card which entitles them to a basic health care package in a health facility.

It is concluded that for Tanzania, it is absolutely not clear at this stage what the equity implications will be of its multiple risk pooling strategy. A process has been set in motion without really knowing where it will lead to (and where it will end) and how it will affect vulnerable and poor people. It can be concluded that there is an urgent need to review the ongoing process and assess its impact on the overall health system and vulnerable members of the population before the user fees and CHFs are introduced further.

Mitigation of negative impacts

This report and the subsequent Technical Paper identify important, practical lessons and policy recommendations on how to mitigate the negative impacts of user fees and how to strengthen exemptions, waivers and CHFs. As we see it at the moment, Tanzania can opt for two strategic directions. One strategy can be to continue on the road of the multiple risk pooling strategies. The other strategy can be to follow the abolishment of user fees at either (1) all levels or (2) at PHC levels. Both strategies will require substantial support from external donors and will require major adjustments in the current funding mechanisms. However, given the negative equity implications for poor people with the multiple risk pooling systems and the complicated, time consuming, costly and unreliable administration that is required for user fee systems and CHF, evidence indicates that it seems a more pro-poor and pragmatic strategy to abolish the user fees for poor people either (1) temporarily till improved exemption and waiver systems have been designed or (2) as long as the poverty situation in Tanzania requires.

In case Tanzania will opt for the continuation of a multiple risk pooling system, then a number of key conditions will have to be met in order to ensure access to health services for poor people. It will be crucial to assess the mix of financing mechanisms and their interactions rather than look at them as stand-alone policies. Furthermore, user fees should be: (1) part of a broader health sector policy, (2) initiated within a coherent financing framework, (3) supported by complementary government policies that promote sustainability and address underlying health system weaknesses, and (4) build on various aspects of contextual support. Necessary conditions are: (1) strong and consistent leadership of the MOH, (2) collection and use of relevant information, and (3) development and maintenance of consensus. Regarding waivers and exemptions, the evidence demonstrates that:

- An explicit national policy on waivers and exemptions should be in place, which includes guidelines for facilities, clear definitions of target beneficiaries and identification criteria that are easily verifiable.
- Key to the success of waivers and exemptions systems is the sufficient and timely financial compensation of providers (instead of expecting them to absorb the cost).
- Compensated user-fee revenue should reach health facilities promptly.

- In the absence of effective performance monitoring and evaluation systems, it is not possible to measure performance of waivers and exemptions and to take any required corrective measures.
- Fee levels and income-eligibility thresholds need to be adjusted and updated periodically. There is no single answer to who should be responsible for the exemption process, but those determining eligibility should be aware of the selection criteria; be adequately trained; and be fully informed about the constraints governing the waivers process. Providers need clear written guidelines about how waivers and exemptions should work, with enough flexibility to allow for regional or local variation if necessary. Several resources point to the central role of communities in this process.
- The poor should not only be waived for user fees but also be reimbursed for their access costs to health care beyond fees, such as transportation, lodging, food costs and opportunity cost.
- Under-coverage will be a constant problem when the poor do not know they are eligible for free or subsidized care and when health facilities are not aware of whom to exempt or waive. Likewise, the population should be informed about the existence of certain exempted services.

For Community Health Funds, both long- en short term recommendations have been identified. Key recommendations include:
- There should be an affordable prepayment membership fee.
- The benefit package and entitlements should be attractive.
- There should be reimbursement to the CHF for exemptions provided to poor people.
- Procedures for record-keeping should be improved to ensure that funds are properly accounted for and deposited. In addition, training should be provided to staff to ensure that they understand the procedures.
- Overall education and promotion is needed to increase understanding of the benefits and management of the CHF. More effort is required to involve district and community leaders in promoting and managing the CHF.
- Implementation of an effective exemption policy is required to ensure that the poor are not excluded from accessing services.

Scenarios and reflections
Considering the severe poverty situation in Tanzania, it is concerning to find that many stakeholders continue promoting and supporting user fees in the absence of effective exemption and waiver systems. This does not correspond with the commitment to reducing poverty in Tanzania as articulated in the PRS. Consequently, immediate political action is required. Looking at strategies for improvement, it is clear that the results of the abolition of user fees for health and education in Tanzania, South Africa and Uganda have been impressive. In Uganda, improvements have been observed in terms of attendance, morbidity and mortality. There also is evidence that access to health services for the poor has improved. As such, abolition can be considered as a pro-poor option to reduce exclusion and self-exclusion among the poor and vulnerable. The studies illustrate, that the abolition of fees needs to be combined with considerable efforts in other areas, such as changed levels of funding (internally and externally), improvements in the allocation and disbursement of funds, improved human resource development, improved incentive schemes for health workers and improved quality of services. This indicates the importance of a broad, strong political support and donor support.

When reviewing the stakeholders' attitudes towards abolition of user fees, it seems that such support seems presently lacking in Tanzania. However, the developments in Uganda and Kenya might have created a momentum for Tanzania to re-think the current multiple risk pooling strategies in the context of the PRS Review and to opt for more pro-poor health strategies. It should be noted that in the current political situation strengthening the existing exemption and waiver systems seems to be the most preferred scenario at this moment. Specific strategies for this have been described above. However, in the light of all the constraints mentioned and in the context of positive developments in Uganda and recent decisions taken in Kenya, the study team would like to recommend to include the suspension of user fees at PHC level in the next PRS document for Tanzania as a real pro-poor health strategy for Tanzania.

As noted by Walford (2001), the PRSPs and PRS processes provide an excellent opportunity to facilitate changes in existing user fee policies and to improve their equity impact. PRS processes can serve as a way to bring poverty up the national and health agenda. Furthermore, they can provide an opportunity to re-open areas of health or budget policies where there is no pro-poor strategy in place.

Finally, they provide an opportunity to lobby key development partners on critical issues that affect health services and health, and to agree on key milestones for sector progress and priorities. The study team hopes that the findings of this study will contribute in such a positive and constructive way to the Tanzania PRS Review Process.

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TECHNICAL PAPER

PART 1 BACKGROUND TO CHAPTER 1

Literature review

Two models of user fee systems

The 'standard model' assumes that fees not only generate resources, but also efficiency and equity gains. Efficiency gains result from the introduction of price signals, which offer incentives for the appropriate use of the referral system by patients, and facilitate the reallocation of resources to more cost-effective primary health care. The equity benefits result, firstly, from the use of resources in ways that benefit the poor (e.g. improvements in coverage and quality of primary health care), and secondly, from the use of exemptions or differential charges to protect the poor. It has been recommended to introduce the 'standard model' nation-wide, starting with curative hospital services, accompanied by decentralisation of resource use control to regional or district level. It is assumed that this combination will facilitate efficient and equitable use of resources (Gilson et al, 1995; in Gilson, 1997).

The 'Bamako Initiative model' aims at the attainment of sustainable financial resources, assured essential drugs, sound management, and decentralised decision-making. It emphasises that revenue should be raised and controlled at the primary level through community-based activities. Community participation in user fee management is a critical mechanism for ensuring (1) that revenues are used in ways that address persistent quality weaknesses, and (2) that there is accountability to the users. The particular financing mechanism adopted should also be decided on by the community (Jarrett and Ofosu-Amah, 1992; McPake et al, 1992; in Gilson, 1997).

Documented equity implications of user fees

The reviewed studies highlight the following equity implications of user fees

1. *Utilization and exclusion*. Studies demonstrating that the introduction of user fees had a positive impact on utilization and inclusion are limited. According to Mackintosh and Tibandebage (2001), the successes are often ignored or under-researched.[1] Ridde (2003) cites two positive examples from Cameroon and Niger.[2] Kipp et al (2001) demonstrate increased utilization rates after the introduction of cost-sharing, which they relate to high community participation in design and implementation.[3] In virtually all cases where user fees were increased or introduced, however, there has been a parallel decrease in service utilization. The magnitude of this drop was frequently larger, and the effect of a longer duration, among poorer and vulnerable population groups. Fees by themselves tend to dissuade the poor more than the rich from using health services, and have been shown to be associated both with delays in accessing care and increased use of self-medication and informal health care. In total, it is estimated that 5-30% of the population of sub-Saharan Africa is unable to pay for health care and as a result does not have access (Ridde, 2003; Wilkinson et al, 2001; various authors, in Gilson, 1997; Bennet & Gilson, 2001; Kivumbi & Kintu, 2002; see also Price, 2002; WHO; UNICEF; Nyonator & Kutzin, 1999). In Kenya, introduction of fees resulted in a decrease of outpatient attendance by 27% at provincial hospitals, 46% at district hospitals and 33% at health centres. In Zambia, outpatient attendances dropped by 35% after fees were introduced and in Ghana a 40% decrease was noted after fees were introduced (Burnham et al, 2004:187).

[1] "Yet the efforts of those who keep some facilities working decently against the odds and who resist the incentives to impose and pocket informal fees are often denied or denigrated; the successes are often at best ignored, at worst undermined" (Mackintosh & Tibandebage, 2001).

[2] The study in Cameroon demonstrated that with an improvement in the quality of care, introduction of fees went hand-in-hand with an increase in service utilization. The increase was proportionally larger for the poor than for the rich. The second study in Niger illustrated that establishment of a user fee system (local tax + low patient contribution), accompanied by measures to improve quality (medicines) and exemptions (with a proper definition of the sector of the population concerned), increased attendance at a health centre by the poor (Ridde, 2003). However, commentaries on these reports express doubt whether the projects can be successfully repeated and applied elsewhere, particularly since they were supported by outside specialized technical assistance and considerable external funding (Ridde, 2003).

[3] The authors mention four possible reasons why utilization rates increased in rural areas (in which the poor tend to cluster): (1) a community initiative was promoted rather than a government cost-sharing programme; (2) local people were empowered to decide how the financing schemes should function and how much should be charged; (3) the communities gave substantial support to health staff in local health facilities; and (4) the communities in rural areas had more ownership of cost-sharing schemes than did those in urban areas (Kipp et al, 2001).

2. *Groups with most regressive outcomes for user fees*. Population groups that have been identified as being most vulnerable to payment difficulties are: (1) women, particularly widows, divorcees and unmarried women with children (i.e. female-headed households); (2) the very old, especially those who live alone and are too old to earn an income; (3) the ultra poor; (4) those without extensive family and social networks (because common strategies to cope with payment difficulties include borrowing from family or friends); and (5) households with high dependency ratios, particularly those with many young children and elderly dependents (Booth et al, 1995, based on a study in Zambia; cited in Russell, 1996; see also Bangser, 2002, on the impact of user fees on women).

3. *Trade-offs at the household levels.* Few studies have analyzed the impact of user fees at the household level (particularly poorer households) and their ability to pay (impact on household budgets, consumption and investment decisions). Russell (1996) points out that this is, nevertheless, an extremely important area of attention, since households often face a combined user fee burden from various essential services. Russell's study concludes that households, in order to mobilize resources, may sacrifice other basic needs such as food and education, with serious consequences for the household or individuals within it. Common household responses to payment difficulties ('coping strategies') range from borrowing to more serious 'distress sales' of productive assets (e.g. land), delays to treatment, use of informal and less effective sources of health care, and, ultimately, abandonment of treatment. Further impoverishment of already marginalized families has also been reported (Russell, 1996; Gilson, 1997).

4. *Nature of payment scheme*. The nature of the payment mechanism has an important influence on its utilization and equity impact. Pure user fee systems are more likely to enhance inequities in access to health care than those which allow for risk-sharing and/or pre-payment (various authors; in Gilson, 1997).

5. *Barriers other than fees*. Several authors point out that in addition to prices, other factors pose a barrier to accessing health care, particularly for the poor: (1) quality of care, (2) travel time, (3) travel costs, (4) waiting times, (5) staff attitude, and (6) inconvenient opening hours (see e.g. Price, 2002; Bennet & Wilson, 2001).

6. *Safety nets*. The implementation of both formal and informal exemptions is usually ineffective and fails to protect the poor (and may benefit more wealthy groups). In some cases, there is a lack of official exemption categories or a lack of good understanding of these categories (see e.g. Nyonator & Kutzin, 1999). Exemptions are rarely implemented when the primary objective of the fee system is financial sustainability, because they necessarily lower revenue generation levels. The differential implementation of fees between geographical areas within a country can create geographical inequities as more wealthy areas charge less than poorer areas, particularly if regions of different income level are expected to recover similar proportions of their cost (various authors; in Gilson, 1997).

7. *Quality*. Increases in user fees have rarely been accompanied by improvements in quality (Bennet & Gilson, 2001). Various country studies suggest that if fees are associated with quality improvements (e.g. increased availability of drugs in health facilities), their negative impact on utilization appears to be offset, and the introduction of fees-plus-quality improvements may even generate utilization increases among the poorest (see e.g. Nyonator & Kutzin, 1999). However, the required quality improvements cannot be addressed simply by revenue collection (various authors; in Gilson, 1997; Nyonator & Kutzin, 1999).

8. *Potential of fees at hospital versus primary care leve*l. There appears to be a greater potential for user fees within hospitals rather than in primary facilities. Generating higher revenue levels without harming the poor appears to be most possible where the presence of risk-sharing arrangements allows cost-recovering fees to be charged for those insured against the need for hospital care. This finding is based on positive outcomes of cost recovery schemes at hospital levels in China, Zaire, Brazil, Korea and Kenya (various authors; in Gilson, 1997).

9. *Adequacy of revenue generated*. Fees do not appear to generate adequate revenue or to be associated with the resource allocations necessary to enable substantial, sustained improvements in health care for the poor (various authors; in Gilson, 1997).

10. *Management.* While the effects to date of user fees on the poor appear almost universally negative, in virtually all cases this has been the result of weak design, planning and implementation (Bennet and Gilson, 2001; Gilson, 1997). Experience from a few small-scale user fees schemes with heavy technical assistance inputs and evaluation components suggests that if appropriately designed and implemented, user fees may deliver benefits to the poor (Bennet & Gilson, 2001; see also Ridde, 2003).

11. *Transparency*. The way services are priced within and across facilities are difficult for potential patients to assess. A way of promoting transparency and limiting 'leakage' in fee collection is to keep accurate records of amounts charged and issue receipts. 'Under-receipting' may indicate under-the-table payments requested of patients. Transparency can also be increased through advertisement of fees within the premises of the facility, preferably at the point of fee collection (Nyonator and Kutzin, 1999).

12. *Increasing voice.* In general, neither those responsible for implementation nor the community have had much involvement in the design of systems that most immediately impact on them (Bennet & Gilson, 2001). This indicates that the contribution of cost-sharing/user fees to increasing the voice of the users of health care has been limited.

Exemption and Waiver systems

Exemptions are used to automatically provide free care because the patient has the characteristic of being targeted. Exemptions can e.g. be provided for certain kinds of health services.[4] A waiver is used to reduce or eliminate fees for the poor, based on an assessment of their ability to pay. As such, waivers relate to direct targeting. The problems commonly associated with these mechanisms are under coverage and leakage. Under coverage occurs when the poor do not receive the intended benefits, because they are by error categorized as non-poor or because they must still pay the fee despite their waiver. Leakage occurs when the non-poor receive benefits intended for the poor. (Grosh, 1994; in Newbrander & Sacca, 1996). Kivumbi and Kintu (2002) mention an additional safety net form, namely the provision of credits. In this case, patients willing to pay at a later time receive treatment on credit.

Best practises of providing waivers to the poor were found in; (1) Thailand, where 80% of the population living below the national poverty line had been given a free health card through a pro-poor target system which included geographic targeting combined with income testing and group targeting; (2) Indonesia where in some provinces 89% of all poor families received a waiver through a pro-poor target system that included geographic and individual targeting combined with uniform poverty proxies; and (3) in Chile where the coverage of the poor population was 90% as a result of? a targeting system that included income thresholds, type of services and other poverty proxies. The lower level services were free. The leakages were high, meaning that non-poor were also included. The system in Chile was found to be the best practise in promoting equity in access and in financing (Bitran et al, 2003).

Community Health Fund

There is great variety in CHF design, some offering specific health service packages and others excluding categories of health services. CHFs are prepaid schemes, where a fixed annual membership fee entitles households (or individual patients) to free health care, while non-members have to pay user fees on a fee-for-service basis. Membership fees are commonly set according to the risk faced by the average community member. This means that there is no distinction in premiums between high and low risk groups. Unlike social health insurance schemes, enrolment is generally voluntary and not linked to employment status (Bennet & Gilson, 2001 and Bonu, 2003).

[4] In Uganda, categories of patients to be exempted include children under 5 years of age, patients suffering from chronic diseases such as AIDS, tuberculosis, cancer; promotive and preventive services such as immunization, ante- and postnatal care, and family planning services; (Kivumbi & Kintu, 2002).

Although the primary purpose is to share the risk between individuals and to extend financial protection to members of the scheme, in practice different stakeholders have different perspectives on the objectives of the CBHI schemes. Three types of criteria (equity, financial sustainability and efficiency) are commonly used to assess health care financing schemes but in many cases there is no clear alignment between scheme-specific objectives and social ones. Mechanisms to promote individual scheme sustainability can conflict substantively with equity concerns. In practice, individual schemes may have to focus more on sustainability issues than equity issues (Bennet, 2004).

CBHI schemes appear particularly appropriate for providing insurance coverage to persons with limited protection from other sources (e.g. not employed in the formal sector). They also seem particularly relevant to low-income countries where government revenue is limited and where there is extensive reliance upon out-out of-pocket payment. The WHO has recommended that out-of-pocket expenditures by poor communities should increasingly be channelled to 'community financing' schemes. Largely anecdotal evidence suggests that it is primarily the rural middle-class that joins the CBHI schemes. There is a concern about what happens to people who are not members of the schemes. Exclusion of the high-risk individuals from scheme membership will affect the sickest and probably the most vulnerable members of the population. Placing limitations on the benefit package will most likely reduce the level of effective protection provided against financial risk. It is assumed that people will prefer CBHI schemes that offer complementary risk protection[5] to that provided by the Government.

Abolishment of user fees

Experiences from the health sector in South Africa
In South Africa, user fees for children aged under 6 years and pregnant women were removed in 1994, and in 1997 all user fees at all primary health care clinics were abolished. The intention of these policy changes was to improve access to health services for the poorest and previously disadvantaged communities. Wilkinson et al (2001) noted that little is known about the impact of removing user fees on the differential utilization of preventive and curative services. The authors found that the total number of consultations for curative care almost doubled, while the number of consultations for preventive services fell. It appeared that the removal of user fees encouraged and increased access to curative services, but subsequent clinic congestion and reduced consultation times may have discouraged some women from attending for antenatal care and from bringing their children for growth monitoring and immunization. It was felt that for this reason: (1) a slower, phased introduction could have avoided some of the reported adverse effects, and (2) governments should closely monitor the impact of such policy changes.

[5] E.g. (1) the extent of co-payment (user fees) for government-subsidized services, (2) the extent of the benefit package or essential package, and (3) user perceptions of relative quality of care in public and private sectors.

PART 2 BACKGROUND INFORMATION TO CHAPTER 2

Background information on PRSP health related targets and their feasibility

Table TP 1: PRSP health related targets and their feasibility			
Target	**Feasibility**	**Target**	**Feasibility**
▪ Reduce infant mortality rate from 99 to 85 per 1,000 live births by 2003	Unlikely to reach	▪ Reduced prevalence of wasting (weight for height) from 7% to 2%	Little progress
▪ Reduce infant mortality rate to 50 per 1,000 live births by 2010 and to 20 by 2025	Unlikely to reach	▪ Contain sero-positive prevalence rate in pregnant women from 5.5-23% (1996) to 6-27% in 2010	Very challenging target
▪ Reduce under-five mortality per 1,000 from 158 to 127 by 2003 and to 79 by 2010	Unlikely to reach	▪ Reduced maternal mortality rate from 529 to 450 per 100,000 by 2003 and 265 by 2010	Indicator not appropriate to asses on short-term,
▪ Increase of children under 2 years immunised against measles and DPT from 71% to 85% in 2003	Target within reach	▪ Increased coverage of births by trained personnel from 50% to 80%	Requires a radical change in present trend
▪ Malaria in-patient case fatality for under-five children decreased from 12.8% to 10% by 2003 and 8% b 2010	Difficult to calculate in HMIS of MOH	▪ Restored life expectancy to 52 years by 2010	Unlikely to reach with HIV/AIDS trend
▪ Reduced prevalence of stunting (height for age) reduced from 43% to 20%	Little progress		

Source: Extracted from Poverty and Human Development Report 2002:104-105)

PART 3 BACKGROUND INFORMATION TO CHAPTER 3

Background information on Health Sector Reforms

Table TP 2: Stages of development towards Health Sector Reform Tanzania	
▪ **First phase: 1961- mid 1970's**	The post-independence focus was on ensuring availability and accessibility to health facilities for all citizens. The first strategic plan, adopted an expansionary strategy for facilities, especially rural health facilities.
▪ **Second phase: End of the 1970's to the early 1990's**	In the 1980s the Government increasingly faced the problem of not being able to meet the costs of free health services and was confronted with a serious deterioration of the government health services. Vertical programmes dominated the health service provision. Community based health care gradually lost its momentum. The health strategy focused on the need for multi-sectoral collaboration in the implementation of health plans, and recognized the contribution of various sectors towards health development.
▪ **Current phase: From 1990 onwards**	This is the period of the contemporary health reforms. The Population and Health Sector Review (World Bank) pointed out that although the network of health services infrastructure was high, the quality of health services was still very poor. A study of health financing in East African revealed that although Tanzania was allocating more to health services than other East African countries, the impact on health status was the same. These results encouraged the government to re-examine its approach to health. The outcome of this examination was the development of the health sector reform strategies which form the core of the current health policy and strategies.

Source: extracted from MOH/SDC, PER 2001(draft) and Schwerzel, e.a., 2003.

Overview of the National Policy Planning Process

Tanzania is part of the global effort of poverty eradication, led by the World Bank. In the policy planning process there are several steps, which are reflected in the table below.

Table TP 3: National Policy Planning Process	
Policy Planning Initiative	**Objective**
Vision 2025	National vision of economic and social objectives: Tanzania wants to be a mid-income country by 2025, with no pockets of abject poverty
National Poverty Eradication Strategy (NPES)	National Strategy for Poverty Eradication by 2010
Tanzania Assistance Strategy (TAS)	Medium-term strategy of government and international community. The framework agrees on important issues of good governance, like sound financial management, efficient public service, anti-corruption measures, domestic resource mobilisation, and partnership with local government and civil society organisations.
Poverty Reduction Strategy Paper (PRSP)	Medium-term strategy of poverty reduction through broad consultation of all stakeholders, in the context of the HIPC initiative. The strategy of poverty reduction is to define clear objectives and target and channel funds as much as possible to district and grass root level. The poverty reduction is an integral part of government reforms. The three objectives are: ▪ To reduce income poverty ▪ To improve the human capabilities, survival and social-well-being ▪ To reduce the extreme vulnerability among the poor

Source: Schwerzel et. al., Cordaid Tanzania Health Sector Plan 2003.

Health Sector Reforms: Strategic Plan

The Plan of Work (POW) 1999-2002 provides an overview of the eight strategies for the Health Sector Reforms. The numbers of the different strategies are relevant for referential purposes in the sense that under these headings extensive policy documents, reports and studies have been published that provide in-depth information about the specific elements of the strategies.

Table TP 4: Strategies in Plan of Work (POW) Health Sector Reforms 1999-2002

Strategies	Focus of Strategies
Strategy 1	**Improve access, quality and efficiency of District Health Services** ▪ Address organisation, management, accountability and financial management ▪ Address accountability of providers to the councils through the Council Health Boards ▪ Address provision of services, referral system, provision of essential clinical and public health packages of services, inter-sectoral collaboration, provision of essential medical and non-medical supplies and community involvement ▪ Address cost-effective health packages
Strategy 2	**Reorient Secondary and Tertiary Services** ▪ Address institutional management ▪ Address linkages with not-for-profit hospitals ▪ Address privatising some elements of hospital care not contained in the essential health package
Strategy 3	**Improve the capacity of the Central Ministry of Health** ▪ Address key management and administration issues, policy development, reorganisation of the MOH, integration of vertical programmes ▪ Address necessary legislation in view of HSR, advocacy for HSR ▪ Development of effective communication system in implementing health sector reforms
Strategy 4	**Human Resource Development** ▪ Focus on capacity building, formal in-service training and technical assistance ▪ Reduction of unqualified and unproductive health workers
Strategy 5	**Strengthen Central Support Systems** ▪ Address personnel management, drugs and supplies management, management of medical equipment, management of physical infrastructure, transport management and communications ▪ Address liberalisation of drug procurement
Strategy 6	**Increase Health Care Financing** ▪ Address financing health care through MOH and Ministry of Local Government ▪ Address development of alternative cost-effective and sustainable health care financing, National health insurance, community health funds, donor funding and development of different options for funding
Strategy 7	**Promote Public/Private Mix** ▪ Address development and promotion of private practice participation, contracting out services, revise legislation and the role of different professional associations
Strategy 8	**Redefine Ministry of Health and donor relation ships** ▪ Address donor co-ordination, sector wide approach and review of progress by MOH and donors in joint funding of health

Source: Danida HSPS II May 1999

Indicators Public Health Sector Performance Profile

Table TP 5: Overview of indicators Public Health Sector Performance Profile	
▪ Total GOT public allocation and donor allocation to health per capita ▪ Recurrent expenditure at each level ▪ Distribution of Medical Officers, AMOs, Public Health Nurses by staffing norms per health facility ▪ % of GOT funds available for budgeted and actual district health activities against the total funds available for districts ▪ Number of districts reporting and showing the use of HMIS and performance monitoring data in the health plans ▪ Proportion of public health facilities in a good state of repair ▪ Average number of public health facilities without any stock of 4 tracer drugs and 1 vaccine ▪ Average number of days with no drug kits in public health facilities ▪ Cost sharing feed collected in relation to the set targets	▪ Total OPD attendance per capita ▪ Proportion of births attended by skilled persons ▪ Proportion of children fully immunised under 1 year ▪ Malaria cases as a percentage of all < 5 year cases presenting at the OPD ▪ Top 6 causes of morbidity among OPD attendants ▪ Consumer satisfaction with the quality of health services ▪ IMR, MMR ▪ Proportion of death among women due to maternal complications ▪ Proportion of children with severe malnutrition (0-5 years) ▪ Proportion of all under five fatality due to malaria ▪ HIV prevalence among ANC attendees ▪ Number of reported HIV/AIDS IEC interventions

Source: Public Health Performance Profile Draft 1: 2001

PART 4 BACKGROUND INFORMATION TO CHAPTER 4

Rationale for the introduction of user fees in Tanzania

Table TP 5: Rationale for the introduction of user fees in Tanzania	
Growing deficit in the overall GOT budget	▪ The 1970s and 1980s showed a poor economical performance and a growing deficit in the Government budget. Dependence on foreign finance increased. National and international political- socio-economic developments contributed to a shift in views
Growing funding gap in the Health sector	▪ The funding gap for total financial requirements of the health sector was 42.86% in 1989/90, 67.4% in 1990/91 and 63.65% in 1991/92. The recurrent budget and fiscal deficit showed an annual growth of 5%. In 1992, the donor support for the health sector was 12 times more then the health sector development budget. It was assumed that the revenues of cost sharing schemes would increase over time.
Expansion of health facilities, and an increase in demand and costs	▪ Between 1980 and 1989 the population increased with 29%, the number of health facilities increased with 10%, the number of medical assistants increased with 285%, the number of outpatients increased with 53.5% while the number of inpatients increased with 43%. Between 1980 and 1989 the recurrent costs grew with 64%
Poor health services	▪ The quality of health services was generally perceived as very poor. It was assumed that this was partly caused by the absence of user fees, and that the revenue from user fees would be used for services which otherwise could not be provided because of inadequate funding. User fees would hence contribute to improved availability and quality of health services. To ensure that revenue from user fees would contribute to quality improvements, the MOH formulated purchasing guidelines for essential items and established advisory committees in each hospital to monitor progress. It was assumed that, in the context of the decentralisation process, the funds generated through cost-sharing schemes would allow for funds to be retained and used at the local level
Strengthening referral system	▪ It was assumed that user fees would (1) reduce the tendency of patients to by-pass the lower level facilities, (2) rationalize the utilisation of health services and (3) strengthen the referral system. Therefore, differentiated charges were introduced; lower charges for primary level and higher charges for other levels.
Ability and willingness to Pay	▪ Many arguments were based on the assumption that even the poor could (had ability) and should contribute something for the services they received. ▪ Willingness to pay assessments indicated that a majority of the people were willing to contribute to health services if services would be improved.
Ensuring equity	▪ By establishing fees according to ability to pay instead of actual costs and by introducing exemption and waiver mechanisms, it was assumed that this would guarantee access to health services for the poor.

Source: Mushi 1996, MOH 1996, MOH 1997, MOH/SDC, 2001, Mushi 2003, Msambichaka 2003

Elements of the Community Health Fund in Tanzania

Table TP 6: Elements of the Community Health Fund Tanzania	
CHF system	▪ An LGA manages and administers the CHF in the context of CHF Act. Management and administration lies (1) at District level with a Council Health Service Board (CHSB), (2) at ward level with a Ward Health Committee (WHC), at village level with a Village Social Services Committee (VSSC). A private HF can participate in the CHF if there is a service agreement (can be obtained through a competitive bid).
Objectives	▪ (1) Mobilize financial resources from the community for the provision of health services to the CHF members, (2) provision of quality and affordable health services, (3) improvement of health services management.
CHF sources	▪ Member contributions, user fees paid in a public health centre or dispensary, GOT contributions, grants from councils or donors and any other legal source.
CHF premium	▪ Every Council can determine the annual level of contribution (based on community consultation). This can vary from time to time.
CHF members	▪ Members register with the CHF and receive a membership card. Membership is restricted to a paid up household except for exemptions that may be issued by the Council. Every member's household is entitled to medical services (which have been pre-paid for) of its choice at selected health care facilities
Exemptions	▪ A Council can make by-laws for the CHF including exemption criteria. The CHSB can set exemption criteria for the users of health care services which are provided by the CHF. ▪ The power to issue exemptions to pay the CHF annual fee is vested in the WHC (after consult with the Village Council). The Council shall authorise the exemption. ▪ The exempting authority has to seek alternative means to compensate the exemption in the CHF.

Source: Community Health Fund Act 2001, MOH 2003

Background information on National Health Insurance Fund (NHIF)

The contribution rates for the NHIF have been set at 6% of the salary, shared 50:50 between employer and employee. This will allow participants to access a minimum package of services from any public or private institution which has been accredited by the NHIF (a semi-private institution). Once the scheme is introduced, free medical care for civil servants will be removed, and fees will be introduced (MOH/SDC 2001). The PER (draft) Update 2004 indicates that the NHIF is part of the on-budget support resource envelope for Health as a PRS Priority sector. The GOT contribution to the NHIF on behalf of public servants amounts to 8% of the Other Charges budget for the FY04 Health sector. The PER 2004 questions whether the NHIF contribution is a priority to the achievement of the PRS and MDG objectives and feels that this should be explored further. Health services which have been reimbursed are pre-dominantly curative and hospital services[6] and are beyond the services included in the Essential Health Package. The reimbursements therefore do not reflect the priority areas of the PRSP. The majority of the NHIF members are formal sector employees and their dependents. They are more likely to be the residents of urban areas then rural areas. This assumption points to a beneficiary group which does not include the poorest people (PER (draft) update 2004:44).

[6] Costs for registration, outpatient care, basic diagnostic tests, inpatient care and surgery services

PART 5 BACKGROUND INFORMATION TO CHAPTER 5

Addis Ababa Consensus on Principles on Cost Sharing in Education and Health in Sub-Sahara Africa

(Addis Ababa 20 June 1997)

1. The Forum on Cost sharing in the Social Sectors of Sub-Saharan Africa was convened in Addis Ababa, from 18-20 June 1997, under the auspices of the United Nations Economic Commission for Africa (UNECA) in collaboration with UNICEF and the World Bank and co-sponsored by the Governments of Netherlands, Sweden, United Kingdom United States. Ministers and senior government officials from 16 sub-Saharan African countries. NGO's and bilateral donors and multilateral agencies took stock of the lessons learned from recent country experiences with cost sharing with a view to arriving at a common understanding on the principles on cost sharing in education and health, and to developing practical guidelines for their implementation.
2. Cost sharing in health and education is an area of social policy in which there has been rapid change and innovations in recent years. Most countries in sub-Saharan Africa have increased cost sharing in education and health of one sort or another, especially at the basic level in an effort to achieve universal coverage during an era of fiscal austerity. Cost sharing in practice has had mixed results: although some countries have succeeded in improving the quality and coverage of services, other countries have found that cost sharing has been associated with an unintended decline in utilization. Given these different experiences, a consensus emerged among the participants in the Forum that the principles of cost sharing, complemented by practical guidelines regarding their implementation, can make a significant contribution to the financing and delivery of social services, as well as to the universal coverage of basic education and basic health.
3. The Forum reaffirmed the importance of investing in the health and education of all, particularly at the basic level, in order to lay the foundations for sustainable and equitable human development. It emphasized that the financing of basic education and basic health should be the responsibility of government. The Forum therefore called for priority to be given by governments, bilateral donors and multilateral agencies to basic education and basic health, thereby assuring a balanced development of social services at all levels. Basic education and basic health are two components of the 20/20 initiative, agreed upon by all governments at the Social Summit in 1995. The 20/20 initiative implies that both governments and aid agencies allocate 20 per cent of their budget to basic social services, including basic education, primary health care including reproductive health and population programmes, nutrition programmes and low-cost water supply and sanitation. The 20/20 initiative was considered as a relevant instrument to prioritise the allocation of government and aid budgets.
4. Cost sharing includes all officially sanctioned contributions made by users to the financing and management of social services. Contributions can be made either by individuals, households, employers or by the community. The can vary from cash to contributions in kind or in the form of labour inputs and participation in management decisions. Cost sharing excludes private out-of-pocket costs that individuals incur in terms of time, travel or other costs when seeking access to these services. These costs, however, are important to consider in assessing the impact of cost sharing on the poor.
5. In addition to mobilizing additional resources for expanding the coverage and improving the quality of social services, cost sharing can also be a powerful instrument to introduce new relationships between users and providers of social services with a view to enhancing the efficiency and effectiveness of service delivery, based on greater accountability on the part of providers and greater responsibility on the part of users.
6. The Forum agreed on the following 15 principles on cost sharing in education and health:
    1. Cost sharing in the form of user charges should be considered only after a thorough examination of other options for financing social services, including tax reform, budget restructuring and expenditure targeting within the government budget and aid flows. General taxation and other forms of government revenue are more effective, efficient and equitable methods of raising revenue for the financing of social services than cost sharing mechanisms.
    2. Though general taxation is a more cost-effective way to raise revenue, there are two specific objectives for cost sharing (i) to limit the financial burden on the budget that

stems from the rapid increase in demand for non-basic services, which the state cannot meet on its own without the diversification of providers, and (ii) to overcome the practical and managerial obstacles that have prevented an adequate level of resources from reaching basic education and basic health.

3. Efforts to reduce costs in the delivery of social services, as well as to increase the efficiency in resources allocations to the primary level, must be considered prior to the introduction of cost sharing.
4. Basic social services should be provided either free of charge or be substantially subsidized. Basic education should be free and other out-of-pocket costs to parents such as school uniforms and school supplies should be minimized. Cost sharing in health should exempt preventive care whose benefits extend beyond the users (e.g. immunization) and selected primary services. Cost sharing should be a stepping stone towards other financing options for health care.
5. When considering cost sharing, it should be as part of a comprehensive sector strategy for both health and education, formulated by government with all stakeholders. The sector strategy should specify clear, measurable and verifiable objectives, the resources required to meet those objectives, and ways of mobilizing and allocating them among competing priorities.
6. Resources generated through cost sharing should be additional and should not be a substitute for existing resource allocations to the education and health sector.
7. To be successful and sustainable, cost sharing must lead to immediate and measurable improvements in the access and quality of services. In this regard, revenue generated through cost sharing must be retained, with the spending authority, at the local level. Disadvantaged regions and communities may need extra financial support to avoid that cost sharing will lead to a widening of regional, socio-economic and gender disparities.
8. Cost sharing must be accompanied by special measures that effectively protect the poor. Experience shows that the poor have not been effectively protected against the negative impact of cost sharing on their access to basic education and basic health. While cost sharing may be necessary because of severe constraints in terms of financial resources and/or institutional capacities, caution must be exercised wherever there is doubt about the ability to protect the poor. No one child should be deprived of his or her right of access to basic education and basic health.
9. Non-discretionary exemption schemes should be preferred from the point of view of efficiency. Discretionary exemption schemes have not succeeded in identifying and protection the poor. Although more benefits may leak to the non-poor, non-discretionary criteria, such as age, gender, region and type of services, are less likely to affect the access of the poor to services. Moreover, discretionary critical, such as income and physical assets can be difficult and costly to administer.
10. Involvement of beneficiaries is critical to the success and sustainability of cost sharing. Community participation and control of resources must be a fundamental characteristic in the process of designing appropriate cost sharing mechanisms and their management. The role, rights and responsibilities of local communities vis-à-vis government and service providers must be discussed and clarified prior to the implementation of cost sharing.

11. Community participation and management must be considered as a substitute for government's responsibility in the financing and management of the social sector, but should be seen as an essential element in improving service delivery.

12. Communities should be made fully aware of the principles and implementation mechanisms of cost sharing. Training and capacity building of community management committees and service providers is essential to its success.

13. Local management committees should be locally elected and fully accountable to the community and should ensure adequate representation of all stakeholders, including a balanced gender presence.

14. Cost sharing mechanisms should be carefully tested through phasing and/or piloting before applying them on a large-scale. Testing is meant to assess their impact on

effectiveness, efficiency and equity at the local level. The administrative costs of implementing cost sharing must be kept to a minimum.

15. Cost sharing mechanisms must be regularly monitored and evaluated with a view to ensuring quick feedback on the consequences of cost sharing, particularly regarding the impact on the poor, women and children.

7. Participants developed practical guidelines for the implementation of several, of the above principles.
8. Participants committed themselves to disseminate the above principles and organize appropriate follow-up activities to the present Consensus at the national and sub-national levels. The follow-up can take the form of relevant policy analysis of, inter alia, the taxation system, budgetary and aid allocations to basic social services, evaluation of the impact of existing costs sharing arrangements in light of the above principles, and the incorporation of lessons from experience and findings of analysis in the formulation of sector-wide development programmes for health and education. The results of policy analysis are expected to encourage an appropriate policy dialogue and lead to necessary policy reforms with a view to making the financing and delivery of social services at all levels more equitable, effective and efficient.

PART 6 BACKGROUND INFORMATION TO CHAPTER 6

User Fee Charges in Tanzania

Table TP 7: User Fee Charges in Tanzania				
Type of service for user fee	***Description/ Clarification***	***Referral Hospital***	***Regional Hospital***	***District Hospital***
1. Consultation	Grade I & II Grade III[1]	500/= 300/=	300/= 200/=	200/= 150/=
2. Drug for out-patient		50/=	50/=	50/=
3. Medical examination				
(a) Students		500/=	500/=	500/=
(b) Civil servants		1,500/=	1,500/=	1,500/=
(c) Special examination test		3,000/=	3,000/=	3,000/=
(d) Workman's compensation		3,000/=	3,000/=	3,000/=
(e) Medical board		10,000/=	10,000/=	10,000/=
4. Gate toll				
(a) Motor vehicles		100/=	100/=	100/=
(h) Motor hikes		50/=	50/=	50/=
(c) Bicycle		20/=	20/=	20/=
5. Mortuary				
(a) Post-mortem		1,000/=	1,000/=	1,000/=
(b) Storage		200/=	200/=	200/=
6. Admission (hospitalization)				
Grade I	Daily fee excluding food, drugs	2,000/=	1,500/=	1,000/=
Grade II	Laboratory services or other tests	1,000/=	750/=	500/=
Grade III	For the whole period of admission including food, drugs and laboratory services or other tests	500/=	300/=	150/=
7. Other services for grade I & II				
Laboratory & eye tests	1,000/= (average)			
Surgery:				
(a) General:				
Major	13,000/=			
Minor	3,000/=			
(b) Ophthalmology:				
Major	13,000/=			
Minor	2,000/=			
(c) ENT:				
Major	7,500/=			
Minor	1,500/=			
(d) Orthopedic/trauma:				
Major	15,000/=			
Minor	3,000/=			
(e) Neurosurgery:				
Major	40,000/=			
Minor	10,000/=			
(f) Urosurgery: Major	8,000/=			

Fee schedule starting from December 1 - 1996[2]

[1] Grades I and II refer to patients receiving extra attention in getting services, i.e. who are kept in self-contained rooms, given special food services. Grade III refers to patients receiving ordinary services. It should be noted that (theoretically) patients in all grades I to III receive the same quality of services in terms of disease management. The difference is largely in hotel services.

[2] The revised user fee schedule is based on the evaluation done by the MOH in early 1996 after two-and-a-half years of policy implementation).The evaluation was done to determine the state of cost-sharing implementation, so as to find ways of improving the implementation process. Important also was the fact that the revision of user fees in 1996 was done to make charging more specific to the type of services sought.

Type of service	*Clarifications*	*Referral Hospital*	*Regional Hospital*	*District Hospital*
1. Registration	Fee charged for first attendance per year	1,000/=	500/=	300/=
2. Drugs and infusions	Fee charged at 50% of the real cost according to prices of the "Medical store department'			
3. Medical examinations				
(a) Students joining school		500/=	500/=	500/=
(b) Employee first appointment		1,500/=	1,500/=	1,500/=
(c) Special tests		3,000/=	3,000/=	3,000/=
(d) Workman's compensation		4,000/=	4,000/=	4,000/=
(e) Insurance	Filling forms for life insurance	4,000/=	4,000/=	4,000/=
(f) Medical board	The cost will be covered by the employer	20,000/=	20,000/=	20,000/=
4. Laboratory tests and other tests				
(a) BS, Urine, Stool	Grade I & II Grade III	300/= 100/=	200/= 100/=	200/= 100/=
(b) WBC, ESR, Grouping & Cross Matching	Grade I &. II Grade III	500/= 200/=	200/= 100/=	200/= 100/=
(c) VDRL test, Widal test, Pregnancy test, and Other biochemistry tests	Grade I & II Grade III	500/= 400/=	400/= 300/=	400/= 200/=
(d) X-Ray (per exposure)	Grade I &.II Grade III	1,000/= 750/=	700/= 500/=	500/= 400/=
(e) Special tests (Ultra sound, ECG, ECHO, Barium meal etc)	Grade I & II Grade III	3,000/= 1,000/=	1,500/= 1,000/=	1,000/= 500/=
5. Dental services				
(a) Extraction of permanent teeth	Grade I & II: per tooth Grade III: per tooth	1,000/= 500/=	800/= 500/=	500/= 500/=
(b) Extraction of deciduous teeth	Grade I & II Grade III	500/= 300/=	400/= 300/=	300/= 300/=
(c) Filling permanent teeth	Grade I & II per surface Grade III per surface	1,000/= 500/=	800/= 500/=	500/= 500/=
(d) Filling deciduous teeth	Grade I & II: per surface Grade III per surface	500/= 300/=	500/= 300/=	500/= 300/=
(e) Root canal treatment	Grade I & II Grade III	5,000/= 2,000/=	4,000/= 1,500/=	2,000/= 1,000/=
(f) Denture full plastic bases each upper & lower	Grade I & II Grade III	15,000/= 12,000/=	13,000/= 10,000/=	10,000/= 8,000/=
(g) Dentures: partial plastic base	Grade I & II Grade III	5,000/= 3,000/=	4,000/= 3,000/=	3,000/= 3,000/=
(h) Repairs of dentures or orthodontic appliance	Grade I & II Grade III	5,000/= 3,000/=	4,000/= 2,000/=	I,000/= 1,000/=
(i) Orthodontic appliance	Grade I & II Grade III	15,000/= 13,000/=	12,000/= 11,000/=	10,000/= 10,000/=
(ii) Scaling per visit	Grade I & II Grade III	1,500/= 5,000/=	1,500/= 5,000/=	1,000/= 5,000/=
(k) Gingivectomy tooth	Grade I & II Grade III	1,500/= 500/=	1,000/= 500/=	500/= 500/=
(I) Oral surgical operations	Grade I & II Grade III	10,000/= 7,000/=	8,000/= 6,000/=	4,000/= 4,000/=
(m) Gold inlays excluding the cost of gold	Grade I & II Grade III	5,000/= 4,000/=	5,000/= 4,000/=	4,000/= 4,000/=
(n) Gold crowns excluding the cost of gold	Grade I & II Grade III	8,000/= 5,000/=	6,000/= 5,000/=	5,000/= 5,000/=
(o) Jacket crowns & post crowns: porcelain,	Grade I & II	15,000/=	10,000/=	7,500/=

bonded or acrylic	Grade III	7,500/=	5,000/=	3,000/=
6. Admission fee				
Grade I Grade III	Paid daily food, laboratory test and other tests fees	3,000/= 1,500/=	1,500/= 1,000/=	1,200/= 750/=
Grade III	The fee charged once for the whole period of admission but excluding drug, laboratory test and other test fees	2,000/=	1,000/=	500/=
7. Surgery				
Major operation: Any surgical procedure under anesthesia	Grade I &II Grade III	15,000/= 3,000/=	10,000/= 2,000/=	5,000/= 1,000/=
Minor operation: Any surgical procedure under anesthesia	Grade I & II Grade III	3,000/= 1,000/=	2,000/= 500/=	1,000/= 300/=
8. Normal delivery	Grade I & II per day	1,000/=	500/=	300/=
9. Physiotherapy	Grade I & II only per day	500/=	300/=	
10. Mortuary fee				
(a) Post mortem		1,000/=	1,000/=	1,000/=
(b) Storage		500/=	200/=	200/=
11. Fees for foreigners	Payments shall be by US dollar or equivalent Tanzanian Shillings	US$	US$	US$
(a) Consultation fee		20	20	20
(b) Appointment consultation		20	20	20
(c) Admission fee: daily fee		30	30	30
(d) Investigation		10	10	10
(e) Special tests		50-200	50-200	50-200
(f) Major Operation		200-2,000	200-2,000	200-2,000
(g) Minor Operation		50	50	50
(h) Post-mortem		100	100	100
(i) Mortuary (storage) fee		30	30	30

Note/clarifications (Cost-sharing programme, 1999)

- Please read carefully, note the fee schedule indicated in the table and apply them accordingly.
- Poor people and other vulnerable groups should be exempted/waived user fees.
- Special hospitals should follow the fee schedule for district hospitals.
- Caesarian section for grade III shall be free.
- Mortuary fee:
    - There shall be a grace period of three days for deaths occurred in the respective hospital. For deaths that occurred somewhere else shall pay from the first day.
    - There shall be a grace period of one day for a dead body brought for postmortem
- Patients referred to government hospital from private hospitals shall follow the fee schedule for grade I.
- The actual cost (prices) of drugs front the Medical Store Department that shall be used for calculating the 50% of drug fees. Revenue collections from drug fee shall be used to purchase drugs on basis of "drug revolving fund".

Charges in the public and private health facilities in Kagera Region

Table TP 8: Reported Charges in various health facilities Kagera Region in Tanzanian Shillings, March 2004						
Services	**Regional hospital Bukoba town**	**Catholic dispensary Rural area**	**Catholic Health Centre Peri-urban area**	**NGO Rural area**	**Private clinic 1 Urban**	**Private Clinic 2 Urban**
Registration	500		500		800	200
Consultation	500	500			800	500
HB test		300	300			500
Blood Slide	100	300	400			500
Urine	100	200	300			300
Stool	100	200	100			300
Blood sugar						1,000
Flat rate for all lab. Tests	500 -700 on average			600	500	
Drugs	Average 1,000 for a 5-7 day course of drugs	Fluctuate	Fluctuate	50 per tablet	Fluctuate	Fluctuate
Normal Delivery		2,000	2,500			
Complicated Delivery			3,000			
Admission of children per day		Max. is 4,000	200 (no ceiling)			
Admission of adults per day	1,000 per week	500 per day Max. is 5,000			2,500 (no ceiling)	
Referral to HF.		300 per km.				

Source: Study team Kagera, March 2004

Stakeholder views

Health Sector Main Review 2004

The Technical Review of the health service delivery at district level concluded only that there is (1) a need to promote more actively the use of CHF and NHIF resources and (2) a need to better understand the exemption mechanisms (Document in file National Review presentations 2004:5). The draft Milestones (March 2004) indicated as the positive step that the upcoming Technical and Main Review 2005 will focus on the analysis of equity and quality in district level health services. Unfortunately, the proposed Milestone for equity in the health sector was not included. The MOH emphasised that, instead of such milestone, the new resource allocation formula (ERAF) should act as a milestone on equity issues. The MOH also emphasised that, given the substantial resource gap in the Health Sector Financing, there is a grave need for additional resources to implement the planned programmes and reforms. The MOH emphasized that increased funding will contribute to increased equity in the health sector (MOH, March 2004).

The DPG questioned the ability of the health sector to achieve the identified goals and targets of the PRS and the MDGs given the extremely disappointing and worrying trend that the FY04 absolute budgetary allocation by the GOT to the Health sector has been declining (SDC/DPG, March 2004). However, the concern of the DPG was mainly related to the need for a substantial budget increase in the Health Sector on one hand and the concerning decline of the GOT contribution to the health sector on the other hand. The DPG did *not* reflect on the potential consequences the donor pressure might have on the position of the MOH to maintain the current user fee systems (as a felt need to generate resources). In this sense the impact of user fee systems on the poorest groups in Tanzania and the negative impact of user fee systems on the achievement of the PRS objectives were not formally addressed by the DPG.

Although critical concerns have been raised by various stakeholders and although the MOH commissioned in 2003 important studies to (1) assess the impact of exemptions and waivers on cost sharing in Health Facilities and (2) to assess the factors affecting the enrolment and coverage in CHFs, the most recent PER Update for FY 2004, and milestones prepared for the Health Sector Main

Review in March 2004, unfortunately did not reflect major concerns about the impact of the user fee policy. The general impression was that the MOH believes that their overall strategy addresses equity implications of user fees and as such the topic was embedded in the Review's discussion of March 2004. Unfortunately, equity as milestone for the coming years was deleted from the list of the MOH. (NGO statement for 2004 Joint Health Sector Review and Poverty Reduction Strategy Review 2004:2-3).

General observations from the interviews

Rationale and achievements of user fee policy objectives

There was general consensus among the interviewed stakeholders on the main reasons why user fees were introduced in Tanzania: revenue raising, enhancing equity, reducing frivolous consumption and improving quality of care. Few interviewees associated user fees with poverty reduction as a rationale for their introduction. Stakeholders' responses indicate that they find it very difficult to give a correct, conclusive statement on the extent to which user fees have achieved their objectives. Due to inadequate financial management systems, there is likely to be a gross over- or understatement of the actual contribution from user charges. However, most respondents agreed that user fees have contributed significantly to quality improvements in some specific areas, such as the availability of drugs. However, this was more based on their personal impression then on reliable data.

User fee policy

Stakeholders mostly recommended a phased approach to introducing user fees, starting with the higher levels of health care and gradually going down to PHC levels. As such, they seem to agree with the approach taken by the Tanzanian government. They did explicitly note, however, that the Tanzanian approach has created many loopholes for excluding the poor from using health care. The present user fee policy, the exemptions in particular, tends to benefit the better off more than the poor and vulnerable people. Regarding whether it is reasonable to abolish fees, most stakeholders shared the view that there is a need to strengthen exemption and waiver mechanisms for protecting the poor rather than abolishing fees. The following strategies were mentioned:

- Improving accountability among health workers, the primary implementers of the user fee policy.
- Improving transparency to all stakeholders, i.e. Collect and disseminate information on what is actually collected, how is it being spent, how the exemption system operates, and what the exemption criteria are (these should be clear and unambiguous).
- Making community members responsible for deciding who is eligible for exemptions instead of relying on professional, technical criteria.
- Establishing a well-targeted fee structure and insurance system in line with the exemption system.

Poverty Reduction Strategy

Most resource persons recommended that in the second PRS, the Tanzanian government should further strengthen its commitment to increased funding to the health and education sectors, so as to create a sustainable infrastructure for improving people's health and education levels which are important tools in the fight against poverty.

Inventory of lessons learned on user fee systems

1. Gilson, 1997

From: Gilson, L. 1997. 'The lessons of user fee experience in Africa'. In: *Health Policy and Planning* 12(4): 273-285. (Based on the review of a various studies and reports).

1. Key bottlenecks to effective implementation

1. Weak design of user fee systems

- Complex fee structures that are difficult to administer (e.g. itemized, detailed billing).
- Fee types (e.g. general consultation fee) which deter patient utilization because they are not linked to the care received.
- Failure to revise fees annually in line with inflation, undermining revenue generation.
- Complex and/or unworkable exemptions mechanisms which require too much information and are therefore costly to administer.

- Implementation of fees at the lowest, poorest levels within the system where little revenue can be generated.
- Lack of co-ordination and fine-tuning between fee levels across the health system, with the potential to create perverse utilization levels (e.g. user fees at secondary levels are lower than at primary levels) and inequities (e.g. higher fee levels in poorer areas).

2. Poor capacity for local level financial management and fee system implementation
- Lack of financial management skills throughout the health system, but especially at district or community level.
- Lack of appropriate financial management information and audit systems.
- Lack of information with which to target the poorest effectively through exemptions.
- Limited local authority to take appropriate resource use decisions without reference to higher authorities.
- Limited effectiveness in collecting fee revenue, undermining revenue generation rates and revenue use of quality improvements.
- Lack of guidance on financial management and control practices, e.g. on who is eligible for exemptions; how to account for revenue generated; and on procedures for using revenue.
- Failure to retain fee revenue locally, undermining the incentive to collect it and user it for local level quality improvements.
- Total retention of revenue locally leading to limited redistribution of resources between geographical areas with different capacities to raise revenue.
- No procedures that would allow the impact of policy implementation to be monitored.

3. Weak supporting systems
- Poor quality public services which undermine the population's willingness to use services (e.g. drug shortages, unfriendly staff).
- Inadequate human resource policies which do not promote or sustain staff morale.
- Inadequate drug supply and distribution systems.
- Operational inefficiencies within the health system which contribute to quality failures (e.g. drug wastage and abuse leading to shortages).
- Limited funding for the supervision and support needed by the primary level.
- Inadequate management information systems e.g. which do not allow resource use to be related to services provided.
- Organizational structures which generate weak and conflicting lines of accountability both downward to community level, and upwards to technical supervisors.

4. Contextual constraints
- The population's lack of experience in paying for public health services, which generates an unwillingness to pay for them, particularly when perceived quality is low.
- Weak banking and communication systems, undermining local level financial management and the potential for support.
- A variety of socio-cultural and political constraints at both local and national levels, that e.g. preclude consideration of the needs of the poor in decision making, allow richer groups to be incorrectly exempted (leakage) and prevent the reallocation of resources to primary health care that would most benefit the poorest.

2. Enhancing the impact of user fees on their objectives – lessons for policy design

1. Fee system design
- Use a simple fee structure, linked to treatment received (e.g. prescription fee).
- Set affordable price levels.
- Use simply-to-apply exemption categories (e.g. characteristic targeting).
- Ensure the price structure is advertised within health facilities.
- Coordinate the price structure across health system levels.
- Readjust prices periodically.
- Ensure that some revenue is retained at the point of collection for use in quality improvements.
- Establish guidelines and procedures to promote revenue use for perceived quality improvements.
- Develop community mechanisms at primary levels.

2. *Complementary government policies*

a. Financing policy framework
- Maintenance of existing levels of government funding for health system as a whole.
- Development of complementary risk-sharing financing mechanisms.
- Establishment of resource reallocation mechanism favoring relatively under-resources geographical areas and more cost-effective services.
- Promotion of community solidarity mechanisms which can assist the ultra-poor.
- Development of community management mechanisms, which ensure accountability to community.

b. Policies to support sustainability
- An effective reward and discipline system for health staff, including training.
- An effective drug procurement and supply system.
- Effective management and clinical supervision and support for 'local' level (district or community).
- Management-oriented information systems which allow monitoring by providing data on e.g. revenue collected, revenue use patterns.
- The development of skills and systems to enable decentralization of resource use, control and management within wider system to appropriate level.
- A supportive legal framework for fee/sustainability policies.

3. *Contextual support*
- Institutional capacity within health system to provide support to local level decision makers.
- Adequate leadership and advocacy skills within the health sector to develop political support for appropriate design and policy.
- Wider institutional support (e.g. banking facilities; communication facilities).
- Consumers' willingness and ability to pay.
- Professional ethics to counterbalance health workers' responsiveness to financial incentives.

3. The process of implementation

Stage 1
- Identifying problems likely to affect implementation of broad fee system design (e.g. poor quality of care, lack of willingness to pay, opposition from critical stakeholders.
- Collecting baseline data by which to assess implementation impact and effectiveness (e.g. ability to pay data.

Stage 2
- Review of the fee system design and careful planning to address, as far as possible, the expected problems of implementation.
- Identifying factors constraining and facilitating effective implementation.
- Developing strategies to offset potential constraints on implementation.

Stage 3
- Implementation of steps to develop key prerequisites for effective implementation.
- Initial implementation of fees.
- Monitoring impact/effectiveness of fees, and the factors influencing impact.
- Operational research to support implementation.

Stage 4
1. Review and revision of fee implementation approach.
2. Next stage of implementation.
3. Further monitoring.

2. Bennet & Gilson, 2001

- What does it mean for a health financing system to be pro-poor? The most important dimensions are that the system should:
  - Ensure that contributions to the costs of health care are in proportion to different households (ability to pay).
  - Protect the poor (and the nearly poor) from the financial shocks associated with severe illness.

- Enhance the accessibility of services to the poor (particularly with respect to perceived quality and geographic access).

User fees

- Carefully design, plan and implement user fees, waivers and exemptions.
- Invest in the quality of care.
- Involve those responsible for implementation and the wider community in design and implementation.
- Accompany user fees by a resource allocation mechanism that re-allocates resources from wealthier to poorer areas.

Community-based health insurance

- The very poor require special arrangements to enable them to access benefits under these schemes (e.g. subsidies from government or from higher income scheme members.
- Governments need to play a re-distributive role between schemes to ensure that schemes in poorer areas do not offer poorer benefits.

Designing and implementing pro-poor financing schemes

1. Integrating a concern for the poor during the design phase.
2. Building capacity to develop pro-poor schemes:
    - Encourage broader consultation with groups representing and working with the poor.
    - Clearly community the new policy to the general public and build consensus on the desirability, rationale and direction of reform.
    - Develop technical skills and involve technicians into policy making.
    - Develop new skills for the people working in the health care system (training of health sector staff).
    - Develop proper systems for financial and information management purposes.
    - Carefully phase financing reforms.

3. Using financing mechanisms to promote high quality and responsive services for the poor.
4. Designing and implementing exemption mechanisms:
    - Ensure that the exemption system is given high priority by politicians and bureaucrats alike.
    - Prevent establishing incentives not to exempt, perhaps by limiting the amount of revenue that can be retained locally from fees or by identifying specific and different sources of funding for the exemptions, and by giving equal weight to the goal of exemption and to revenue generation in implementation guidance.
    - Communicate the exemptions policy to health workers and the general population whilst allowing some flexibility in implementation to enable exemption mechanisms to be adapted in response to local circumstances, but only within limits set by clear central guidance.
    - Provide clear central guidelines on eligibility criteria so that they distinguish between the poor and the non-poor, are reasonably easy to implement at the local level;and to monitor performance against these guidelines: how many exemptions are given, to whom, by whom?
    - Encourage exemption screening to take place close to the household in the community or local health care facility through mechanisms that involve both community members and health workers and by individuals trained for the task.
    - Avoid the capture of exemptions by non-poor groups such as civil servants, otherwise revenues from the scheme will be limited, but recognise that allowing some degree of capture by more wealthy groups, particularly within local communities, may build sustained support for the exemption mechanism.

5. Monitoring and evaluating impact on the poor:
    - Possible indicators: price of specific health services as a percentage of household income; percentage of cases exempted; social and economic characteristics of those receiving exemptions.

3. Newbrander, Collins and Gilson, 2002

Principles to follow when designing equitable user fee systems are:

- Combine financing mechanisms, because user fees alone are not cost effective.

- Combine low fees, age exemptions, and limited waives for primary and consultation services with means testing for higher-cost inpatient services.
- Allocate more central funding to facilities in poorer areas to off-set the lower revenue they generate through user fees.
- Focus on granting exemptions for the poor and vulnerable, such as the children of the poor.
- Protect the poor and prevent others from becoming poor.

To make user fee systems effective in protecting equity while raising revenue, several critical elements must exist:

- Leaders must be committed to the principle of equity.
- Clear guidelines need to be established for implementing the user fee system and applying exemption systems.
- Facilities must have the capacity to administer the system, exempt the poor, and correctly use the collected fees to benefit the community and the poor.
- The public must have information about the user fee system, uses of fee collected, and eligibility for exemptions.
- Facilities must be accountable to communities for the use of revenues raised.

General principles for the choice of fees and targeting mechanisms

- Use low fees or no fees for public health services.
- Relate fees to the costs of services.
- Vary fees according to ability to pay.
- Encourage medically necessary consultations (e.g. free or inexpensive doctor's visits).
- Adapt means testing to the situation.
- Inform patients about fees.
- Use all-inclusive (bundled) fees only when all services are available.
- Provide emergency services for free; collect fees later from those who can afford to pay.

Means testing procedures

- Use documentary evidence.
- Means-test in the facility.
- Keep administrative costs low.
- Discourage waivers.
- Determine who recommends a waiver.
- Determine who approves a waiver.
- Use standard questionnaires.
- Use means testing for high-priced services.
- Set policies about partial payment and negotiate fees in advance.
- Determine the duration of waiver certification.
- Consider referral waivers.
- Control credit.

Implementing new fees and targeting mechanisms

- Introduce acceptable fee types first.
- Set fees low.
- Reduce exemptions over time.
- Gradually establish more stringent means testing.
- Introduce fees gradually, beginning with the highest-level-facilities.

Management

- Set targets.
- Conduct continuous monitoring.
- Account for exemptions and waivers.
- Review patient characteristics.

PART 7 FINDINGS FROM KAGERA REGION

6.1 Introduction to the data collection in Kagera Region

The findings from Kagera Region are based on different sources of information. A first source was the Rural Kagera Core Welfare Indicator Questionnaire (CWIQ) Survey[7] (EDI and DRDP, 2004). A second source was the study on Health Care Financing Options in Kagera Region (Mubyzazi et al, 2002). A third source of data was generated by the study team in Bukoba District. In total 59 resource persons[8] participated in a small-scale assessment. The findings are summarized in this Chapter.

6.2 Kagera Region characteristics

Kagera Region is located in the north of Tanzania, west of Lake Victoria. Kagera Region comprises of five districts; Karagwe, Bukoba Rural, Muleba, Biharamulo and Ngara. Kagera has an estimated population of 2,000,000 individuals. It is estimated that 20% of the population lives in a peri-urban area, while 80% lives in a rural area. Agriculture is the most common occupation in the rural communities. Almost 50% of the population is under the age of 15 years. Only about 4% percent are 65 years or older. Forty percent of the individuals in Kagera Rural live below the Basic Needs Poverty Line[9]. In 2000, the poorest 20% of the population of two villages[10] reported that the increase of health care costs posed a problem for all groups (97% by the poorest and 91% by the richest respondents). In addition, the costs of transport were too high for a majority of the poor and less poor (Dercon and van den Broek, 2002).

6.3 Findings from the CWIQ Survey 2004

Health related findings

Fifteen percent of the Kagera Rural population (300,000 people) had been ill and experienced the need for health services in the four weeks preceding the survey. The most common self-reported health problems were malaria (50%), chronic conditions (20%), diarrhoea (15%) and ear, nose or throat problems (10%). The incidence of illness was highest among children under the age of 5 (24%) and individuals over the age of 50 (28%). Furthermore, 133,000 children under five years old (43% of the population) were found chronically malnourished (stunted) and 29,000 children (8% of the population) acutely malnourished (wasted) Table 6.1 indicates the main factors.

Table TP 9: Factors influencing the nutritional status of under-five children, March 2004

- Children who were looked after by their mother were at a significantly lower risk of suffering from malnutrition than those who live separately from their mothers.
- Both short and long term malnutrition is more common among children of mothers who have had no formal education.
- Almost 50% of the under-five children whose mothers have never attended school are too short for their age.
- Occurrence of both stunting and wasting was found to be more common in children from poor households compared to children from non poor households. Severe stunting among the under-five children was found to be 36% in households where the food supply is never sufficient.

Source: Kagera Rural CWIQ Survey 2004 (EDI and DRDP, 2004)

The presence and educational level of the mother and the poverty status of the household were found to have a direct effect on the nutritional status of the under-five children. The survey also found that both stunting and wasting was prevalent among children who did not have access to health facilities. This was especially the case for 9% of the children who were suffering from wasting.

[7] CWIQ is an off-the-shelf survey package developed by the World Bank to produce standardised monitoring indicators of welfare. A 2250 households participated in Kagera.

[8] (1) 19 Health workers from Government Health Facilities (HF), Faith-based HF, NGO managed HF and private clinics; (2) 11 NGOs; (3) Community Health Fund staff?; (4) 4 Guardians of orphans; (5) 4 orphans; (6) 10 HIV positive clients; (7) 8 persons with a disability; (8) 1 Government Social Welfare Officer. Data collection included: desk study, interviews and Focus Group Discussions (FGDs).

[9] The Basic Needs Poverty Line is defined by what a household, using the food basket of the poorest 50 percent of the population, needs to consume to satisfy its basic food needs to attain 2,200 Kcal/day per adult equivalent. The share of non-food expenditures of the poorest 25 percent of households is then added.

[10] Buhembe and Nyakatoke.

Critical factors that hamper access to health services
The study of Mubyazi et al (2002) reflected income levels in Kagera. These could be divided into (1) people with a monthly income of less than Tshs. 5,000/= (29%), (2) people with a monthly income between Tshs. 5,000/= - 10,000/= (30%) and (3) people with a monthly income of less than Tshs. 16,000/= (69%) of the respondents. People with an income of Tshs. 5,000 or less live mainly in the rural areas. Critical factors that prevented people from adequate access and use of health facilities included (1) living in a rural area (only 19% report access within 30 minutes walking), (2) distance as a deterrent to use health services (15% in rural areas), (3) costs of transport for people living far from a health facility (31%), (4) costs of treatment as a deterrent to use (47-60% of the population not seeking health care while ill), (5) deteriorated quality of services especially at peripheral health facilities (availability of drugs, shortage of staff), (6) age (23% of the people older then 60 years live within 30 minutes of a health facility and (7) gender-poverty status. Women from poor households a remote likely to give birth at home than women from non-poor households (Mubyazi et al, 2002 and CWIQ survey, 2004).

6.5 Findings from the assessment carried out by the study team, 2004

Exclusion of vulnerable groups and poor people
The study team collected addition data in March 2004. Interviews with poor people and specific categories of vulnerable people revealed that people are excluded from access to health services. The equity implications of user fees show that the poorest people cannot afford to pay the user fees. The poorest people indicated that they could not afford the payment of Tshs. 400/= for a card in a public health facility. For this, people depend on support of their relatives, the sale of private property or the support from an NGO supported programme. The groups which systematically face exclusion of basic health services are; (1) Orphans, (2) Widows, (3) AIDS clients, (4) Elderly, (5) People with disabilities, (6) Pregnant women and (7) under-five children. Equal access to health services is prevented by; (1) poverty, (2) geographical barriers and distance, (3) gender aspects, (4) demotivated health staff and (5) informal charges. It was reported that unequal access has contributed to; (1) delayed and inadequate treatment, (2) sale of private property, (3) reduced food intake (to save money), (4) child labour and (5) petty crime (to generate money). The poorest people indicate they have better access to the public HFs because of the lower user fee level. It is felt that there is a higher chance to get a waiver in a public HF. Table 6.4 and 6.5 provide experiences of 10 HIV positive clients and 8 disabled people.

Table TP 10: View of 10 HIV positive clients towards impact of userfees, March 2004

- We receive free services from the NGO for medical treatment, counselling, home based care, HIV testing. If we are referred to the hospital (e.g. laboratory tests, x-ray) we have to pay for those costs ourselves. If we are admitted in the hospital, the NGO can provide the drugs and the drips. The other costs we have to pay. If the NGO would not be here to help us, we could not afford all the treatment we need. This is because we (1) have no reliable income (anymore), (2) are too weak to work, and (3) the drugs are too expensive.
- If we have to pay but we do no have money we feel embarrassed. If we cannot pay, we (1) borrow from friends, (2) do manual work, or (3) go home.
- The Social Welfare Officer can provide an exemption but we are not automatically exempted. We have never asked for an exemption. The waiting time for an exemption is so long (3 days) that people decide to go home. The NGO can provide a letter for the Social Welfare Officer to get an exemption but if he is not around then we face a delay.
- It is difficult to pay Tshs. 10,000/= for a CHF card since we do not have money. We might be able to afford a lower fee (e.g. Tshs 5,000 or below).

Table TP 11: Views of 8 persons with a disability towards impact of userfees, March 2004

- Most persons with a disability are poor. We feel that persons with disabilities should be treated free and should receive a waiver. We should also be prioritized during the visits to a HF.
- Some of us have been denied services in the Regional hospital since we were not able to pay. We had to find money first before we could get treatment. We have not been granted with an exemption of a waiver in our area. We are willing to contribute for health services if we have money to pay.
- Female people with a disability face extra constraints. The double disadvantage is that they are women and have a disability. They are not been given a priority. Women have experienced abuse during Antenatal clinics and deliveries.

- In the hospitals special devices for persons with disabilities are not available; prosthesis calipers, walking sticks, Braille, hearing aids, sunglasses (for albinos).
- Barriers to access services are related to poverty, perceptions of the attending health staff, and absence of a government policy towards people with a disability.

Exemptions and waivers

The Social Welfare Officer (SWO) of Bukoba Regional Hospital is the person responsible for granting an exemption or a waiver. In addition to this responsibility, he/she has also other duties in the hospital (e.g. anaesthetics), taking care of referral of "dumped babies" to an orphanage, refer the "helpless" and the "loitering" to a home care facility. The SWO felt that the exemption and waiver guidelines are clear but cited a range of problems: (1) some people pretend that they are poor while they are not, (2) rich people with chronic diseases prefer free treatment, (3) Government exemption and waiver cards are not accepted in the mission hospitals even if one lives nearby a mission hospital, and (4) Kagera Regional hospital is the only hospital where people can obtain an waiver. The official regulation is that the exemption/waiver card is only for hospital services and is not applicable to PHC facilities. The SWO expressed concern that if fees are to be introduced in health centres and dispensaries, the health staff first will need training on the exemption and waiver procedures since this will be a new procedure at PHC level. He felt that otherwise the system may be misused. At this stage, it is only the Regional SWO who is authorized to provide an exemption/waiver card. There is no limit to how many people can be given a waiver per day. On average 5-8 people receive a waiver per week. This is most often the case for the in-patients and not for the out-patients. According to the SWO, nobody is turned away because he/she cannot pay. Exemptions are given on weekdays by the Social Welfare Officer. During the weekend, the attending doctor can indicate the need for a waiver. Usually the exemption is given for the duration of one month. This can be renewed afterwards. The SWO indicated that there is an increase of people requesting a waiver due to the improved sensitization on this.

The private (non-profit and for profit) sector in Kagera did not use an exemption of waiver system. Private for profit clinics do not provide an exemption of waiver to patients (only in rare cases) and do not participate in a CHF. They have not been invited to do so but would be willing to participate. Non-religious NGOs indicated that they felt forced to introduce user fees due (1) the reduction of external funding and (2) the donor demands for increased sustainability of the programme. It was felt that this had a negative impact on the poorest project beneficiaries. NGO did not follow an exemption and waiver system either. It was found that the Catholic HFs did not have a formal exemption and waiver policy in place. Payment of user fees in instalments was allowed and accommodated the poorest groups. In some situations, a Congregation assisted the poor from private funds. The Catholic HFs realized that the poorest people cannot afford their services but also needed to charge User Fees to sustain their facilities. It was indicated that the poorest people were referred to the Government HFs in case of prolonged and costly health services.

Not many people receive a waiver considering the poverty level in Kagera. This was confirmed by resource persons. The general opinion is that poor and vulnerable people are not protected by the existing exemption and waiver systems. Resource persons indicated that the elements of the exemption and especially the waiver system are not clear. The waiver system is not well understood and many people are not aware of its existence. Experiences of resource persons indicate that the exemption and waiver system is not transparent. It is felt that the procedures are too bureaucratic and should become more straightforward. It was emphasised that poor people who require a waiver often do not receive it while *big shots* manage to get free or subsidized treatment. NGOs indicated that the exemption and waiver procedures are stigmatizing the clients and that the Social Welfare staff are not helpful to poor people. It was emphasised that the identification of people who cannot pay for health services was difficult. Resource persons felt that the people who are best placed to assess the ability of poor people to pay and the need for a waiver are; Social Welfare Officers, Health Workers, Village Leaders and the Community. However, there was disagreement on the role of the Health Worker in the waiver system. NGOs indicated that Health staff should be given the mandate to provide a waiver so that patients can receive treatment immediately. Other resource persons felt that the health workers should not have to decide on this. It was the general opinion that waivers were not an obvious option for poor people.

Is CHF the solution?

An exploratory study[11] in Kagera Region[12] identified factors that influence participation in a Community Health Fund (Mubyazi et al, 2002). The key findings are presented in Table 6.5.

Table TP 12: Key-findings from Kagera study on Preferred Health Care Financing Options, 2002	
Topics	**Findings**
CHF	▪ The CHF was largely acceptable to the majority of the community members. There was a strong support for the CHF scheme among district level managers and hospital managers. The CHF was considered more advantageous then the traditional out-of-pocket payment at the point of delivery of health services. ▪ The majority of health care providers and household respondents preferred cash payment to payment-in-kind. The preferred time of payment in the rural areas is during the harvest season (81%). People indicated that they would only be willing to accept a new payment scheme (such as CHF) if the standard of services would improve and when funds would be handled in an honest way.
Concerns	▪ There was great concern about the appropriate rate of CHF payment for individual households who would be interested to join the CHF. Community members had a great concern about the acceptability and affordability of the premium of Tshs. 10,000/= per household per annum. ▪ The majority (58%) of the household respondents preferred to pay by instalments, while only 28% would prefer payment in cash at once.

Source: Mubyazi et al, 2002

Kagera does not have a Government CHF in place. However, there is a CHF in place which is managed by the Evangelical Church of Tanzania (ELCT). The ELCT managed CHF was initiated by the Church in 2001. Currently, 22 ELCT and Catholic HFs participate in the CHF. CHF members can choose out of these facilities. Currently, the CHF operates in two Districts. There will be expansion to one district per year. The focus is on the Church facilities. In a later stage the Government may join. The CHF system includes: (1) registration, (2) payment, (3) receipt, (4) ID card with a photo, (5) computerized registration, (6) banking of premium on one bank account, (7) payment of claims from HF, (8) internal audits, (9) external audit, (10) building up of a financial buffer for unforeseen situations. There are three categories of premiums to choose from (per person per year) (1) Tshs. 20,000 (coverage to Tshs. 200,000/=), (2) Tshs. 10,000 (coverage to Tshs 100,000/=), and (3) Tshs. 5,000/- (coverage to Tshs. 50,000). It was emphasised that the people in the highest paying category make less use of the CHF facility. The CHF coordinator indicated that there is a need to add another category for the poor people (e.g. Tshs. 2,000/= per person per year). The coverage of the CHF excludes; (1) glasses, (2) plastic surgery, and (3) medical exams not prescribed by a Medical Doctor. All other health services can be covered by the CHF. After three years of being operational, the CHF had 3,183 members (per December 2003). The number is increasing but the projected membership for this period was estimated higher (10,000 people in five years). The participation in the CHF is slower than expected. This seems related to the introduction of the National Health Insurance Fund (NHIF). This has been advertised and confuses people since people have the impression that the NHIF and the CHF are the same. In 2003, the income from premiums was Tshs. 29,400.000/= and the treatment costs paid were Tshs. 26,500,000/=. The income from co-payment (300/= for consultation) was Tshs. 2,000,000/=. The positive balance can be carried forward and can be used for investments in member HFs.

It was found that the Catholic HFs that participate in the CHF promote the CHF participation among the poorest people because this is beneficial for both the poor and the income situation of the HFS (it provides a more stable income). It also became clear that NGOs are not creative in the potential use of the CHF membership for the poorest groups. This option could for example be much more integrated in project proposals to donors as a standard support option. This will benefit the poorest groups, the HFs and the CHF. The study team found that the CHF has a high potential but this potential is currently under-utilized and therefore not realized. The CHF should increase its finance

[11] A multistage-strategic random sampling method was adopted. In each district or town council area, four villages or streets were selected. In each area, 25 households were randomly selected and male or female heads of households were selected. Key-informants included; (1) members of the Council Health Management Teams (CHMTs), (2) District Executive Directors (DEDs), District Planning Officers (DPOs) and members of Hospital Management Teams (HMTs). In addition, FGDs were held.

base and promote support for the poorest people through more creative solutions such as: (1) improved marketing among [rivate clinics, NGOs, FBOs, donors, business people and companies and (2) promotion of CHF membership inclusion into project proposals. It was felt that the CHF can be a pro-poor solution, but should be designed to include the introduction of lower premiums for the poorest groups. If that does not happen, an improved exemption and waiver system could work as a more pro-poor strategy.

Preferred scenarios by respondents
Respondents indicated the preferred scenario for an adjusted user fee scheme. It was overall felt that in any scenario people's access to basic health services for the poor should be increased. User fees should not be introduced at PHC level, only at hospital level. It was felt that not much money would be lost. The Government should compensate for the 'lost' funds through alternative strategies (e.g. revenues, improved insurance schemes). In case the Government would still continue with the introduction of user fees at PHC level then; (1) the exemption and waiver systems should be improved, (2) the introduction should be gradual (e.g. only HC level first), (3) user fees should be affordable, and (4) the quality of services should improve

6.6 Overview of Tables

Table TP 13: Definitions about poor people. Who are the poor people in Kagera Region, March 2004

▪ People with temporary houses ▪ People without a proper shelter ▪ People without any income ▪ People with no viable income ▪ People who can not earn a living? ▪ People who are unemployed ▪ People who cannot pay the school fees or the uniform ▪ People who cannot afford to pay medical bills ▪ People without proper clothes ▪ People with a small shamba ▪ People with poor agricultural output ▪ People without land for cultivation ▪ People without animals	▪ People who face food insecurity ▪ People are unable to feed themselves ▪ People who are chronically ill ▪ People with a poor general condition ▪ Widows ▪ Elderly people ▪ Lonely aged people without relatives ▪ People who are disabled ▪ A person who has no help ▪ People who take care of orphans ▪ People who do not have anybody to support her/him ▪ People who cannot afford essential commodities such as kerosene (Mafuta ya taa) and soap

Source: All participants in Kagera study carried out by REPOA team

Table TP 14: Views of 4 guardians taking care of orphans towards impact of user fees, March 2004

- On average our monthly cash income is between Tshs. 3,500 –Tshs. 5,000/-. For food we depend on the Shamba. If we need extra cash money, we will offer to work (e.g. cattle keeping, agriculture, cleaning). We rely on the sale of beans, coffee, sweet potatoes, eggs, milk, and scones.
- The priority purchases are: Kerosene, matchbox, soap, sugar, salt, body lotion, stationery.
- We estimate that 20% of the people are poor in our area. These people have nothing to sell. People stay at home in case of illness and wait for help from anybody, use local herbs or buy a few tablets in the kiosk. Sometimes local healers offer free treatment.
- If we can, we will sell family commodities (radio, goat, shamba) up to the value of Tshs 20,000/= to Tshs. 100,000/= to visit a traditional healer or for the payment of a delivery in case of a complication during the pregnancy.
- The traditional healer is visited for mental illness, chronic illness which does not respond to modern treatment, beliefs in supernatural powers, abdominal complaints, and infertility.
- We cannot afford the user fee charges in the NGO. We prefer to visit the Government dispensary since it charges only Tshs 400/=.
- The payment of Tshs. 400/= in the Government dispensary is also a problem. For this we depend on the assistance of our children who can pay for us. Otherwise we just stay at home.
- Sometimes we can pay in installments. This is a better and preferred option.
- The NGO should provide free treatment to the guardians of the orphans as well because we are very poor.
- There is no support for the poor people from the churches and the village government. The village leaders do not provide waiver letters
- Poor people should be treated free of charge or NGOs should support them.
- The CHF is known and seems helpful but the problem is to pay for the whole family. We have then to select one family member who can participate in the CHF. One person will choose a child who is frequently sick. One other person will choose herself since she is the bread winner and has to care for the children.

Table TP 15 Views of 4 orphans towards impact of user fees, March 2004
▪ We receive support from the NGO and our relatives. ▪ Some of us look after our brothers and sisters. ▪ For medical treatment we receive support from the NGO or in the school dispensary (the fee for medical costs – Tshs 5,000/= - are included in the school fees).

Table TP 16: View of 10 HIV positive clients towards impact of userfees, March 2004
▪ The monthly income fluctuates between Tshs. 6,000/= and Tshs 10,000/=. ▪ Most important payments are for salt, kerosene, sugar, food, house rent. ▪ We receive free services from the NGO for medical treatment, counseling, home based care, HIV testing. ▪ If we are referred to the hospital (e.g. laboratory tests, x-ray) we have to pay for those costs ourselves. ▪ If we are admitted in the hospital, the NGO can provide the drugs and the drips. The other costs we have to pay. ▪ If we have to pay but we do no have money we feel embarrassed, look for help or will wait for our death. ▪ If we cannot pay, we (1) borrow from friends, (2) do manual work, or (3) go home. ▪ The Social Welfare Officer can provide an exemption but we are not automatically exempted. ▪ We have never asked for an exemption. Some do not know that it exists. The waiting time for an exemption is so long (3 days) that people decide to go home. The NGO can provide a letter for the Social Welfare Officer to get an exemption but if he is not around then we face a delay. ▪ If the NGO would not be here to help us, we could not afford all the treatment we need. This is because we (1) have no reliable income (anymore), (2) are too weak to work, and (3) the drugs are too expensive. ▪ It is difficult to pay Tshs. 10,000/= for a CHF card since we do not have money. We might be able to afford a lower fee (e.g. Tshs 5,000 or below).

Table TP 17: Views of 8 persons with a disability towards impact of userfees, March 2004
▪ Most persons with a disability are poor. We feel that persons with disabilities should be treated free and should receive a waiver. We should also be prioritized during the visits to a HF. ▪ Some of us have been denied services in the Regional hospital since we were not able to pay. We had to find money first before we could get treatment. ▪ We have not been granted with an exemption of a waiver in our area. ▪ Female people with a disability face extra constraints. The double disadvantage is that they are women and have a disability, they are not been given a priority, they are often abused during Antenatal clinics and deliveries. ▪ The costs for x-ray and ultrasound are too high. ▪ In the hospitals special devices for persons with disabilities are not available; prosthesis calipers, walking sticks, Braille, hearing aids, sunglasses (for albinos). ▪ Barriers to access services are related to poverty, perceptions of the attending health staff, and absence of a government policy towards people with a disability. ▪ We are willing to contribute for health services if we have money to pay. ▪ Informal charges: We do not receive receipts for all the payments. Most often we receive a receipt for the registration card and the drugs. ▪ We are not well informed on the CHF.

Table TP 18: Government dispensary (1) and health center (1) user fees, March 2004
▪ No User Fee is charged at dispensary and health center level. ▪ Charges have not been introduced in Government PHC facilities. Councilors in Bukoba town did not agree upon it. It is a political issue since counselors fear that they will lose the votes. The Government respects the decision of the counselors.

Table TP 19: Private clinics (2) and user fees, March 2004
▪ The private clinics have fixed charges for registration, laboratory and admission. ▪ There are no free services. Charges are for the running costs of the HF. ▪ Waivers can be given to somebody unable to pay but this is an exception. ▪ Poor people may get a waiver if another person is willing to pay on their behalf. ▪ Waivers are sometimes given for pediatric emergencies and chronic diseases. ▪ Charges for drugs fluctuate depending on the type of drugs, costs of the drugs and transport costs ▪ The clinic does not participate in a CHF. This option has not been discussed by the CHF with the clinic. ▪ Poor people prefer the public facilities because of the lower charges.

Table TP 20: NGO clinics (2) and user fees, March 2004

- The guardian has to pay 50% of the medical costs (on average between Tshs 1,500/= and Tshs 2,000/=). As a result the attendance of guardians reduced. If guardians cannot afford to pay cash, they can pay in kind (e.g. food). The food is provided to the children in the day care centre. Guardians prefer to visit the Government facility since the dispensary requires a flat fee of Tshs 500/= for the total service.
- The NGO programme (external funding) pays all (100%) the health costs for the orphans
- Children not covered by the programme pay 100% of the total costs. Not many children outside the programme visit this clinic.

Table TP21: Views of 19 Health Workers towards impact of User Fees, March 2004

- Are well informed on the National User Fee system and are informed on Government criteria for waivers: (1) Disabled, (2) People older then 60 years, (3) Mentally handicapped people, (4) Depending on conditions. Most of the respondents mix the words exemption and waiver.
- More people make use of the public health facilities compared to the private facilities. This is related to the fee levels. The private facilities are not considered ethical since they charge high fees and prescribe extra expensive drugs.
- Poor people cannot afford the health services. They will not receive the required services. People may resort to traditional herbs or may die. Especially elderly and disable people are affected. Pregnant women can often not afford the delivery in HFs since they first will have to buy the items such as razorblades, stitches, gloves, etc.
- User fees contribute to increasing services nearby the villages, availability of drugs, increased ownership and will prevent misuse of drugs by people who are not sick. However, user fees have also contributed to misuse of the money by those who are handling the funds. This has created a bad image to the public. There are no bribes to be paid.
- If people know that the services are good, they will travel a long distance to that particular HF. Good services include; consultation, laboratory, inpatient facility, safe deliveries and professional health staff.

Table22: Views of 2 private clinics towards the impact of User Fees, March 2004

- Groups affected by the user fees are the poor and the unemployed.
- People do not have equal access to health care services since HFs are not equally distributed. There are clear geographical differences.
- Impact of user fees on poor people: (1) may not seek treatment at all and (2) may opt to visit a local healer.
- Assistance by poor people may be found from the Social Welfare Office.
- The CHF is pro-poor and is a step forward in health coverage for poorer people.

Table TP 23: Views of 4 Catholic Diocese health resource persons towards user fees, March 2004

- User Fees are charged in the Diocese since 1912.
- User fees differ per health facility and can be decided by the Management Team (MT) in the HF.
- At all levels (hospital, health center and dispensary) services are charged except for MCH and TB patients. The charges are differentiated (for consultation, laboratory, and treatment). Some health interventions receive external donor funding.
- The user fees contribute to the running costs of the HFs. If people are unable to pay then this affects the income of the HF.
- Fees have not been raised since 1997 due to the prevailing economic situation in the area (in dispensary).
- Some areas in the Diocese are extremely poor (e.g. affected by war between TZ and Uganda, HIV/AIDS, poor soil fertility, impact of El Nino rains in 1998).
- Most people who visit the HF are better off and better? manage to pay than people nearby the HF.
- Waivers can be given to people who are unable to pay. There is no formal waiver system in place. This depends entirely on the health staff in the HF.
- In principle everybody has to pay but if one fails, we inform the village leaders, present the bill and wait for payment afterwards. However, exemptions are given for TB patients, MCH services and ANC services. Under-five children, elderly people and AIDS patients have to pay as well. Nobody is turned away because he/she can not pay. However, poor people know that they cannot afford to pay the services and will not come. If they come they will settle the bill afterwards or not at all.
- The current revenue generated does not cover the running costs of the facility. There is no formal poor policy. We have to cover our running costs since we do not receive financial assistance from the Diocese.
- The Health centre stopped payment of Tshs 5,000 upon admission since people could not manage to pay this. Registration and investigation costs are compulsory upon admission but the other costs can be paid slowly by slowly until the whole amount is recovered. This system works. If a person is very poor and cannot pay then he will be given first aid treatment and will be referred to a government facility. In

this way the health centre prevents that they have accumulated bills which people cannot afford.
- The HC does not have a fund for poor people. Sometimes the Congregation provides support to poor people and will settle the bill from a poor fund.
- CHF participation is encouraged. The CHF refund is smooth and people can receive services up to a certain ceiling. The Congregation has paid the CHF premium for a few patients.

Table TP 24: Views of 10 NGOs towards impact of User Fees, March 2004

- The majority (10) was well informed on the elements of the Tanzanian user fee system.
- The majority (10) was able to mention the groups entitled to exemption of user fees (e.g. under-fives, pregnant women, TB patients and HIV clients) and waivers (the poor people).
- The majority (7) feels that poor people have more access to the public health services then to private health services because of the level of user fee charges (the fees are higher in the private HFs). The poor also have a higher chance to get a waiver in a public facility then in a private facility. If people can afford, they do prefer the private HFs.
- The majority (8) feels that there is a negative impact of user fees on poor people. Especially orphans, widows, AIDS patients, elderly and people with disabilities cannot afford to pay for the services. Even Tshs. 500/= for a card is difficult to pay. It is observed that also under-five children and pregnant women face problems. The main problems are seen in the rural areas. The consequence of the inability to pay user fees is that people resort to (1) delayed treatment which leads to complications, (2) inadequate treatment, (3) increased morbidity and mortality, (4) traditional medicine, (5) sale of property, (6) child labor, (7) theft, (8) starvation to save money. The economic impact of user fees on families is substantial. The majority of NGOs feels that the exemption and waiver systems do not function.
- The majority (7) feels that people do not have equal access to health services due to (1) poverty, (2) absence of HFs in areas, (3) geographical barriers and distance, (4) bribery practises, and (5) demotivated health staff in some areas.
- Gender plays a role because of (1) dependency on the husband for income and the use of his bicycle for transport, (2) less confidence in health professionals, (3) limited education, and (4) not willing to leave the house unattended to seek health care.
- The majority (7) declined from the introduction of user fees because of their mandate to assist the poorest people in the project area. The NGOs provide free or subsidized health services with support from external funders. One NGO decided that, since the programme budget was reduced, the guardians of orphans (even though they are poor) had to pay 50% of the health costs. This decision contributed to a reduced attendance in the NGO clinic by guardians.
- The FBOs (Catholic and Lutheran) participate in a CHF and collaborate together.
- The majority of the NGOs (7) have not registered patients in a CHF.
- The majority (8) of the NGOs has no experience with a CHF but the CHF is considered as pro-poor.

Table TP 25: Experiences with the Exemption and Waiver system by resource persons, March 2004

- For a poor person being sick means trouble.
- The elements of the exemption and especially the waiver system are not clear. The waiver system is not well understood and many people are not aware of its existence. The waivers are not an obvious option for poor people.
- A waiver system is not transparent. The exemption and waiver procedures are too bureaucratic and should be made more straight forward. People who require a waiver often do not get it while *big shots* manage to get free or subsidized treatment. The Social Welfare people are not helpful to poor people.
- NGOs indicate that the exemption and waiver procedures are stigmatizing the clients.
- The identification of people who can not pay is difficult.
- People who are best placed to assess the ability of poor people to pay and the need for a waiver are for example; Social Welfare Officers, Health Workers, Village Leaders and the Community.
- There is disagreement on the role of the Health Worker in the waiver system. NGOs indicate that Health staff should be given the mandate to provide a waiver so that patients can receive treatment immediately. Other resource persons feel that the health workers should not have to decide on this. People will try to win the sympathy of the health worker and will come in a *shabby* appearance to let people think that they are poor.

Table TP 26: View of the Social Welfare Officer Bukoba Regional Hospital towards Exemption and Waiver system, March 2004.

- In the Regional hospital the Social Welfare Officer is the person responsible for granting an exemption or a waiver. In addition to this responsibility he/she has also other duties in the hospital (e.g. anesthetics), taking care of referral of “dumped babies” to an orphanage, refer the “helpless” and the “loitering” to an elderly home.
- The exemption and waiver guidelines are clear but there are problems; (1) people pretend that they are poor while they are not, (2) rich people with chronic diseased prefer free treatment, (3) Government exemption and waiver cards are not accepted in the mission hospitals even if one lives nearby a mission hospital and (4) Kagera Regional hospital is the only hospital where people can get an waiver. The exemption/waiver card is only for hospital services.

- Exemptions can be provided to people with a chronic disease such as hypertension, diabetes mellitus, and asthma since they require frequent treatment.
- Poor people who cannot pay receive a waiver. We rely on the village leaders who know the people who are poor. If the village leader provides a letter to a poor patient, then a waiver can be granted.
- There is no limit to how many people can be given a waiver per day. On average 5-8 people receive a waiver per week. This is most often the case for the in-patients and not for the out-patients. Nobody is turned away because he/she cannot pay.
- The assessment of the poor patient includes; (1) the way they live, (2) income status, and (3) a physical assessment of the patient.
- The patient receives a specially designed exemption/waiver card which has to be signed by the MOH. A person can only receive free treatment when he/she has received a card. For acute and emergency cases, the exemption is granted immediately to save the patient.
- Usually the exemption is given for the duration of one month. This can be renewed afterwards.
- Exemptions are given on weekdays by the Social Welfare Officer. During the weekend, the attending doctor can indicate the word *Emergency* on the patient file so that the patient can get immediate treatment and can receive an exemption/waiver card during the week.
- If fees are to be introduced in health centres and dispensaries, the exemption card may be misused. Others may pay something in order to get an exemption card. At this stage it is only the Regional SWO who is authorized to provide an exemption/waiver card.
- There is an increase of people requesting a waiver due to the improved sensitization on this.

Table TP 27: Views of the Coordinator ELCT Community Health Fund, March 2004

- The ELCT managed CHF is initiated by the Church in 2001. Currently 22 ELCT and Catholic HF participate in the CHF. CHF members can choose out of these facilities. Currently the CHF operates in two Districts. There will be expansion to one district per year. The focus is on the Church facilities. In a later stage the Government may join. People trust the Church for the management of the CHF.
- The CHF system includes: (1) registration, (2) payment, (3) receipt, (4) ID card with a photo, (5) computerized registration, (6) banking of premium on one bank account, (7) payment of claims from HF, (8) internal audits, (9) external audit, (10) building up of a financial buffer for unforeseen situations.
- There are three categories per person per year: (1) Tshs. 20,000 (coverage to Tshs. 200,000/=), (2) Tshs. 10,000 (coverage to Tshs 100,000/=), (3) Tshs. 5,000/- (coverage to Tshs. 50,000). The people in the highest paying category make less use of the CHF facility. The coverage excludes; (1) glasses, (2) plastic surgery, (3) medical exams not prescribed by a Medical Doctor.
- After three years the CHF has 3,183 members (per December 2003). The number is increasing but the projected membership for this period was estimated higher (10,000 people in five years). The participation in the CHF is slower then expected. This seems related to the introduction of the National Health Insurance Fund (NHIF). This has been advertised and confuses people. People think the NHIF and the CHF are the same.
- In 2003 the income from premiums was Tshs. 29,400.000/= and the treatment costs paid were Tshs. 26,500,000/=. The income from co-payment (300/= for consultation) was Tshs. 2,000,000/=.
- The positive balance can be carried forward and can be used for HF investments.
- There is an external budget for CHF marketing.
- The Churches have special funds for the support of poor people. The churches are concerned about the poverty levels in the area. We may have to add an other category for the poor people (e.g. Tshs. 2,000/= per person per year). This depends on the inflation and price development in Tanzania.
- The Government CHF is not community based but operates at District level. The mandate and policies are at District level. In Kagera there is no Government CHF yet. The Government is interested to participate in the Kagera ELCT managed CHF. This would be a positive development.
- More marketing of the CHF is needed. The focus is on communities and Church health facilities, not on potential employers.

Table TP 28: Views of 59 Resource Persons towards preferred scenarios for the User Fees in Tanzania, March 2004

Introduction of User Fees at Primary Health Care Level (Minority View)	**No introduction of User Fees at Primary Health Care Level (Minority View)**
▪ Access to basic health services for the poor should be increased. ▪ A functional exemption and waiver system should be put in place. This is a pro-poor strategy but the system should be transparent. ▪ Under-five children and elderly people should be exempted from user fees. ▪ User fees should not be introduced at the PHC facilities. This will affect the areas where many of the poor people live. ▪ User fee in the rural areas should be abandoned, especially at	▪ Charges should be at all levels of the health system but it should remain cost *sharing*. This means that people should not have to pay the actual costs of the services (cost *covering*). ▪ Charges at all levels create equity. People will belief that if they pay for the services, they will be of a better quality. Those

dispensaries. That is where most of the people go to. ▪ The Government should subsidize the PHC services. The Government should be committed to help all its people. NGOs have to come in to assist as well. ▪ Fees should only be charged in hospitals and not in health centres and dispensaries. If the services are charged at PHC level, people will not use them. More corruption might take place if charges are introduced at this level. ▪ If fees are abolished at PHC level, the Government should compensate for the money lost through (1) Government revenues (2) insurance systems, (3) cooperative unions (4) revolving drug funds. Not much money will be lost since the generated income is a small portion of the total budget.	services are also given a higher value. ▪ Fees should be introduced at all PHC levels. However fees should be reasonable. It will improve quality of the services and it will reduce disturbance to the people. They will get what they need and do not have to be transferred to the private pharmacies. The current drug kit system does not cover all requirements. Additional funds will overcome this problem. ▪ Fees at PHC level should be introduced gradually.

Table 29: Views of 59 Resource Persons towards the Community Health Fund, March 2004

Positive Views about Community Health Fund	More Critical and Concerned Views about Community Health Fund
▪ A CHF is a pro-poor solution for Tanzanians since it will help people to get access to health services. People can receive treatment when they have no money. Eventually it will cover all communities. It is part of the solution. ▪ The CHF is beneficial since it reduces tension in families. One is sure to receive treatment. It is helpful to those without a reliable income. ▪ People appreciate the CHF.	▪ More information and sensitization is required on the CHF. ▪ It is not 100% effective since it is limited to certain health facilities. If one travels outside Kagera, he/she can not use the CHF card in other areas. The CHF only operates in 2-3 districts. ▪ The annual lowest fee of Tshs. 5,000/=, per person, per year, is still too high to pay for by poor people. ▪ The co-payment of Tshs 300/= is a barrier as well. ▪ The problem is to pay for the whole family. We have then to select one family member who can participate in the CHF. ▪ For the poor people a waiver system is more pro-poor then a CHF. If people receive a waiver they have better access to health services. It will prevent misuse of CHF by the local leaders. ▪ If many people are poor the fund will not have enough money. ▪ The CHF is not the solution. It will exclude the poorest people unless other money is generated for the poor so that they can participate or contribute to the fund. Poor people can not afford to pay Tshs. 10,000/= if they can not pay in installments.

ANNEXES

ANNEX 1 TERMS OF REFERENCE

Equity Implications of Health Sector User Fees
in Tanzania
Research and Analysis Working Group

Purpose of the analysis
The proposed analysis will examine the equity implications of the user fee system in Tanzania, with particular reference to proposed (and actual) charges at primary health care facilities. The analysis will contribute to the current review of the Poverty Reduction Strategy (PRS) and seeks to address one of the guiding PRS questions in relation to health:

> "The Government should consider suspending cost sharing for basic health services at least until the time when an effective system of exemptions for the poor is put in place. In preparing for this, a cost-benefit assessment should be undertaken to determine how much is gained by fees as compared to how much is lost by excluding the poor."
>
> Policy Eradication Division, Vice President's Office

The analysis will be a review of relevant literature on the subject from Tanzania, regionally and internationally in the form of research studies, Ministry of Health documents, academic papers as well as "gray literature" from non-governmental organizations and community based groups that have documented the impact of user fees on the poor. It will also include key stakeholder interviews with officials from Ministry of Health, Ministry of Finance, PoRALG and other agencies; civil society; and donors. See "Methodology" section below for further details.

Three overall questions will guide the analysis:

1. What has been the impact of user fees in the health sector?

2. What might be the potential impacts of further extension/roll out of user fees to the dispensary and health centre level?

3. What options exist for revising the current user fee system to achieve greater equity and effectiveness?

Details are provided in the "Key Issues" section below.

Background
Since the 1980s, and particularly in the wake of economic structural adjustment programmes, many African countries have implemented user fee systems in the health sector. The rationales for user fees have focused on raising revenue, enhancing efficiency and sustainability, improving services, reducing "frivolous consumption" of health care, substituting formal fee systems for informal charging, extending coverage and increasing equity. At the same time, numerous key policy documents at both the international level and in Tanzania specifically have focused on goals of improving access, equity, special attention to vulnerable groups and the reduction of poverty (Vision 2025, Poverty Reduction Strategy, Tanzania Health Policy, Tanzania Health Sector Strategic Plan, etc.).

Evidence suggests mixed results in achieving goals of improved services and greater equity through the establishment of user fees in health. While fees have, in some case, generated needed income for health facilities, several studies show that revenues generated are often not more than 5-10 percent of recurrent costs (although could cover a higher proportion of non-recurrent costs). In addition, that user fees are often not accompanied by improvements in quality or availability of drugs. While there is some evidence that fees bring needed resources to health facilities in Tanzania, the 2003 Public Expenditure Review for the health sector states: "cost-sharing to date has contributed relatively little to the overall sectoral resource envelope."

In a 1996 review of user fee systems in Africa, the following conflicting impacts were noted:

- Fees by themselves tend to dissuade the poor from using health services more than the rich and are associated both with delays in accessing care and with increased use of self-medication and informal sources of care
- If fees are associated with quality improvements, this offsets their negative impact on utilization; the introduction of fees plus quality improvements may even generate utilization increases among the poorest
- Fees do not appear to generate adequate revenue or to be associated with the resource re-allocations necessary to enable substantial and sustained improvements in health care for the poor
- The implementation of both formal and informal exemptions or sliding scales that could protect the poor from the full burden of fees is usually ineffective

Numerous studies point to regressive outcomes of fees including in Zimbabwe where women limited their ante-natal care and gave birth at home in higher numbers; in a regional hospital in Nigeria where maternal deaths rose by 56 percent along with a 46 percent decline in deliveries after introduction of fees; in Tanzania where a decline of 53 percent among outpatients visits in public hospitals was noted after fees were introduced; in Kenya where the introduction of fees in government outpatient facilities led to a reduction in utilization of STD services; and in Swaziland where people most affected by the introduction of fees were patients who are either low income, need to make multiple visits, or who decide their illness is not serious enough to justify the costs of care.

As a result of this and other evidence there is an increasing concern about the impact of user fees on the poor and a declining popularity of user fees as a health care financing mechanism in the international policy literature. For the most part, the supposed benefits have not been supported by evidence and the international policy climate has shifted the balance of emphasis from efficiency to equity.

Tanzania has already introduced user fees at the hospital level and is preparing to further introduce fees at the dispensary and health centre levels (in some districts primary level facilities are already charging official fees). Particularly given the need to increase revenue within the sector and concerns about "donor fatigue" and long-term sustainability, many people argue that fees are critical to maintaining both basic and tertiary health services in the country.

At the same time, others have raised the concern that user fees are limiting the capacity of poor people to get care. The recently concluded Policy and Service Satisfaction Survey, Tanzania Participatory Poverty Assessment and "gray literature" point to the grave dilemma that poor people face in paying for health care: forced to pay for services, they are thrust into even greater poverty.

The imperative to raise revenue for services and to strive for sustainability is real and valid goals. The dilemma then becomes how to achieve these goals without excluding the poorest Tanzanians from health care, particularly at the primary levels. A strong exemption system may be part of the answer, although various studies point to the misuse of exemptions in clinic settings; nearly non-existent records and monitoring systems for exemptions; leakages to the non-poor; and, discretionary waiving of fees or application of fees.

Objective and key issues

This analysis seeks to examine how much is gained by user fees in the health sector as compared to the impact of fees on poor people's access to health services. Special attention will be focused at the primary level of care: dispensaries and health centres.

In particular, this study will examine:

1. **The impact of user fees in the health sector overall in relation to:**
   - New resources generated and used at the facility level
   - Local ownership and accountability, and provider responsiveness resulting from fees
   - Whether and how revenue generated by fees is used to improve services
   - Transaction costs and administration requirements of implementing the system, to the extent this information is available in the literature

- Access to services for the poor due to fees (by which categories of client; age, sex, socio-economic group; at what levels of health facility)
- Effectiveness of the exemption and waiver mechanisms including if the data points to particular categories of clients who are most affected
- Contribution to the overall resource envelope of the health sector in general
- Payment of "unofficial fees" by the poor after the introduction of official fees

2. The potential impacts of further extension of user fees to the dispensary and health centre level in terms of:

- New resources generated and used at the facility level
- Local ownership and accountability, and provider responsiveness resulting from fees
- Whether and how revenue generated by fees might be used to improve quality of care
- Transaction costs and administration requirements of implementing the system
- Access to services for the poor due to fees (by which categories of client; age, sex, socio-economic group; at what levels of health facility)
- Effectiveness of the exemption and waiver mechanisms
- Contribution to the overall resource envelope of the health sector in general
- Payment of "unofficial fees" by the poor after the introduction of official fees

3. Options that exist for revising the current user fee system to achieve greater equity and effectiveness, including:

- The optimal scenario for utilization of fees to maximize new resources to the sector while minimizing possible negative impacts, for example:
- Fees imposed at all levels of health care delivery
- No fees charged at any level
- Fees charged at hospital level but not at dispensary/health centre
- Other
- A potential exemption and waiver system that would enable persons entitled to these mechanisms to utilize them, including how current problems faced in implementation of the exemption/waiver system could be overcome
- Other key requirements of the system in order to increase access of the poor to a basic level of quality care

In order to compare other recent policy developments relevant to the study, the consultant(s) should examine the recent experience in Uganda of abolishing fees in the health sector and the abolition of fees for basic education in Tanzania.

Methodology

The analysis will be a review of research studies, reports and other relevant literature on the subject from Tanzania, regionally and internationally. It should include the 2003 Policy and Service Satisfaction Survey (PSSS), the Tanzania Participatory Poverty Assessment (TzPPA); recent Public Expenditure Reviews (PERs); Ministry of Health documents; "gray literature" such as Masters and Doctoral theses, and studies and reports from NGOs, CBOs and others working on the health and well-being of the poor; and studies funded and/or carried out by REPOA, ESRF, IDS, IHRDC and other research institutions.

Interviews should be conducted with key persons in the Ministry of Health and other relevant government agencies (e.g. Ministry of Finance); civil society (NGOs, CBOs, religious groups, etc.); and donors in the health sector. While ideally interviews would also be conducted with a sampling of health care providers particularly at the dispensary and health centre level, time may not permit.

Relying on secondary data provides an opportunity to synthesize the extensive data already collected on this issue, although it presents limitations in terms of collecting first-hand views of some stakeholders, particularly health workers themselves. Therefore, the consultant(s) should include in the analysis key research questions related to the topic that should be asked in future.

Consultants

An individual or team of two to three individuals is requested to submit a proposal to undertake this analysis. The following documents are required as part of a complete proposal:

- A proposal of three to five pages that outlines the consultant(s) interpretation of the Terms of Reference and proposed approach and methodology for carrying out the analysis to produce insightful and useful results
- Timetable for carrying out the assignment, including completion of
- detailed outline ("inception report")
- first draft
- final draft following comments from reviewers
- Budget, including direct costs of the research and fees
- CVs of principle consultant(s)

Outputs
A comprehensive paper of not more than 30 pages with a succinct Executive Summary that highlights key findings and recommendations. An editor will develop a separate synthesis paper of approximately 10 pages.

Timeframe
In order to contribute to the PRS Review Process, the final draft of the study must be completed no later than 30 April, 2004. The workplan, above, should reflect this end-date and intermediary deadlines.

Management
RAWG will review the inception report, first draft and final drafts of the paper, and will be responsible for identifying a writer for the synthesis report

Budget
Proposed by Consultant(s)

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ANNEX 2 DATA MATRIX FOR CATEGORISATION AND IDENTIFICATION OF KEY ISSUES

DATA MATRIX TO ASSIST WITH DATA COLLECTION AND DATA ANALYSIS

Guiding questions per section:

- **In which type of documents/studies do these particular topics receive attention and quantify/score how often these topics are mentioned in the categories of literature? This indicates what areas are prioritized and what areas are neglected/forgotten/ hardly subject of research**

- **What are the views/ideas/suggestions of the key-stakeholders that were interviewed (per stakeholder) such as Ministry of Health, Ministry of Finance, PO RALG, Other relevant ministries, Donor agencies, NGOs, FBOs, Other Civil Society Organisations, Universities, Research Institutes?**

Issues mentioned in the TOR	*Related topics to be looked at and high lighting of the key findings/ideas/thoughts/visions per topic in the literature*
1. Equity implications of the user fees in Tanzania	▪ In Tanzania, in Uganda and Kenya, in Africa (as a continent)?
2. Poverty Reduction Strategies	▪ In general, in Tanzania? ▪ What are the other guiding PRS questions in relation to health (apart from the one that is mentioned in the TOR)? ▪ What did earlier PRS reviews (in TZ) say on equity of user fees? Is there a trend or a shift in PRSP thought over user fees?
3. Proposed charges at primary health care facilities (health centre/dispensary)	▪ In Tanzania, In Uganda and Kenya, in Africa (as a continent)? ▪ Charges to be converted to US Dollar rates to allow for comparison? Charges in relation to income level and poverty level ▪ What are the fee levels in the hospitals in Tanzania (Government and private)? ▪ What are the proposed and actual charges at PHC level in Tanzania (Government and private)?
4. Actual charges at primary health care facilities	▪ In Tanzania, in Uganda and Kenya, in Africa (as a continent)? ▪ Charges to be converted to US Dollar rates to allow for comparison? ▪ Charges in relation to income level and poverty level (In $ rate)?
5. Rationale for introduction and implementing user fees in the health sector	▪ For raising revenue? ▪ For enhancing efficiency? ▪ For enhancing sustainability? ▪ For improving services? ▪ For reducing frivolous consumption of health care? ▪ For substituting formal fee systems for informal charging? ▪ For extending coverage? ▪ For increasing equity? ▪ For improving access? ▪ For special vulnerable groups? ▪ For reduction poverty? ▪ Others, which ones?

6. Results in achieving goals through the establishment of user fees	▪ Improved Services? ▪ Greater equity and for who? ▪ Generated income for health facilities? ▪ How much percent (%) is the generated revenue out of the recurrent costs and the non-recurrent costs? ▪ Does user fees contribute to quality improvements and which ones? ▪ Does user fees contribute to availability of drugs and which ones? ▪ Has the cost-sharing (in TZ) contributed to the overall resource envelope and to what extent?
7. Impacts of user fees documented	▪ What definitions are used about the poor? ▪ Fees tend to dissuade poor from using health services more then the rich? ▪ Do fees limit poor people to get access to care? ▪ Fees are associated with delays in accessing care? ▪ Fees lead to increased self-medication and informal resources of care? ▪ Do fees lead to quality improvement and does this lead to increase or decreased utilization of health care services? ▪ Do fees generate adequate revenue? ▪ Do fees contribute to re-allocation of resources to enable substantial and sustained improvements in health care for the poor? ▪ Does formal fee exemption lead to effective protection of the poor and prevention of full payment of fees? ▪ Does informal fee exemption lead to effective protection of the poor and prevention of full payment of fees? ▪ What kinds of informal fee exemption systems are applied? ▪ What are regressive outcomes of fees for categories of patients and diseases (e.g. ante-natal care, decline in safe deliveries, decline in OPD visits, reduced utilization of STD services, people with multiple visits, lower income category patients, delay to seek treatment because illness is not serious enough)?
8. Exemption strategies for user fees	▪ What exemptions strategies (formal and informal) are commonly used? ▪ Which categories of patients are exempted and for what reasons? ▪ Which exemption strategies are successful and not successful and for what reasons?
9. Suspension of user fees	▪ At which level of health services has this been done? ▪ What are documented practices? ▪ What are experiences in Africa (as a continent)? ▪ What are experiences in Tanzania and Kenya and Uganda? ▪ Is the Government/Ministry of Health willing to suspend user fees? ▪ What are pro and contra arguments?
10. Policy implications for financing health care	▪ Concern about impact if user fees on the poor as a health care financing mechanism? ▪ Declining popularity of user fees as a health care financing mechanism? ▪ Evidence of supposed benefits of user fees? ▪ Are fees critical to maintain basic and tertiary health services in the country? ▪ Do the user fees thrust people in greater poverty?
11. Impact of the user fees in the overall health sector and the potential impact of further extension of user fees at PHC level in Tanzania	▪ New resources generated and used at the facility level? ▪ Local ownership and accountability, and provider responsiveness resulting from fees? ▪ Whether and how revenue generated by fees is used to improve services? ▪ Transaction costs and administration requirements of implementing the system? ▪ Access to services for the poor due to fees (by which categories of client; age, sex, socio-economic group; at what levels of health facility)? ▪ Effectiveness of the exemption and waiver mechanisms including if the data points to particular categories of clients who are most affected?

(These are the key questions in the TOR)	▪ Contribution to the overall resource envelope of the health sector in general? ▪ Payment of "unofficial fees" by the poor after the introduction of official fees?
12. Options for revising the current user fees in order to achieve greater equity and effectiveness	▪ What is optimal scenario for utilization of fees to maximize new resources while minimizing negative impacts? ▪ Fees imposed at all levels of health care delivery? ▪ No fees charges at any level? ▪ Fees charges at only hospital level and not at dispensary/health center level? ▪ A potential waiver and exemption system what would enable persons entitled to these mechanisms to use them? ▪ Key requirements of the system in order to increase access of the poor to a basic level of quality care? ▪ What is considered to be a basic level of quality care for the poor? What should be in the minimum package and what would be the cost of such a minimum package?
13. Contribution to PRS Review process	▪ What arguments form a strong case for policy makers to reconsider further introduction of the user fees at PHC level? ▪ What is a pro-poor health policy for Tanzania? ▪ What is the right balance between the need to finance health services, the pressure to become less dependent on external donor funding and the need to maintain accessibility of quality health services for the lower income groups? ▪ What are effective safety nets for the poor? ▪ What legislation and systems are required to establish suitable safety nets? ▪ What are useful guidelines for the health workers at PHC level who have to deal with the user fees issues? ▪ What can be an effective exemption strategy at PHC level? At what level should user fees be retained? ▪ Who is best placed to assess the ability to pay and the need for exemption? ▪ How to compensate for the money that is lost as a result of exemption? ▪ At what level should user fees be retained? ▪ What are mechanisms for payment of fees in the context of household expenditure pattern and gender relations?

ANNEX 3 GUIDELINES FOR DATA COLLECTION

1. GUIDELINES FOR INTERVIEWS IN DAR ES SALAAM

Note for the interviewer

You can make a selection out of the set of questions, depending on the resource persons you meet. However, make sure that the key issues are sufficiently addressed. The supporting questions (small font) are there to probe further (if needed) and a reminder for the interviewer.

Introduction of the consultant

Introduction of the assignment

Request how much time the respondent has available. Indicate the expected duration of the interview.

Guiding questions in logical sequence

- Could you indicate what the current status and progress is with the Poverty Reduction Strategy in Tanzania?
- What are positive achievements over the past 3 years?
- What have been major constraints in achieving the set goals over the past years? What have been the reasons behind the constraints?
- What are your expectations of the upcoming Poverty Reduction Review? What are priorities that should be addressed? What are expected outcomes? What do you personally hope what will be the outcome of the Review?
- Could you indicate how the health sector in Tanzania implements the PRS? What are key strategies?
- What can you say about the commitment of your organization (e.g. MOH) to the PRS?
- Is the user fee system, exemption systems, waiver systems and CHF approaches an integrated part of the PRS in Tanzania? Is there a trend or a shift in PRSP thinking over user fees over the years?
- What is the current status of the User Fee System, Exemption Systems, Waiver Systems and CHF Systems in Tanzania? Have official policies been formulated? What are key elements in the design of the various systems?
- What have been the main reasons /rationale for the introduction of user fees user fee systems/exemption systems/waiver systems/CHF?
    - For raising revenue?
    - For enhancing efficiency?
    - For enhancing sustainability?
    - For improving services?
    - For reducing frivolous consumption of health care?
    - For substituting formal fee systems for informal charging?
    - For extending coverage?
    - For increasing equity?
    - For improving access?
    - For special vulnerable groups?
    - For reduction poverty?
    - Others, which ones?

- What has actually caused the delayed introduction of the CHF in all the Districts in Tanzania? How come that only approximately 30 Districts have introduced the CHF?

- What are your views in terms of the achievement of user fees policy in Tanzania as of to date?
  - Improved Services?
  - Greater equity and for who?
  - Generated income for health facilities?
  - How much percent (%) is the generated revenue out of the recurrent costs and the non-recurrent costs?
  - Does user fees contribute to quality improvements and which ones?
  - Does user fees contribute to availability of drugs and which ones?
  - Has the cost-sharing (in TZ) contributed to the overall resource envelope and to what extent?

- What are your views regarding the current implementation of the user fees policy in Tanzania in terms of benefits, gains and losses?

- Would you know the actual contribution of the user fee to the (National) annual budget in terms of percentage over the past 3 years? Have you seen a downward or an upward trend?

- What are your views on charges, waivers and exemptions in relation to people's access/utilization of health care services?

- Do you agree/ support the current user fees system? Why or Why not?

- What are ongoing or expected developments regarding the User Fee System, Exemption Systems, Waiver Systems and CHF Systems in Tanzania?

- When will the user fees be introduced at PHC level? What has been the rationale behind the proposed introduction of user fees at PHC level while the education fees have been abolished? Is the proposed introduction of user fees at PHC level a clear wish of the Government or would the Government actually prefer to abolish the user fees? Does donor pressure or other external pressure play a role in the decision to introduce user fees at PHC level?

- Is or will there be an explicit exemption/waivers policy to help mitigate the potential negative impacts of user fees? How effective is it to be able to control leakages?

- How do you define poor people or poor categories in Tanzania? What are the criteria you or your organization use?

- In what way do the User Fee System, Exemption Systems, Waiver Systems and CHF Systems address the situation of the poorest people in Tanzania?
  - Does formal fee exemption lead to effective protection of the poor and prevention of full payment of fees?
  - Does informal fee exemption lead to effective protection of the poor and prevention of full payment of fees?
  - What kinds of informal fee exemption systems are applied?

- What are your views regarding the impact of user fees on the poor and other vulnerable groups of people?
  - Fees tend to dissuade poor from using health services more then the rich?
  - Do fees limit poor people to get access to care?
  - Fees are associated with delays in accessing care?
  - Fees lead to increased self-medication and informal resources of care?
  - Do fees lead to quality improvement and does this lead to increase or decreased utilization of health care services?
  - What are regressive outcomes of fees for categories of patients and diseases (e.g. ante-natal care, decline in safe deliveries, decline in OPD visits, reduced utilization of STD services, people with multiple visits, lower income category patients, delay to seek treatment because illness is not serious enough)?

- Can you mention positive experiences and results with the exemption/exemption systems/waiver systems/CHF? (e.g. improved access to care, improved revenues, improved quality of care)

- Can you mention negative experiences and results with the user fees/exemption systems/waiver systems/CHF? What are the main constraints?
    - Concern about impact if user fees on the poor as a health care financing mechanism?
    - Declining popularity of user fees as a health care financing mechanism?
    - Evidence of supposed benefits of exemption?
    - Are fees critical to maintain basic and tertiary health services in the country?
    - Do the user fees thrust people in greater poverty?

- Do you see differences in experiences between the public and the private sector? Do poor people have better access to the private or the public services? Is that the private for profit services or the non-for profit services?

- Which groups cannot have access to health services due to the user fees? What is the main reason of this and what happens to these people?

- Do you feel that people have equal access to health services in Tanzania? Is so, Why? Is not, Why not?

- Do you think that a CHF will be the solution for the poorest people in Tanzania or will they still be excluded from access to health services?

- Who is best placed to access the ability to pay and the need for exemption?

- What are the main barriers for accessing health care needs and for which groups? Who is really loosing out in Tanzania? Role of gender patterns?

- Could you rank these barriers in terms of priority?

- What do you think is the optimal scenario for utilization of fees in Tanzania in order to generate resources while minimizing negative impacts on poor people?
    - Fees imposed at all levels of health care delivery?
    - No fees charges at any level?
    - Fees charges at only hospital level and not at dispensary/health center level?
    - A potential waiver and exemption system that would enable persons entitled to these mechanisms to use them?

- If fees are abolished at PHC level (dispensary and health centre), how should then be compensated for the money that is lost?

- What do you see as a pro-poor health policy for Tanzania in relation to (1) user fees, (2) exemptions, (3) waivers, (4) CHF? What are your views regarding the Vision of implementing PRS with or without user fees? What is the right balance between the need to finance health services, the pressure to become less dependent on external donor funding and the need to maintain accessibility of quality health services for the lower income groups?

- What are your views regarding the feasibility of suspending the introduction of exemption at PHC level? Can this decision still be reversed? Why or Why not?

- What should first be in place if the user fees are to be suspended? What are effective safety nets for the poor? What legislation and systems are required to establish suitable safety nets?

- What could be main constraints for the implementation of the above?

- What solutions do you propose if the policies are to fully be implemented?

Thank you for your participation in this interview. This is much appreciated.

2. GUIDELINE FOR DATA COLLECTION IN KAGERA

Preparation and data collection guide for REPOA assignment in Kagera

1. Preparation of activities

- Collect relevant documents from MOH, ELCT, Catholic Church and NGOs in Bukoba on issues related to the user fee system, exemption system, waiver system, Community Health Fund poverty analysis, criteria to identify the poor in Kagera. The documents can be studies, annual reports, papers, guidelines, policy documents (on user fees, exemption and waiver).
- Identification of key resource persons in the MOH, ELCT, Catholic Church and NGOs or CBOs (dealing with HIV/AIDS, orphans, disabled, mental patients, very poor people, other marginalized groups in Kagera) and make appointments for the week 5-10 April.
- Identification of resource persons that have experiences with the Community Health Fund and make appointments for the week 5-10 April.
- Identification of communities or community groups which participate in the Community Health Fund (making appointments?).
- Identification of 1 dispensary and 1 health centre of the MOH, ELCT, Catholic Church and private clinics to be visited (2 facilities per category of providers). Preferably it should include health facilities which participate in the Community Health Fund. Making appointments for the period 22-26 March and 5-10 April.
- Seek approval from the MOH, ELCT and Catholic Church to visit some of the health facilities.
- Identification of groups or categories poor people (women, street children, orphans, AIDS clients, disabled) which can be met for a Focus Group Discussion. Identification can be done together with either the NGOs and Churches (Catholic and ELCT).

2. Relevant contacts in NGOs, CBOs, ELCT, Catholic Church (Names have been removed for privacy reasons)

- ELCT: Zonal Coordinator KZACP, PHC Coordinator and Medical Secretary.
- Catholic Church: Health coordinator, Medical Secretary.
- Medecins du Monde and TADEPA: Project advisor and Programme coordinator TADEPA.
- World Vision: Zonal Coordinator or representative dealing with child supported programmes.
- Huyawa: Project Coordinator.
- Partage: Project Coordinator.
- DANIDA: Regional Advisor.
- NGOs involved with disabled people.
- Kemondo Orphan Care Centre.
- PHD Reseacher regarding impact of HIV/AIDS on elderly people.
- Centres who provide direct support for the very very poor people in Bukoba vicinity.

3. Interview guide and data collection guide

3.a Activities

- To introduce the assignment
- To carry out the data collection
- To prepare a written summary of the key findings per activity. This should include (1) the name of the resource person (s), (2) name of the organisation, (3) name of the health facility, (4) Date of the data collection.

3.b Guiding questions

For key resource persons, Health Workers, NGOs, FBOs, CBOs?

- What is the current user fee in place in (a) in Tanzania and (b) in your organisation?
- What are the actual charges?
- How are charges defined and decided upon?
- Which services are charged and which services are free? What are the actual charges at the moment? At which level are these charges asked? Dispensary? Health Center? Hospital?

- Which groups are exempted from user fees?
- Which groups receive a waiver from user fees?
- The system that you follow (user fee collection, exemptions and waivers) is that the National system or is decided upon in your organization or facility?
- Do you feel you have enough information, guidance, tools at hand to implement the user fee system, exemption and waiver system adequately? If not, what is the reason? What guidelines would you need?
- Do you know the actual income you receive through the user fees per month and per year?
- Is the actual income stable or does it fluctuate very much?
- Do you know your overall health budget for the organisation/facility?
- Would you know the actual contribution of the user fee to your annual budget in terms of percentage?
- Do you work with a Community Health Fund?
- Since which year did you start with the introduction of user fees/exemption systems/waiver systems/CHF?
- If yes, what was the reason /rationale for the introduction of user fees user fees/exemption systems/waiver systems/CHF?
    - For raising revenue?
    - For enhancing efficiency?
    - For enhancing sustainability?
    - For improving services?
    - For reducing frivolous consumption of health care?
    - For substituting formal fee systems for informal charging?
    - For extending coverage?
    - For increasing equity?
    - For improving access?
    - For special vulnerable groups?
    - For reduction poverty?
    - Others, which ones?
- If no, why did you not introduce user fees/exemption systems/waiver systems/CHF?
    - At which level of health services has this been done?
    - Is the Government/Ministry of Health willing to suspend user fees?
    - What are pro and contra arguments?
- Can you explain the design of the user fees/exemption systems/waiver systems/CHF that you have adopted?
    - What exemptions and waiver strategies (formal and informal) are commonly used?
    - Which categories of patients are exempted and for what reasons?
    - Which exemption strategies are successful and not successful and for what reasons?
    - What are the transaction and administrative costs and requirements of the system?
- Can you mention positive experiences and results with the user fees/exemption systems/waiver systems/CHF? (e.g. improved access to care, improved revenues, improved quality of care)
- Can you mention negative experiences and results with the user fees/exemption systems/waiver systems/CHF? What are the main constraints? Do people have to pay unofficial fees? Can you say more about this?
- Do you see differences in experiences between the public and the private sector? Do poor people have better access to the private or the public services? Is that the private for profit services or the non-for profit services?

- What is the impact of the user fees on poor people?
- Do you feel that user fees should be introduced at dispensary and health center level? Why? Why not?
- How do you define poor people or poor categories in Kagera? What are the criteria you use?
- Which groups cannot have access to health services due to the user fees? What is the main reason of this and what happens to these people?
- Do you feel that people have equal access to health services in Kagera? If so, why? If not, why not?
- What are the main barriers for accessing health care needs and for which groups? Who is really loosing out in Kagera? Role of gender patterns?
- Could you rank these barriers in terms of priority?
- If people have to choose between the costs for health care and other personal costs which would be prioritized?
- What do you think is the optimal scenario for utilization of fees in order to generate resources while minimizing negative impacts on poor people?
  - Fees imposed at all levels of health care delivery?
  - No fees charges at any level?
  - Fees charges at only hospital level and not at dispensary/health center level?
  - A potential waiver and exemption system that would enable persons entitled to these mechanisms to use them?
  - Key requirements of the system in order to increase access of the poor to a basic level of quality care?
  - What is considered to be a basic level of quality care for the poor? What should be in the minimum package?
- If fees are abolished at PHC level (dispensary and health centre), how to compensate for the money that is lost?
- Who is best placed to access the ability to pay and the need for exemption?
- What do you see as a pro-poor health policy for Tanzania in relation to (1) user fees, (2) exemptions, (3) waivers, (4) CHF?
- Is the CHF the solution for Tanzania or will this still exclude the poorest people? Why?

Thank you for your cooperation

ANNEX 4 TOOL FOR ANALYSIS OF POVERTY REDUCTION STRATEGY DOCUMENTS

CHECKLIST FOR THE ANALYSIS OF THE TANZANIA PRSP

a. General

1. What are the key policies and sectors in the PRSP?

2. What are the central values? Does the PRSP explicitly mention (and define) equity? Does the PRSP explicitly mention the poor?

b. What is the role/attention for health and the health sector?

3. How frequently does the PRSP refer to 'health' and health related issues?
   It mentions 'health' … times

4. In the context of poverty reduction, does the PRSP explicitly assign a particular role or function to health?
   - ❑ It does:
   - ❑ It does not

b. To what extent does the PRSP define poverty (evidence-based health policy making)?

5. Does the PRSP define poverty?
   - ❑ It does:
   - ❑ It does not

6. Does the PRSP mention studies that have measured the scope, depth and distribution of poverty (e.g. Living Standard Measurement Surveys, household surveys, living conditions surveys, Qualitative Poverty Assessments, Participatory Poverty Assessments?)
   - ❑ It does:
   - ❑ It does not

7. Does the PRSP identify the poor (particular groups of people)?
   - ❑ It does:
   - ❑ It identifies societal poverty averages only
   - ❑ It does not

8. Does the PRSP identify the poorest geographical regions?
   - ❑ It explicitly does
   - ❑ It addresses the regional distribution of poverty, but does not specifically identify the poorest regions
   - ❑ It does not

9. Is gender identified as a social dimension of poverty?
   - ❑ It is
   - ❑ It is not

c.1 To what extent does the PRSP address health from a pro-poor perspective (health-specific analysis: evidence-based health policy making)

10. Does the PRSP mention studies that have measured the burden of disease among the poor (e.g. Demographic and Health surveys)?
    - ❑ It does:
    - ❑ It mentions studies that have measured the burden of disease among the population, but does not explicitly refer to the poor
    - ❑ It does not

11. Does the PRSP identify the burden of disease among the poor?
- ❑ It explicitly describes the diseases that are most commonly found among the poor
- ❑ It describes the burden of disease among the population, but does not explicitly refer to the poor
- ❑ It does not explicitly describe the population health status, except for an overview of social/health indicators

12. Does the PRSP mention studies that have analyzed why the health system fails to serve the poor?
- ❑ It explicitly does:
- ❑ It implicitly does:
- ❑ It mentions studies that have analyzed the constraints of the health system, but does not explicitly refer to the poor
- ❑ It does not

13.a Does the PRSP identify why the health system fails to serve the poor?
- ❑ It explicitly describes why the health system fails to serve the poor:
- ❑ It describes why the health system fails to serve the population, but does not explicitly refer to the poor:
- ❑ It does not describe the constraints of the health care system

13.b Does the PRSP identify what groups do not have access to health care (disabled people, HIV/AIDS clients):
- ❑ It does:
- ❑ It does not

13.c Does the PRSP describe existing financial barriers to health care, particularly for the poor?
- ❑ It does:
- ❑ It does not

c.2 Health sector strategy and policies

14. What are the overall objectives of the strategy and how are they subdivided into pillars or themes?

15.a Does the PRSP explicitly mention the central values underlying the strategy?
- ❑ It does:
- ❑ It does not explicitly mention these values, but it is possible to identify them (implicit values):

15.b Does the PRSP explicitly mention equity as a central value underlying the strategy?
- ❑ It does:
- ❑ It does not, but it does explicitly mention

16. Does the strategy include specified strategies and a detailed time-line? Is the strategy budgeted and what level of detail is presented?

17. Is the strategy based on poverty-related health data (evidence-based)?
- ❑ The strategy targets the named poorest regions
- ❑ The strategy targets the named poorest and vulnerable groups
- ❑ The strategy targets the burden of disease among the poor (HIV/AIDS, communicable diseases)
- ❑ The strategy targets those services that are known to benefit the poor (primary health care, sexual and reproductive health, child health, etc)
- ❑ The strategy includes the health needs of (poor) women

18. Does the strategy include (re)allocation proposals, including to the poorest regions and the health services that predominantly benefit the poor?
- ❑ It does:
- ❑ It does, but without explicitly mentioning the poor:
- ❑ It does not

c.3 User fees

19. Does the strategy include or propose user fees?
- ❑ It does:
- ❑ It does not

20.a Does the PRSP mention the rationale and/or objectives of user fees?
- ❑ It does:
- ❑ It does not

20.b Are the user fees directly related to health professionals' salaries or institutional funding?
- ❑ They are:
- ❑ They are not

21. Does the PRSP mention studies that have analyzed the affordability of health services:
- ❑ It does, explicitly paying attention to the poor's ability to pay:
- ❑ It does:
- ❑ It does not

22. Does the PRSP mention the level of health care delivery at which user fees are or will be asked (primary health care facilities (dispensary and health centre level), hospital facilities)?
- ❑ It does:
- ❑ It does not

23. Does the PRSP mention user fees in relation to both the public and the private sector?
- ❑ It does, explicitly paying attention to the equity implications for the poor:
- ❑ It does:
- ❑ It does not

24. Does the PRSP include information on the set-up and design of user fee policies and implementation (community participation)?
- ❑ It does:
- ❑ It does not

25.a Does the PRSP include explicit statements on how user fees are excluding the poor compared to the non-poor?
- ❑ It does:
- ❑ It does not

25.b Does the PRSP propose measures to reduce (existing) financial barriers to health care and/or to help mitigate the potential negative impacts of user fees (exemption systems, waiver systems, CHF approaches)?
- ❑ It does, explicitly mentioning the poor
- ❑ It does:
- ❑ It does not

26. Does the PRSP include information on the user fees in the education sectors?

ANNEX 5 TANZANIA COUNTRY PROFILE

1. Tanzania Data Profile World Bank

Tanzania Data Profile			
Click on the indicator to view a definition	**1998**	**2001**	**2002**
People			
Population, total	32.1 million	34.5 million	35.2 million
Population growth (annual %)	2.6	2.2	2.1
National poverty rate (% of population)	..	35.7	..
Life expectancy (years)	..	..	43.1
Fertility rate (births per woman)	5.6	..	5.0
Infant mortality rate (per 1,000 live births)	..	..	104.0
Under 5 mortality rate (per 1,000 children)	..	..	165.0
Births attended by skilled health staff (% of total)	..	..	..
Child malnutrition, weight for age (% of under 5)	..	..	..
Child immunization, measles (% of under 12 mos)	78.0	83.0	89.0
Prevalence of HIV (female, % ages 15-24)	..	8.1	..
Literacy rate (5 of ages 15 and above)	72.7	76.0	77.1
Literacy female (% of ages 15 and above)	63.4	67.9	69.2
Primary completion rate, total (% age group)	..	53.7	57.7
Primary completion rate, female (% age group)	..	54.7	58.6
Net primary enrollment (% relevant age group)	45.8	54.4	..
Net secondary enrollment (% relevant age group)	..	..	..
Environment			
Surface area (sq. km)	945.1 thousand	945.1 thousand	945.1 thousand
Forests (1,000 sq. km)	..	..	..
Deforestation (avearge annual % 1990-2000)	..	..	..
Freshwater resources per capita (cubic meters)	..	..	2,586.6
CO2 emissions (metric tons per capita)	0.1	..	..
Access to improved water source (% of total pop.)	..	..	..
Access to improved sanitation (% of urban pop.)	..	..	..
Energy use per capita (kg of oil equivalent)	373.3	404.0	..
Electricity use per capita (kWh)	59.5	58.5	..
Economy			
GNI, Atlas method (current US$)	7.5 billion	9.4 billion	9.7 billion
GNI per capita, Atlas method (current US$)	230.0	270.0	290.0
GDP (current $)	8.4 billion	9.3 billion	9.4 billion
GDP growth (annual %)	3.7	6.1	6.3
GDP implicit price deflator (annual % growth)	14.2	6.2	4.2
Value added in agriculture (% of GDP)	44.8	44.8	44.4
Value added in industry (% of GDP)	15.4	16.0	16.3
Value added in services (% of GDP)	39.8	39.2	39.3
Exports of goods and services (% of GDP)	13.6	15.3	16.7
Imports of goods and services (% of GDP)	28.3	23.9	23.6
Gross capital formation (% of GDP)	13.8	17.0	16.7
Technology and infrastructure			
Fixed lines and mobile telephones (per 1,000 people)	5.2	17.1	24.1
Telephone average cost of local call (US$ per three minutes)	0.1	0.1	0.1
Personal computers (per 1,000 people)	1.8	3.6	4.2

Internet users	3,000.0	60,000.0	80,000.0
Paved roads (% of total)	4.2	..	..
Aircraft departures	6,100.0	4,400.0	4,500.0
Trade and finance			
Trade in goods as a share of GDP (%)	24.4	26.6	27.3
Trade in goods as a share of goods GDP (%)	38.4	41.9	43.0
High-technology exports (% of manufactured exports)	3.2	1.6	..
Net barter terms of trade (1995=100)	101.0	95.0	..
Foreign direct investment, net inflows in reporting country (current US$)	172.3 million	327.2 million	240.4 million
Present value of debt (current US$)	..	..	1.8 billion
Total debt service (% of exports of goods and services)	21.0	10.2	8.9
Short-term debt outstanding (current US$)	917.2 million	558.2 million	642.9 million
Aid per capita (current US$)	31.1	36.9	35.0
Source: *World Development Indicators database*, August 2003			

2. Tanzania Millennium Goals Country Profile

Tanzania Country Profile				
Click on the indicator to view a definition	**1990**	**1995**	**2000**	**2001**
1 Eradicate extreme poverty and hunger	*2015 target = halve 1990 $1 a day poverty and malnutrition rates*			
Population below $1 a day (%)	..	19.9	..	..
Poverty gap at $1 a day (%)	..	4.8	..	..
Percentage share of income or consumption held by poorest 20%	..	6.8	..	..
Prevalence of child malnutrition (% of children under 5)	28.9	30.6	29.4	..
Population below minimum level of dietary energy consumption (%)	36.0	..	47.0	..
2 Achieve universal primary education	*2015 target = net enrollment to 100*			
Net primary enrollment ratio (% of relevant age group)	51.4	47.7	46.7	..
Percentage of cohort reaching grade 5 (%)	78.9	81.3	81.8	..
Youth literacy rate (% ages 15-24)	83.1	87.1	90.5	91.1
3 Promote gender equality	*2005 target = education ratio to 100*			
Ratio of girls to boys in primary and secondary education (%)	96.8	96.8	98.9	..
Ratio of young literate females to males (% ages 15-24)	86.5	90.7	94.3	94.8
Share of women employed in the nonagricultural sector (%)	..	..	..	..
Proportion of seats held by women in national parliament (%)	..	18.0	16.0	..
4 Reduce child mortality	*2015 target = reduce 1990 under 5 mortality by two-thirds*			
Under 5 mortality rate (per 1,000)	163.0	164.0	165.0	165.0
Infant mortality rate (per 1,000 live births)	102.0	103.0	104.0	104.0
Immunization, measles (% of children under 12 months)	80.0	78.0	78.0	83.0
5 Improve maternal health	*2015 target = reduce 1990 maternal mortality by three-fourths*			
Maternal mortality ratio (modeled estimate, per 100,000 live births)	..	1,100.0	..	..
Births attended by skilled health staff (% of total)	44.0	38.0	35.0	..
6 Combat HIV/AIDS, malaria and other diseases	*2015 target = halt, and begin to reverse, AIDS, etc.*			
Prevalence of HIV, female (% ages 15-24)	..	..	8.1	8.1
Contraceptive prevalence rate (% of women ages 15-49)	9.5	18.0	25.4	..
Number of children orphaned by HIV/AIDS	..	..	1.1 million	810.0 thousand
Incidence of tuberculosis (per 100,000 people)	..	..	359.1	..
Tuberculosis cases detected under DOTS (%)	..	61.0	45.0	..
7 Ensure environmental sustainability	*2015 target = various (see notes)*			
Forest area (% of total land area)	45.0	..	43.9	..
Nationally protected areas (% of total land area)	..	15.6	15.6	..
GDP per unit of energy use (PPP $ per kg oil equivalent)	0.9	1.0	1.1	..
CO2 emissions (metric tons per capita)	0.1	0.1	0.1	..
Access to an improved water source (% of population)	38.0	..	68.0	..
Access to improved sanitation (% of population)	84.0	..	90.0	..
Access to secure tenure (% of population)	..	..	..	..
8 Develop a Global Partnership for Development	*2015 target = various (see notes)*			
Youth unemployment rate (% of total labor force ages 15-24)	..	..	..	..
Fixed line and mobile telephones (per 1,000 people)	..	3.1	10.1	16.0
Personal computers (per 1,000 people)	..	1.6	2.8	3.3
General indicators				
Population	25.5 million	29.6 million	33.7 million	34.4 million
Gross national income ($)	4.8 billion	4.9 billion	9.0 billion	9.4 billion
GNI per capita ($)	190.0	160.0	270.0	270.0
Adult literacy rate (% of people ages 15 and over)	62.9	69.2	75.0	76.0
Total fertility rate (births per woman)	6.3	5.8	5.3	5.2
Life expectancy at birth (years)	50.1	48.5	44.4	43.7
Aid (% of GNI)	28.8	17.1	11.4	13.3

External debt (% of GNI)	158.5	144.5	82.2	71.9
Investment (% of GDP)	26.1	19.8	17.6	17.0
Trade (% of GDP)	50.1	59.3	37.7	39.9

Source: ***World Development Indicators database, April 2002***

Note: **In some cases the data are for earlier or later years than those stated.**

Goal 1 targets: **Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day. Halve, between 1990 and 2015, the proportion of people who suffer from hunger.**

Goal 2 target: **Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.**

Goal 3 target: **Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015.**

Goal 4 target: **Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.**

Goal 5 target: **Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.**

Goal 6 targets: **Have halted by 2015, and begun to reverse, the spread of HIV/AIDS. Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.**

Goal 7 targets: **Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources. Halve, by 2015, the proportion of people without sustainable access to safe drinking water. By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.**

Goal 8 targets: **Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Address the Special Needs of the Least Developed Countries. Address the Special Needs of landlocked countries and small island developing states. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term. In cooperation with developing countries, develop and implement strategies for decent and productive work for youth. In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries. In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.**

ANNEX 6 RESOURCE PERSONS

Name of Resource Person	Position of Resource Person
1. Pastor Balami, Jonas	▪ Coordinator of HUYAWA Programme
2. Mr. Balengaagabo, Yusufu	▪ Person with a disability
3. Ms. Bangser, Maggie	▪ Member of R&AWG in REPOA and Coordinator Women Dignity Programme
4. Mr. Barongo, James Bushweka	▪ Project Coordinator TADEPA
5. Ms. Bernard, Marcelina	▪ Guardian in PARTAGE VP 14 Ruhano Ishozi Bukoba Rural District
6. Dr. Borg, Jan	▪ DANIDA Advisor Ministry of Health Kagera Region
7. Dr. Briggs	▪ Health Financing Specialist GTZ
8. Ms. Buberwa, Christina	▪ Nurse Midwive and HIV Counsellor in TADEPA Clinic Bukoba Regional Hospital
9. Dr. Bugimbi, M.	▪ Medical Doctor in charge of Bukoba Medical Center
10. Mr. Byeshurilo, Thomas	▪ Person with a disability
11. Ms. Davies, Sian	▪ Project Advisor Medecins du Monde
12. Sr. Donati, Winifrida	▪ Clinical Officer St. Theresia Kajunguti Dispensary
13. Ms. Erasto, Fortunara	▪ Client in TADEPA Clinic Bukoba Regional Hospital
14. Ms. Emmanuel, Christina	▪ Guardian in PARTAGE VP 15 Bukoba Rural District
15. Mr. Ernest, Dina	▪ Kindergarten Teacher in PARTAGE VP 14 Ruhano Ishozi Bukoba Rural District
16. Sr. Felix, Mecktilda	▪ Sr. In Charge of Kashozi Rural Health Centre
17. Mr. Felix, Patrick	▪ Laboratory Assistant in PARTAGE VP 14 Ruhano Ishozi Bukoba Rural District
18. Ms. Francis Adventina	▪ Client in TADEPA Clinic Bukoba Regional Hospital
19. Ms. Gaspar, Anastella	▪ Client in TADEPA Clinic Bukoba Regional Hospital
20. Dr. Gomile, Michael	▪ Health policy analyst Christian Social Services Commission
21. Ms. Halfan, Aura	▪ Clinical Officer in charge of Rwamishenye Health Center
22. Mr. Hashim, Jamila	▪ Client in TADEPA Clinic Bukoba Regional Hospital
23. Ms. Herman, Agnes	▪ Coordinator Pharmacy, PARTAGE
24. Dr. Hingora, Ahmed	▪ Programme coordinator, Health Sector Programme Support (HSPS), Health Sector Reform Secretariat, Department of Policy and Planning, Ministry of Health
25. Mr. Ishabaki, Valence	▪ Clinical Officer in TADEPA Clinic Bukoba Regional Hospital
26. Ms. Kahatano	▪ Senior Nurse Midwive Kahororo Dispensary
27. Mr. Kalokola	▪ Field Assistant in PARTAGE VP 15 Bukoba Rural District
28. Mr. Kamara, Fidelis	▪ Field Assistant in PARTAGE VP 15 Bukoba Rural District
29. Ms. Kanywa, Joyce	▪ Nurse Midwive in PARTAGE VP 14 Ruhano Ishozi Bukoba Rural District
30. Ms. Kitunzi	▪ Nurse Midwive and HIV Counsellor in TADEPA Clinic Bukoba Regional Hospital
31. Mr. Kuper, Meinolf	▪ Resource Person Health Financing with GTZ
32. Mr. Lindeboom, Wietze	▪ Consultant with REPOA
33. Ms. Lukamisa, Fraiska	▪ Nurse Midwive in PARTAGE VP 14 Ruhano Ishozi Bukoba Rural District
34. Mr. Kadebe, Michael	▪ Principal Account President's Office, Regional Administration and Local Government
35. Ms. Kahangwa, Agnes	▪ Coordinator preventive services PARTAGE
36. Ms. Kalugila, Jenetina	▪ Guardian in PARTAGE VP 14 Ruhano Ishozi Bukoba Rural District
37. Mr. Katera, Lucas	▪ Researcher with REPOA
38. Mr. Kemibala, David	▪ Medical Doctor Hindu Union Charitable Dispensary
39. Ms. Kikuli	▪ Budget Officer, Budget Section Department of Policy and Planning
40. Mr. Magambo, Peter	▪ Person with a disability
41. Mr. Makundi, Emanuel	▪ Sociologist and Health Systems Analyst National Institute for Medical Research
42. Dr. Mallya, Dorothy	▪ Acting Chief Nursing Officer, Ministry of Health
43. Mr. Mapunda, Maximillian	▪ Health Economist WHO
44. Mr. Marcelina, Steven	▪ Client in TADEPA Clinic Bukoba Regional Hospital
45. Mr. Mashanga, Sweetbert	▪ Person with a disability
46. Ms. Masilingi, Grace	▪ Person with a disability
47. Mr. Mbaleki, Gaspar	▪ Client in TADEPA Clinic Bukoba Regional Hospital

48. Ms. Mfunjo, Hilda	▪ Nurse Midwive St. Theresia Kajunguti Dispensary
49. Mr. Mosha, Leocardia	▪ Client in TADEPA Clinic Bukoba Regional Hospital
50. Mr. Muchunguzi, Ceasar	▪ Social Welfare Officer Bukoba Regional Hospital
51. Mr. Mukakendage	▪ Orphan in PARTAGE VP 15 Bukoba Rural District
52. Ms. Mulisa, Bernadeta	▪ Nurse Officer in TADEPA Clinic Bukoba Regional Hospital
53. Mr. Mushobozi, Yusto	▪ Client in TADEPA Clinic Bukoba Regional Hospital
54. Mr. Mutalemwa, Anthony	▪ Project Coordinator CHAWATA
55. Ms. Mwadasiro, Mariam	▪ Librarian with REPOA
56. Mr. Mwaimu	▪ Planner MOEC
57. Mr. Mwesiga, Medard	▪ Orphan in PARTAGE VP 15 Bukoba Rural District
58. Dr. Njau, Faustine	▪ Head, Health Sector Reform Secretariat, Department of Policy and Planning, Ministry of Health
59. Mr. Nyika, Konde	▪ Person with a disability
60. Mr. Nyamwihura, Elias	▪ Coordinator of Kagera Orphans Trust Fund
61. Mr. Nyamwhihura	▪ Guardian in PARTAGE VP 15 Bukoba Rural District
62. Ms. Okwany, Auma	▪ Lecturer in Rural Development, Environment and Population Studies, Institute of Social Studies, The Netherlands
63. Ms. Omari, Mariam	▪ Client in TADEPA Clinic Bukoba Regional Hospital
64. Mr. Paschal, Petro	▪ Orphan in PARTAGE VP 14 Ruhano Ishozi Bukoba Rural District
65. Mr. Rajabu, Rashid	▪ Client in TADEPA Clinic Bukoba Regional Hospital
66. Mr. Reid, Graham	▪ Tanzania Essential Health Intervention Project
67. Mr. Ruhakingira, Anatoly	▪ Project Coordinator PARTAGE (curative services)
68. Ms. Rugakingira, Gelda	▪ Person with a disability
69. Mr. Rugarabamu, Willibord	▪ Diocesan Health Coordinator, Bukoba Catholic Diocese
70. Mr. Ruhumuliza	▪ Orphan in PARTAGE VP 15 Bukoba Rural District
71. Ms. Rushoke, Elly	▪ Orphan in PARTAGE VP 14 Ruhano Ishozi Bukoba Rural District
72. Sr. Rwakalema, Mecktilda	▪ Nurse Midwife In Charge St. Theresia Kajunguti Dispensary
73. Ms. Rwamahe, Specioza	▪ Resource Person Medecins du Monde
74. Mr. Rwamdeke, Sylidion	▪ Person with a disability
75. Mr. Mike Rowson	▪ Medact, Director
76. Mr. Sagday, Servus	▪ Senior Officer Poverty Eradication Unit Vice President's Office
77. Dr. Schleimann, Finn	▪ Regional Technical Health Advisor DANIDA
78. Ms. Ellen Verheul	▪ Wemos
79. Ms. Wilberd, Joyce	▪ Matron in VP 14 Ruhano Ishozi Bukoba Rural District

ANNEX 7 ITINERARIES

1. Itinerary Patricia Schwerzel

Date	Itinerary Patricia Schwerzel
03-03-2004	▪ Preparation for REPOA Assignment
04-03-2004	▪ Preparation for REPOA Assignment ▪ Communication with REPOA and team of consultants
08-03-2004	▪ Preparation of Data Matrix
09-03-2004	▪ Preparation of Data Matrix ▪ Categorizing of available documents
11-03-2004	▪ Traveling from Bukoba to Dar es Salaam ▪ Meeting with REPOA Coordinator for assignment ▪ Assessment of documents in REPOA library ▪ Meeting with team member to prepare the assignment
12-03-2004	▪ Meeting with Resource Person in GTZ Office ▪ Meeting with R&AWG to discuss the TOR ▪ Meeting with team member to develop tools for data collection
13-03-2004	▪ Assessment and selection of documents in REPOA Library ▪ Copying of essential documents
14-03-2004	▪ Document study ▪ Preparation of debriefing for team of consultants
15-03-2004	▪ Assessments and selection of documents in REPOA Library ▪ Copying of essential documents ▪ Meeting with resource person R&AWG/Women Dignity Programme
16-03-2004	▪ Traveling from Dar es Salaam to Bukoba ▪ Meeting with assistant for data collection in Kagera Region
17-03-2004	▪ Preparation of Inception Report for REPOA ▪ Preparation of Guide for data collection in Dar es Salaam and Kagera ▪ Preparation of Table of Content ▪ Follow-up communication with team of consultants
05-04-2004	▪ Follow-up with team of consultants ▪ Debriefing with assistant regarding data collection in Kagera ▪ Desk study
06-04-2004	▪ Meeting with NGO Partage in Bukoba regarding user fee practises ▪ Visit to dispensary in Kajunguti regarding user fee practises ▪ Visit private clinic in Bukoba regarding user fee practises
07-04-2004	▪ Visit to project areas of NGO Partage in Ishozi and Bwanjai for a FGD with orphans and guardians ▪ Visit to Kashozi Health Center regarding user fee practises
08-04-2004	▪ Meeting with ELCT resource person regarding user fee practises ▪ Meeting with health workers of NGO TADEPA and HIV positive clients who receive support from TADEPA ▪ Meeting with resource person from ELCT coordinated Community Health Fund ▪ Meeting with HUYAWA resource persons regarding the position/exclusion of street children ▪ Meeting with EDI Research Director regarding findings of CWIQ survey in Kagera
09-04-2004	▪ Meeting with Social Welfare Officer regarding exemption and waiver practises in Bukoba Regional Hospital ▪ Meeting with assistant regarding findings of data collection in Kagera
13-04-2004 to 19-04-2004	▪ Desk study on relevant documents to assess what additional information is required
20-04-2004	▪ Assessments of documents received by team of consultants and indication of additional information that is required
21-04-2004 to 12-05-2004	▪ Preparation, writing and editing of draft report for REPOA
25-04-2004	▪ Meeting with team member in the Netherlands to discuss draft final report
31-05-2004 to 09-06-2004	▪ Preparation, writing and editing of draft report for REPOA

2. Itinerary Leontien Laterveer

Date	Itinerary Leontien Laterveer
03-03-2004	▪ Preparation of draft research questions PRSP analysis and user fee literature review ▪ Email correspondence with Team Leader in Bukoba on Plan of Action ▪ Start literature search and collection (web)
04-03-2004	▪ Contact various resource persons for literature suggestions ▪ Continued literature search and collection (web)
08-03-2004	▪ Continued literature search and collection (web)
09-03-2004	▪ Continued literature and collection (web) ▪ Initial review of collected literature ▪ Visit Library Erasmus University Rotterdam ▪ Correspondation with Team Leader in Bukoba on data collection matrix
10-03-2004	▪ Continued literature search, collection and reading
11-03-2004	▪ Start preparation of short report on preliminary findings for study team
15-03-2004	▪ Send preliminary findings and reference list to Team Leader and co-consultant
30-03-2004	▪ Email correspondence on progress with co-consultant in Dar es Salaam and Repoa ▪ Reading of Briefing Document, Inception Report, proposed planning by Team Leader ▪ Start preparation of Chapter 3 ▪ Additional information collection on PRSP (web)
31-03-2004	▪ Continued preparation of Chapter 3 ▪ Report on progress to Team Leader in Bukoba
13-04-2004	▪ Continued preparation of Chapter 3
14-04-2004	▪ Continued preparation of Chapter 3
15-04-2004	▪ Finalisation of Chapter 3 ▪ Send report to Team Leader in Bukoba
16-04-2004	▪ Document analysis of user fee studies ▪ Start preparation of Chapter 5
17-04-2004	▪ Continued reading and preparation of Chapter 5
19-04-2004	▪ Continued reading and preparation of Chapter 5
20-04-2004	▪ Finalisation of Chapter 5 ▪ Send report to Team Leader in Bukoba
26-04-2004	▪ Preparation of reference list, annexes and send documents to Team Leader in Bukoba
27-04-2004	▪ Preparation of annexes draft final report
03-05-2004 and 10-05-2004	▪ Reading and commenting report chapters
11-05-2004	▪ Telephone meeting with team leader
18-05-2004 and 24-05-2004	▪ Additional data collection
25-05-2004	▪ Meeting with team leader in the Netherlands to discuss draft final report
02-06-2004	▪ Preparation of annexes
07-09-2004	▪ Co-reading and finalisation draft report

3. Itinerary Michael Munga

Date	Itinerary Michael Munga
11-03-2004	▪ Meeting at REPOA office with Patricia Schwerzel and REPOA Coordinator for assessment
12-03-2004	▪ Meeting with REPOA Working Group
18-19-03-2004	▪ Literature collection ▪ Preliminary appointment setting ▪ Attending workshop of Health NGOs as an invitee of WDP to collect relevant documents
30-03-2004	▪ Desk study of collected literature ▪ Visit identified stakeholders' offices to make appointments for interviews ▪ Interviews with WHO and MOEC key informants
01-04-2004	▪ Desk study of collected literature and information from internet ▪ Continued follow up of scheduled interviews
02-04-2004	▪ Continued study of documents availed by Team Leader and others personally collected

03-04-2004	▪ Continued desk study / review of literature
05-04-2004	▪ Conducted in-depth interview with respondent from GTZ [a]
06-04-2004	▪ Conducted interview with DANIDA and WDP respondents ▪ Report writing for preliminary findings.
07-04-2004	▪ Conducted three in-depth interviews with NIMRI, TEHIP and Christian Social Services Commissions' respondents
14-04-2004	▪ Start preliminary report writing
15-04-2004	▪ Traveling to Dodoma to collect quantitative data on user fees contribution on local authorities health budgets and to interview a key informant in PORALG
19-04-2004	▪ Obtaining clarifications on some issues from interviewed respondents and start report writing
20-04-2004	▪ Report writing
21-04-2004	▪ Report writing
22-04-2004	▪ Report writing
23-04-2004	▪ Report writing
24-04-2004	▪ Report writing
12-05-2005 to 01-05-2004	▪ Interviews with MOH staff and reporting

4. Itinerary Tiimanywa Lutaremwa

Date	Itinerary Dr. Tiimanywa Lutaremwa
22-03-2004	▪ Preparation of REPOA assignment in Kagera ▪ Discussion on data collection tools
23-03-2004	▪ Preparation of appointments with resource persons
24-04-2004	▪ Interview with TADEPA Health Coordinator ▪ Interview with HUYAWA Project Coordinator ▪ Interview with Coordinator Kagera Orphans Trust Fund ▪ Preparation of assignments with resource persons
25-03-2004	▪ Interview with Diocesan Health Coordinator Bukoba Catholic Diocese ▪ Interview with Medical Doctor from private clinic (ELCT) in Bukoba ▪ Interview with Coordinator Kagera Orphans Trust Fund ▪ Interview with the General Secretary of the Disabled Association for Tanzania
26-03-2004	▪ Interview with the Medical Doctor of the Hindu Union Dispensary ▪ Preparation of write-up interview findings
05-04-2004	▪ Interview with Health Workers of Kahororo dispensary (Government) ▪ Interview with Health Workers of Rwaminshenye Health Center (Government)
06-04-2004	▪ Interview with core staff of NGO Partage (support to orphans) ▪ Interview with Health Workers of Kajunguti Dispensary (Roman Catholic)
07-04-2004	▪ Field visit to Partage project areas to conduct Focus Group Discussion with orphans and guardians
08-04-2004	▪ Interview with Coordinator HUYAWA (support to orphans) ▪ Interview with health workers and clients of NGO TADEPA (support to HIV positive people)
09-04-2004	▪ Meeting with Social Welfare Officer of Bukoba Regional Hospital
10-04-2004	▪ Focus Group Discussion with persons with disabilities

[a] Roughly each interview took an average of about 1 and half hours to be completed.

ANNEX 8 MAP OF TANZANIA