

Assessment of the Community Health Fund in Hanang District, Tanzania

July 2002

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Abstract

The Tanzanian Community Health Fund (CHF) was established by the Ministry of Health on a pilot basis in December 1995. Its purpose was to ensure the availability of quality health services at affordable prices and to mobilize additional resources for the provision of health care. The CHF is essentially a district-level prepayment scheme for primary care services targeted at the rural population and the informal sector. A household joins the CHF by paying an annual membership fee, which provides unlimited access to outpatient services at CHF-participating facilities. User fees at health centers and dispensaries are implemented as part of the introduction of the CHF, as is an exemption policy to ensure that families who cannot afford to pay the membership fees obtain a free CHF card. CHF providers are mainly public sector facilities, although the intention of the scheme is to include private sector and mission providers. The CHF is currently operating in 23 districts, with the goal of implementation in all districts by 2003. In 2001, the CHF Act established the CHF as a key component of the health financing strategy.

This assessment was conducted in Hanang District to provide CHF administrators with data and recommendations to improve the management and utilization of the CHF throughout Tanzania. The assessment findings reveal that the CHF is mobilizing resources (both CHF membership and user fees) for health care services, though the majority of the contribution for the last two years is from user fees. Membership rates are fairly low and, with the exception of 1999, have declined since the implementation of CHF in Hanang in 1998. CHF resources have been used to improve the quality and range of services throughout Hanang district. However, the majority of CHF funds have been used for the construction of the district hospital and many facilities/wards have significant unused balances of CHF funds.

Assessment findings suggest that overall CHF management and information systems require improvement. The CHF has a decentralized management structure, which seeks to promote involvement of the communities, but in practice community participation is limited. Training for district, ward, and health facility staff is needed to strengthen their capacity to effectively manage the CHF. In addition, effective implementation of an exemption policy is required to ensure that the poor are not excluded from accessing care.

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Acronyms

CRHCS	Commonwealth Regional Health Community Secretariat
CHF	Community Health Fund
CHSB	Council Health Services Boards
DHMT	District Health Management Team
DMO	District Medical Officer
HH	Household
HMIS	Health Management Information System
MOH	Ministry of Health
NHI	National Health Insurance
PHR<i>plus</i>	Partners for Health Reform <i>plus</i> Project (USAID)
SOW	Scope of Work
SWAP	Sector-Wide Approach
Tsh	Tanzanian Shilling
USAID	United States Agency for International Development
WEO	Ward Executive Officer
WHC	Ward CHF Health Committee

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Executive Summary

Background

The Tanzanian Community Health Fund (CHF) was established by the Ministry of Health (MOH) on a pilot basis in Igunga district in December 1995. Its purpose was to ensure the availability of quality health services at affordable prices. It is today essentially a district-level prepayment scheme for primary care services targeted at the rural population and the informal sector. The CHF providers are primarily public sector facilities, although the intention of the scheme (and the government health reform plan) is to include private sector and mission providers in districts where they exist. User fees at the health center and dispensary are implemented as part of the introduction of the CHF, as is an exemption policy to ensure that families who cannot afford to pay the membership fees obtain a free CHF card. CHF membership fees are to be established by the community, and fees collected go into a district CHF account along with user fees paid and matching funds from the central government. The CHF's primary support has come from the World Bank in the form of matching funds and technical assistance in management and coordination of the CHF.

In 1998, the MOH decided to expand the CHF to nine additional districts. In the process of expansion, several evaluations of the CHF were conducted by the MOH and the World Bank. In 2001, the Community Health Fund Act was passed establishing the CHF as the official health plan at the local/community level. Through this Act, the CHF is now being rolled out on a national basis. It is currently established in 23 districts, with the goal of implementation in all districts by 2003.

This is the first assessment of the CHF in Hanang district, which was one of the nine roll-out districts during the initial phase of expansion in 1998. In contrast to previous evaluations of the CHF, this assessment focuses primarily on the management and operational aspects of the CHF program. It is the first part of a series of activities aimed at improving performance of the CHF in Hanang district, using tools and techniques that can be replicated throughout Tanzania. It was conducted with a view to:

- ▲ Identifying the strengths and weaknesses of the CHF, including a review of problems previously identified in World Bank and MOH evaluations in other districts;
- ▲ Providing recommendations to assist Tanzanian health officials to develop a plan of action to improve management and increase membership and utilization of the CHF in Hanang district and throughout Tanzania;
- ▲ Developing a plan for implementing the recommended changes with assistance from the Partners for Health Reform *plus* (PHR*plus*) project.

The assessment included all levels of the CHF (central, district, ward, health facility, and community levels). Information was collected on the management and organizational structure of the CHF, financial management and administration, recording and reporting systems, exemption policy, membership and utilization trends, promotion and marketing of the fund, resource mobilization, and member and non-member perceptions of the CHF. Information was gathered through semi-structured interviews with individuals involved in the administration of the CHF at all levels and providers and managers at participating and non-participating health facilities. Facility and district records and reports

were also reviewed. Focus groups discussions were conducted at the village level with CHF members and non-members. Also, exit interviews were conducted at both CHF and non-CHF facilities.

Overview of the CHF in Hanang District

The CHF was officially established in Hanang district in September 1998. When the CHF was introduced, services at health centers and dispensaries were provided free of charge. The introduction of user fees coincided with the introduction of CHF. The CHF in Hanang district operates out of MOH facilities and private dispensaries serving NAFCO (parastatal) wheat farms in the district. None of the mission dispensaries and health centers are part of the CHF, that is, they do not enroll members nor do they provide free services for CHF members.

A household joins the CHF by paying an annual membership fee of Tsh.10,000 per household. (A household consists of a head of household, spouse, and dependent children below the age of 18. In polygamous situations, each wife constitutes a separate household.) A household may be issued a free CHF card by the district council, if it is deemed unable to pay. To date, however, few families have been exempted from CHF or user fees.

Hanang district was the first district in Tanzania to set its CHF fee at Tsh. 10,000 – other districts had set the CHF fee at Tsh. 5,000. One of the key reasons influencing the District Council's decision to set the fee at Tsh. 10,000 was the need to raise funds for construction of the district hospital. The fee was set by the District Council and the District Health Board with little community input – information about the CHF and the fee was not widely disseminated from the onset. Nonetheless, there was general acceptance of this fee at the ward and village level.

From 1998-2000, Hanang district relied on its ward executive officers (WEOs) to collect CHF membership fees. Due to alleged problems arising from the use of WEOs, who also serve as general tax collectors, a new CHF collection policy was implemented in 2000 mandating that CHF membership fees be collected at the health facility only.

CHF membership is voluntary for all residents, except for civil servants, from 1998 to 2001. Prior to the introduction of National Health Insurance (NHI) in July 2001, CHF membership was compulsory for civil servants and the fee was automatically deducted from their salaries. As of July 2001, NHI covers all civil servants for health care services and the associated fees are deducted from their salaries. At the time of the assessment, civil servants in Hanang claimed that CHF fees were still being deducted, and, thus, they were double-paying for health care.

CHF membership provides member households with unlimited access to outpatient services at CHF-participating facilities. There is no limit on the number of visits per year by a CHF member household or individuals within the household. The policy is that CHF membership also covers referrals to Dareda Hospital in Babati district, although few people know of the policy and it appears to be applied only on a selected basis. It is the intention of the district to cover services at the Hanang District Hospital once it is operational.

Summary of Key Findings

Membership and Utilization

CHF membership is fairly low for Hanang District. According to the annual district CHF reports, CHF membership rates for the district increased from 2 percent of households during the last quarter of 1998, when the CHF was implemented in Hanang, to a peak of 23 percent in 1999. CHF membership rates declined significantly in 2000 to 4 percent, and appear to have dropped even further in 2001 to 3 percent, as of the end of October. In 2001, CHF membership fees collected contributed to less than 20 percent of the total fees collected at health facilities. The high enrollment rates in 1999 can be explained, in part, by the one-time district-wide information and mobilization campaigns conducted in May/June 1999.

Across the CHF facilities visited, the average 2001 membership rate was 5 percent, ranging from 0.3 percent to 13 percent. While CHF members represent only 5 percent of total households in these areas, CHF member visits account for 53 percent of total utilization at the health facilities in 2001. The average number of visits per CHF member household to the facilities visited was 32; the average per individual was four visits.

Most of the in-charges at facilities visited believe that community members from different backgrounds join CHF, not just the wealthy. However, given the original policy that required civil servants to join the CHF, a large percentage of CHF members tends to be civil servants, and thus relatively wealthier and well-educated. The average CHF member household size across the facilities visited was 8 persons, slightly larger than the regional average of seven persons.

In-charges at facilities visited believe that CHF members are not overusing health services by coming to the health facility for minor conditions. Most, however, felt that CHF members may seek care more readily when ill because they have prepaid for services.

In four of six facilities visited that had complete utilization data available for 1998-2001 (through September), utilization of health services has dropped significantly since the implementation of the CHF and user fees in 1998. One of the explanations given for the decline in utilization is that the implementation of user fees reduced the number of people who sought care for minor illnesses or who visited the facility only to collect drugs for future illness or to sell for profit.

CHF Organizational and Management Structure

The CHF is a district-based program, officially managed and administered by the district health board, which acts at the district CHF board, and is guided by the district council. The district health board is responsible for implementing the CHF, and for authorizing and monitoring the use of CHF funds. At the local level, the ward CHF health committee (WHC) is responsible for the management, administration, and promotion of the CHF. Community participation in the CHF is primarily through elected members of the district health board and WHC.

In practice, the district health management team (DHMT) has the primary responsibility for supervision of the CHF at the district level. Given its other responsibilities, there is a need to develop mechanisms to allow the DHMT to improve its supervision procedures. At the ward level, responsibility for the management of the CHF program has fallen on the facility in-charges in most of the wards visited. WHCs were only functioning in one of seven wards visited, and only four wards in the entire district had submitted ward health plans since the inception of the CHF in 1998.

While many CHF members and some non-members were aware that that the WHC is responsible for the local management of the CHF, very few were well-informed about the composition of the committee, or its specific roles and responsibilities. Most CHF members in the wards visited had never been invited to or attended a meeting for CHF members, and did not know how the CHF was managed or decisions made regarding the use of CHF funds.

Financial Results and Financial Management

Financial management and information systems require improvement. The assessment team found many inconsistencies in membership, utilization, and financial data between the national and district level, district and facility level, and records within the facility. Assistance to rationalize and simplify the record-keeping at the facility and district level is needed.

For the district as a whole, fees from CHF membership have decreased significantly from 1999-2001, while user fees have increased moderately over the same period. The increase in user fees collected is inconsistent with the general decline in utilization. One potential reason for the inconsistency is that more patients are willing to pay because of better services, or fewer exemptions are being given. Another reason may be related to improved financial management, so that more of the funds paid are being recorded and deposited.

The involvement of the WHC in management of CHF funds varies from ward to ward. In many cases, the WHC does not function, and the facility in-charge and the district medical officer make decisions about the use of CHF funds.

The procedures in place for facilities to access the funds are not always followed and some facilities and wards are more pro-active in using the funds than others. The record-keeping procedures and the level of accuracy varied among facilities. None of the facilities maintained their own records of deposits or expenditures. Only in one facility was there knowledge of the approximate amount of funds available for use.

The actual funds collected were lower than the expected collections based on utilization and CHF membership data. There is need for improve financial management to ensure that all funds are properly collected, recorded, and deposited into the CHF account.

Impact of CHF in Hanang District

Despite the issues around accessing funds, CHF funds have financed visible improvements in participating facilities and appear to have positively impacted health services in Hanang district. CHF funds are used to improve health facilities and services through the purchase of drugs and equipment, and refurbishment health facilities. From 1998–2000, however, the majority (59 percent) of CHF expenditures were used for the construction of the district hospital.

There is also evidence of significant unused funds, due to inactive WHCs, particularly in wards without health facilities. While CHF funds are being used to improve district health services, only half of the the total CHF funds collected between 1998–2000 were used by facilities/wards by the end of 2000. During 2000, most wards expended less than 20 percent of CHF funds collected in 1998 and 1999, and had significant unused balances in their district CHF sub-accounts by January 2001.

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 constitute 10 percent of the 2001 budget through the end of October – CHF membership and user fees account for 8 percent and the matching grant 2 percent 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 percent of fees collected in 1999 to 77 percent 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 percent–88 percent).

Exemption Policies

As part of the CHF Act and the original design, there was a provision to provide a free card to families who could not afford CHF membership fees. The design specified that communities would identify families eligible for free cards. In Hanang district, lists of families proposed for free cards were submitted to the District Council more than 18 months ago. No one has been approved for a free card to date, because it was felt that the lists submitted included too many people.

Few people are being exempted from user fees or CHF membership fees in Hanang district. One of the reasons for the limited number of exemptions is because district officials do not adhere to the national exemption policies. There was also a general perception among the DHMT officials that there are very few people who cannot afford to pay – though some may be reluctant to pay. Although this assessment did not seek to investigate ability to pay, it can conclude that the policies in Hanang district are insufficient to protect the poor from the burden of health costs.

Knowledge of and Perceptions toward the CHF Program

Knowledge of the CHF program is relatively high, particularly among people who live in the village where the health facility is located. Most learned of the CHF program through the CHF promotional campaigns that took place in May/June 1999 and/or at the health facility. Few community members had learned about the CHF through village or religious leaders.

Members and non-members who know of the program understand the CHF to be a prepayment scheme whereby a household pays Tsh. 10,000 per year and household members receive unlimited services at any CHF-participating facility for one year. They also know that there is a matching grant component to the program. The name for the CHF program in Swahili is *tele kwa tele*, which translates in English to “one-for-one.”

Most non-members and several CHF members were not aware that the membership fee included referrals to Dareda hospital, with presentation of a referral letter from the in-charge and a CHF membership card. Knowledge about the organizational and management structure of the CHF is low among CHF members and non-members.

Most CHF member and non-members had positive attitudes towards the program. Most believe that the CHF program has led to improved services at participating facilities, although the data show that only a few facilities rely on CHF funds for drug supply. All CHF members believed that the cost of health services used by their household in a year exceeded the annual membership fee of Tsh. 10,000, and, thus, that the benefits of the program outweigh the cost.

The most common reason cited for not joining was that it was difficult to pay Tsh. 10,000 all at once. Many thought it was easier to pay Tsh. 1,000 when one is sick. Many non-members felt that the CHF was not beneficial to individuals or small households, or households situated far from the health

facility. In addition, some community members said that they were not members because the CHF program did not include mission facilities, which they believed provided higher quality health services.

All of the in-charges interviewed at CHF and non-CHF facilities believed that the CHF is a beneficial program. In-charges at CHF-participating facilities said that it had enabled them to purchase additional drugs, supplies, and equipment, and make needed improvements in the health facility. In addition, many providers felt that the CHF program benefited relatively poorer households who cannot afford to pay Tsh. 1,000/1,500 per visit to the dispensary/health center. They did not believe the CHF led to overuse of health services, but rather enabled community members to seek care immediately when ill rather than wait until the illness became serious.

General Conclusions

The CHF has made some progress in meeting its original objectives, although there are many areas for improvement. In accordance with the three main objectives outlined in the CHF Act, the broad findings are:

- 1) *To mobilize financial resources from the community for the provision of health care services to its members:* The CHF is mobilizing resources (both CHF membership and user fees) from the community for health care services. The majority of the contribution for the last two years is from user fees.
- 2) *To provide quality and affordable health care services through a sustainable financial mechanism:* The CHF has improved the quality and range of services in Hanang district. While the CHF can continue to be sustainable as complementary financing mechanism, it is not designed, nor is it able, to recover the full cost of services.
- 3) *To improve health services management in the communities through decentralization by empowering the communities in making decisions affecting their health:* The CHF has a decentralized management structure, which promotes involvement of the communities. In some cases, ward leaders are actively involved in CHF management. Most WHCs, however, are not always functional.

The framework of the assessment was not specifically designed to evaluate CHF success in meeting objectives of the CHF Act, but rather to review overall performance and identify areas for improvement. In that vein, the more specific conclusions are:

- ▲ Enrollment rates are fairly low.
- ▲ Financial management and information systems require improvement.
- ▲ The involvement of the WHC in the management of CHF funds varies from ward to ward.
- ▲ There is a need to develop mechanisms to allow the DHMT to improve its supervision procedures.
- ▲ While CHF funds have improved health facilities and services in the communities, the majority of the CHF funds were used for construction of the district hospital.
- ▲ Most wards/facilities have significant unused balances of CHF funds.
- ▲ The most common reason cited for not joining was that it was difficult to pay Tsh. 10,000 all at once.

- ▲ People believe that the CHF has led to improved services at participating facilities.
- ▲ Community members have little understanding of, or participation in, the management of the CHF.
- ▲ Currently, there are no mechanisms to ensure that the poor have access to care.

General Recommendations

Based on the findings of this assessment, the following recommendations are offered for the short term (six to nine months) and longer term (following 12 months):

Short Term

- ▲ The goal of the CHF should not be focused solely on maximizing enrollment rates, but rather improving overall management.
- ▲ 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.
- ▲ 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.

Longer Term

- ▲ 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. Education should also be targeted to those communities far from a health facility.
- ▲ Analysis of the financial impact of covering hospital-based services is needed to ensure that hospital care does not deplete CHF funds.
- ▲ 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.
- ▲ Implementation of an exemption policy is required to ensure that the poor are not excluded from accessing services.
- ▲ Strengthening capacity of the DHMT required to ensure improved supervision and technical support of the CHF.

1. Background to the Assessment

USAID/REDSO/ESA requested that the Partners for Health Reform*plus* (PHR*plus*) project, in collaboration with the Commonwealth Regional Health Community Secretariat for East, Central, and Southern Africa (CHRCS), provide technical assistance to strengthen and improve the sustainability of existing community-based health financing schemes in the East and Southern Africa (ESA) region. With the support of the Tanzania Ministry of Health (MOH) and USAID/Dar Es Salaam, it was agreed that an assessment of the Community Health Fund (CHF) in Hanang district, Tanzania, and subsequent assistance to improve management of the CHF would be the first activity in this area.

The Tanzanian CHF was established by the MOH on a pilot basis in Igunga district in December 1995. Its purpose was to ensure the availability of quality health services at affordable prices. It is today essentially a district level prepayment scheme for primary care services targeted at the rural population and the informal sector. CHF members contribute a fixed annual fee per household, in exchange for free health services. The CHF providers are primarily public sector facilities, although the intention of the scheme (and the government health reform plan) is to include private sector and mission providers in districts where they exist. User fees at health centers and dispensaries are implemented as part of the introduction of the CHF, as is an exemption policy to ensure that families who cannot afford to pay the membership fees obtain a free CHF card. CHF membership fees are to be established by the community, and fees collected go into the district CHF account along with user fees paid and matching funds from the central government. The CHF's primary financial support has come from the World Bank in the form of matching funds and technical assistance at the central MOH.

In 1998, the MOH decided to expand the CHF to nine additional districts: Nzega, Iramba, Singida Rural, Kilosa, Iringa Rural, Mbinga, Songea Urban, Songea Rural, and Hanang. In the process of expansion, several evaluations of the CHF were conducted, including quantitative evaluations in Igunga and Singida Rural districts. Problems documented in these earlier evaluations of the CHF in other districts include:

- ▲ Low enrollment
- ▲ Inadequate community awareness about the CHF
- ▲ Inadequate community involvement and ownership
- ▲ Poor quality of care and lack of accountability to community
- ▲ Minimal use of exemption program
- ▲ "Leakages" or loss of fees collected
- ▲ Overuse of services by CHF members
- ▲ Misuse of membership cards

In 2001, the Community Health Fund Act (Annex A) was passed establishing the CHF as the official health plan at the local/community level. Through this act, the CHF is now being rolled out on a national basis. It is currently established in 23 districts, with the goal of implementation in all districts by 2003.

This is the first assessment of the CHF in Hanang district, which was one of the nine roll-out districts during the 1998 expansion. This assessment focuses on the management and operations of the CHF. Given the potential role of the CHF in financing primary health care services in Tanzania, there was agreement on the importance of improving its performance and maximizing its effectiveness. This assessment is the first part of a series of activities aimed at improving performance of the CHF in Hanang district, using tools and techniques that can be replicated throughout Tanzania.

2. Scope of Work and Objectives of Assessment

This assessment was conducted as part of an overall Scope of Work (SOW) to fulfill three objectives:

- ▲ To conduct an assessment of the CHF in the Hanang district in order to identify the strengths and weaknesses of the CHF, including a review of problems previously identified in World Bank and MOH evaluations in other districts.
- ▲ To provide recommendations to assist Tanzanian health officials to develop a plan of action to improve management and increase membership and utilization of the CHF in Hanang district and throughout Tanzania.
- ▲ To develop a plan for implementing the recommended changes with PHRplus assistance.

PHRplus conducted an assessment of the CHF in Hanang district to develop recommendations to improve the CHF management, including marketing, operations, and service delivery. The assessment included all levels of the CHF (central, district, ward, health facility, and community). Visits were made to MOH and parastatal health centers and dispensaries, which are the service facilities included in the CHF program in Hanang district. The assessment also included data collection from facilities and individuals not currently participating in the CHF to determine reasons for not participating in the CHF. The assessment aimed to identify the strengths and weaknesses of the CHF, and to review the problems previously identified in World Bank and MOH evaluations in other districts, and by CHF/MOH officials in Dar es Salaam.

The original SOW had envisaged visits to 3–4 wards in the district, each of which would have a MOH health center, and also two villages within each ward that have MOH dispensaries. In actuality, Hanang district only has one MOH health center, and the structure of the wards is such that there are not dispensaries and health centers within the same ward. After discussion with Hanang district officials, it was decided to conduct data collection at five MOH dispensaries and one MOH health center, and four private/mission dispensaries and health centers.

Information was collected on the organization and administrative structure of the CHF, management of funds, data collection and reporting systems, exemption policy, membership and utilization trends, promotion and marketing of the fund, resource mobilization, and member and non-member perceptions of the CHF. Information was gathered through semi-structured interviews with individuals involved in the administration of the CHF at all levels, and providers and managers at participating and non-participating health facilities. Facility, district, and central level records and reports were also reviewed. Focus groups discussions were conducted at the village level with CHF members and non-members. Also, exit interviews were conducted at both CHF and non-CHF facilities.

The original SOW is included in Annex B.

3. Data Collection Methodology

The primary data collection phase for this assessment was from November 26–December 14, 2001. Data was collected at the national, district, ward, and community level through semi-structured interviews, focus group discussions, and reviews of records and documents. Limited additional data collection and verification occurred during a follow-up visit to Hanang district in April 2002.

The wards, villages, and health facility sites included in the assessment were selected in collaboration with Hanang district health officials by considering CHF membership rates and trends in membership rates, type of health facility (public, private, participating in CHF or not), and distance from Katesh, the district headquarters.

3.1 Central Level

At the central level, data collection consisted of review of reports and documents, as well as semi-structured interviews with CHF officials:

- ▲ Mr. Rogatian M. Shirima, CHF Coordinator, MOH
- ▲ Dr. K. A. Mmuni, Community Health Fund Management Consultant
- ▲ Dr. F.N. Njau, Head Health Sector Reform Secretariat, MOH

Data gathering at the central level focused on:

- ▲ CHF and health sector reform in Tanzania
- ▲ Role of districts in the CHF design and policy
- ▲ Management and organizational structure of the CHF
- ▲ National exemption policy and implementation in CHF districts
- ▲ Financial sustainability
- ▲ Promotion and marketing of CHF
- ▲ CHF Act of 2001 and plans for roll-out to all districts
- ▲ Differences in CHF experiences in 10 districts

3.2 District Level

At the district level, the assessment included semi-structured interviews and review of reports and documents. The officials interviewed were:

- ▲ District Executive Director/District Council

- ▲ District Health Management Team (DHMT)
- ▲ District Medical Officer
- ▲ District Accountant

Information was gathered regarding:

- ▲ Socio-demographic characteristics of the district/ward population
- ▲ Administrative and management structure of the CHF
- ▲ Responsibilities of District Council, District Health Board, DHMT, and Ward CHF Health Committee (WHC)
- ▲ Establishment of CHF membership fees
- ▲ Number of CHF members
- ▲ Record-keeping and recording systems
- ▲ Funds flow and management
- ▲ Exemption policy, procedures, and practices
- ▲ Private sector involvement
- ▲ CHF and user fees collected
- ▲ Community involvement in management of CHF and use of CHF funds
- ▲ Promotion and marketing of the CHF

3.3 CHF Participating Facilities

At the facility level, semi-structured interviews were conducted with the in-charge and other staff at one health center, and six dispensaries to gather information on:

- ▲ Services provided and fees charged
- ▲ Availability of drugs and other supplies
- ▲ Provider knowledge and perceptions of CHF and CHF members
- ▲ Procedures for managing CHF fees and user fees
- ▲ CHF fees and user fees collected
- ▲ Use of CHF funds
- ▲ General record-keeping procedures at the facility
- ▲ Promotion and marketing of CHF at the facility level

Quantitative data were collected through review of CHF member cards, CHF log book, health management information system (HMIS) Book 2, facility receipt books, receipts from the District Accountant for funds deposited, and patient registries.

In addition to the officials based in the facility, ward councilors and ward executive officers (WEOs) were also interviewed where they were available.

Exit interviews were conducted with five patients at all but one of the CHF-participating facilities visited,¹ to gather information on perceived quality of care.

3.4 Non-participating Facilities

Information was also gathered at facilities not participating in the CHF using semi-structured interviews with health providers and administrators. One mission health center and three private/mission dispensaries were visited to gather information on:

- ▲ Services provided and fees charged
- ▲ Sources of funding
- ▲ Availability of drugs and other supplies
- ▲ Provider knowledge and perceptions of CHF
- ▲ Interest in joining the CHF
- ▲ Reasons for not joining the CHF

3.5 Community Level

At the community level, the assessment included four focus group discussions (each with 10-12 participants) with CHF members and five focus group discussions with non-members.

Focus group discussions gathered information on:

- ▲ Community awareness of CHF policies and procedures
- ▲ Knowledge about exemption policy, procedures, and practices
- ▲ Attitudes towards the CHF and health care services
- ▲ Reasons for joining or not joining the CHF
- ▲ Ability and willingness to pay for health services
- ▲ Community involvement in CHF planning, management and use of funds

Table 1 presents an overview of facilities visited and facility records reviewed, additional data collection carried out at the facilities visited, and data limitations encountered at particular facilities. The interview guides and questionnaires used for interviews, focus group sessions, and exit interviews are attached in Annex C.

¹ There were no patients at Getanuwas dispensary on the day the assessment team visited the facility.

Table 1: Health Facilities Visited, Data Collected, and Data Limitations

Health Facility	Wards in Facility Catchment Area	Facility Records Reviewed										Additional Data Collection					
		Patient registry	CHF and non-CHF registries available	HMIS records (Book 2)	CHF member log	CHF member cards	Facility receipt books	District receipts for funds deposited	Monthly CHF membership status form	Data limitations	Interview w/ in-charge	CHF member focus group	Non-member focus group	Exit interviews			
MOH Health Facilities																	
Bissotu Ziwani Disp.	Bissotu	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Endasak Disp.	Endasak Maskaroda Measkron	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dawar Disp.	Gendabi	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Getanuwas Disp.	Getanuwas	X	X						X					X			
Katesh Health Center	Katesh Mogitu	X												X			X
Sirop Disp.	Sirop Simbay	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Private/Mission Health Facilities																	
Bissotu Plantation Disp.	Plantation Mulbadaw village	X	X						X					X			X
Endasak Pentacoastal Disp.*	Endasak																X
Gendahbi Health Center (Lutheran Church facility)*	Gendahbi													X			
Nangwa Disp. (Catholic Church facility)*	Measkron Simbay Gisambalang													X			

* Denotes facilities not participating in the CHF.

4. History and Objectives of CHF

The government of Tanzania, in collaboration with the World Bank and other donors, launched the Community Health Fund on a pilot basis in Igunga district in 1995. Its original goals were far-reaching. Community health funds were conceived as a way of “ensuring greater security of access to health care, empowering households and communities in health care decision making, promoting cost sharing with strong local participation, and providing a stimulus to local health care providers (Shirima, 1996).”

The original design envisioned a CHF membership of entire households, whereby families would pay an annual household membership fee that is set by the community. In exchange, a card is issued that entitles the household to a basic package of curative and preventive services. Households would be able to obtain services from both public and private providers. The funds would be pooled at the district level, enabling “the fund to cover expensive hospital costs for catastrophic illness or injury. Households unable to pay the membership fee will be...given a community health fund card prepaid by the community (Shirima, 1996).”

From its inception, the design of the CHF was extremely ambitious and in some areas unclear. For example, it was estimated that 75 percent of all rural households in a district would become CHF members. It was stipulated that communities would set the membership fees. In practice, however, the fee levels are set by the district health board and/or the district council and communities are only informed or urged to accept the set fees. Another ambiguity is in whether benefits would include only services at the dispensary and health center level, or hospital-based services as well. In some cases, design components were revised due to lack of acceptance. One example is the concept of pooling funds at the district level – in all CHF districts, funds are pooled only at the ward level. Due to both the decentralized nature of the Tanzania health system and the lack of clarity in the original design, there are significant implementation differences from district to district.

In April 2001, the Community Health Fund Act was passed by the National Assembly. Some excerpts from this act are:

- ▲ CHF...is a voluntary community-based financing scheme whereby households pay contributions to finance part of their basic health care services to complement the Government health care financing efforts.
- ▲ Objectives of the Fund shall be:
 - △ To mobilize financial resources from the community for the provision of health care services to its members;
 - △ To provide quality and affordable health care services through a sustainable financial mechanism; and,
 - △ To improve health care services management in the communities through decentralization by empowering the communities in making decisions affecting their health.

- ▲ Subject to the provisions of this Act, every members' household shall be entitled to medical services of their choice which have been prepaid for at preselected public, private or charitable operated hospital, health center or dispensary within the respective district.

The language of the CHF Act provides significant room for districts to interpret specific provisions as they wish. Some districts have implemented the CHF in a way to cover health costs for all levels of care for its members. In Songea district, for example, the CHF now offers three levels of membership, allowing members to pay different fees for different packages of services, including outpatient and inpatient treatment at mission hospitals. In most districts, including Hanang, the CHF remains focused on primary care services at health centers and dispensaries.

The descriptions of the CHF also leave room for interpretation with regard to the role of risk-pooling and coverage of tertiary services. One MOH document describes the CHF as “a prepayment scheme that will ensure greater security of access to health care, and empower households and communities in health care decision and participation” (United Republic of Tanzania MOH, 2000). The CHF coordinator said that the CHF is not viewed as an insurance scheme, and that is not how it should be evaluated. For example, there are no mechanisms to minimize adverse selection, because one of the goals of the scheme is to ensure that the sick join the scheme so they can access care. From the perspective of the member, the CHF certainly functions as an insurance scheme, as it mitigates his risk of paying user fees. Nonetheless, this assessment does not evaluate the CHF according to standard insurance principles, as it was not designed as such.

Overall, the CHF is implemented differently from district to district, and continues to evolve. Despite many, and changing, secondary objectives, two core objectives that have remained constant are mobilizing additional resources for the health sector and improving health services.

5. Health Sector Reform Context

The government of Tanzania embarked on a program of health sector reforms beginning in the early 1990s. The overall objective of its reforms is “to improve the health and well-being of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people” (United Republic of Tanzania MOH, 2000). Mobilization of additional resources is a major priority to ensure sustainable financing of the health sector. Other strategies include decentralization of management to the districts, hospital reforms, and better management of donor funding through a Sector-Wide Approach (SWAP).

District health boards and district health management teams were created as the foundation for managing health services at the district level. The district medical officer (DMO) is the leader of the DHMT and is responsible for planning and management of health services within the district level. The DHMT develops and manages its own budgets for operational and capital expenses. The DHMT is also responsible for ensuring integrated delivery of key priority programs, such as maternal child health, family planning, and malaria. Management structures at the district level continue to evolve – the DHMT had reported to the district council, but now council health services boards (CHSBs) are being formed in all districts to oversee the DHMT.

One responsibility that remains somewhat centralized is the distribution of drugs and supplies. Health center and dispensaries are provided with a preset, sealed drug kit each month. There are strict procedures regarding who is required to be present when the drug kit is opened, to ensure an accurate accounting of supplies received. This procedure has resulted in significant improvements in drug availability, as previously drugs and supplies were pilfered. Nonetheless, the preset drug kit is not optimal for all facilities – it is insufficient to meet the drug needs in most facilities. In the few facilities where there may be surplus, DHMT officials may re-allocate drugs to other facilities that have drug requirements in excess of the drug kit.²

Districts receive funding regularly under the SWAP, also referred to as the basket, as well as the MOH budget. The available basket funding is currently \$0.50 per capita, which the districts budget according to their needs. Districts are audited regularly to ensure accountability. While basket funding has improved the reliability of funding, particularly at the district level, there is still a significant funding gap throughout the health sector.

The MOH focuses on three key complementary financing mechanisms for improving long-term sustainability:

- ▲ Cost sharing, referring to user fees at referral, regional, and district hospitals;
- ▲ Community Health Funds to be introduced in all districts throughout Tanzania; and,
- ▲ The National Health Insurance (NHI) scheme, which has just been introduced.

² This was documented in the Hanang district, but may or may not be occurring in other districts.

Cost sharing was introduced in 1993 and refers to fees for hospital services. These fees are charged in all MOH hospitals in all districts. There are no formal user fees for services at health centers and dispensaries, except in districts that have introduced the CHF. User fees at the health center and dispensary level were introduced in conjunction with the CHF, and the policy of a combined introduction will be used to expand the CHF and user fees to all districts.

NHI was introduced in July 2001, covering all civil servants for inpatient and outpatient care. Fees include a deduction from the employee's salary, along with a 3 percent contribution from the employer. There are optimistic estimates of the potential funding contribution from NHI, with estimates that it could fund up to 25 percent of the MOH recurrent budget (United Republic of Tanzania MOH, 2000). Its impact is not yet clear, but policies need to be clarified so that civil servants are not required to participate in both the NHI and the CHF, thereby double-paying for primary care services.

To ensure access to health services for vulnerable groups, there are national exemption policies. Some categories of exemptions include:

- ▲ Children under five years of age
- ▲ Pregnant women
- ▲ Family planning services
- ▲ Tuberculosis
- ▲ Leprosy
- ▲ Other chronic diseases

The districts implementing the CHF are not recognizing all these exemptions. As the CHF expands to all districts, there is a need to re-examine the current exemption policy and to provide more guidance to districts to support implementation.

As the health sector in Tanzania continues to evolve, the CHF is gaining in importance as a key component of the overall financing strategy and as a mechanism for empowering communities. Given the MOH commitment to the CHF, it will be critical to ensure that management is strengthened so as to maximize potential benefits from the CHF.

6. Hanang District

6.1 District Profile

The district of Hanang was created in 1985, making it a relatively new district in Tanzania. Hanang is one of 10 districts that constitute the region of Arusha in northeastern Tanzania. It is located in the Rift Valley highland zone, bordering Mbulu and Babati districts to the north, Kando and Singida Rural districts to the south, and Iramba to the west.

The population of Hanang district is estimated at 180,895.³ The district comprises five divisions, 22 wards, and 54 villages. The main economic activities in the region are agriculture and livestock herding, and, to a lesser extent, fishing and beekeeping. The agricultural sector is made up of small-scale farmers and large NAFCO (parastatal) commercial wheat farms, which are in the process of being privatized and were only semi-operational at the time of the study.

Given the reliance on agriculture, incomes are highly seasonal and the economy is largely dependent on rainfall, which fluctuates from year to year. The district economy suffered greatly from a drought in 2000. However, the district benefits from rich soil and is known as one of the “bread basket” districts of Tanzania due to its high levels of food crop production during years with adequate rainfall. The main food crops are maize, millet, wheat, potatoes, and beans. Other food and cash crops grown in the district include coffee, sugar cane, sunflower, and banana.

The most common diseases for which people seek treatment are: malaria, pneumonia, upper respiratory tract infections, diarrhea, intestinal worms, skin infections, minor surgery, and malnutrition.

6.2 District Health Services Infrastructure

Hanang district has 21 dispensaries, three health centers and 1 new district hospital. Of the 21 dispensaries, 11 are government-owned, eight are private facilities located on the parastatal farms, and two are mission facilities.

The parastatal dispensaries situated on the wheat farms were built to serve mainly farm employees and their families. They are considered private health facilities and, as a general rule, do not receive any government funding or assistance. However, in the case of at least one parastatal dispensary, the district was providing the dispensary with drug kits when they had an excess of kits for MOH facilities. All of the parastatal facilities participate in the CHF program.

³ The 2001 population is the projected population for that year based on the most recent (1988) census data.

Table 2: Hanang District Health Facilities

	Public Facilities	Private/Mission Facilities	Total
Dispensaries	11	10 (2 mission, 8 farm facilities)	21
Health centers	1 (Katesh)	2 (Lutheran Church facilities)	3
Hospital	1 (not treating patients as of 12/01)	0	1

As a result of thusfar unsuccessful attempts to find a buyer for these parastatal farms, the farms are only semi-operational and the funds available for the farm-operated health facilities, historically paid by the farm management, are low, or non-existent in some cases. While these facilities are still operating and serving the remaining farm workers and some villagers from surrounding areas, in one case, health workers had not been paid by farm management for several months and drugs were in short supply.

Two of the three health centers in Hanang are mission facilities, operated by the Lutheran Church. The one public health center in the district is located in the town of Katesh, which is also the district administrative headquarters and the main commercial town. The health center has served as a district hospital in the absence of such a facility. It provides inpatient, outpatient, and diagnostic services and has 34 beds.

The official designated district hospital for Hanang is Dareda Hospital, which is located in neighboring Babati district. Construction of the new Hanang District Hospital in Katesh began in 1999 and was completed at the time of the study. In November 2001, the offices of the DHMT were moved to the new hospital, but no patients were being treated as of December 2001. The staffing level for the new hospital was approved in late 2001, and the staff will be hired in 2002.

7. CHF in Hanang District

7.1 Start-up Phase

The CHF was officially established in Hanang district in September 1998. When the CHF was introduced, services at health centers and dispensaries were provided free of charge. The introduction of user fees coincided with the introduction of CHF. Hanang did not have a district hospital at the time, but was planning to construct one.

Hanang district was the first district in Tanzania to set its CHF fee at Tsh. 10,000 – other districts had set the fee at Tsh. 5,000. According to Mr. Shirima, CHF Coordinator, one of the key reasons influencing the District Council's decision to set the fee at Tsh. 10,000 was the need to raise funds for construction of the district hospital. Prior to discussions in Hanang regarding the CHF, the District Council had already decided that each family living in Hanang district must contribute Tsh. 10,000 toward the construction of the hospital. Thus, when the CHF fee was discussed, there was a general feeling that the fee should not be less than Tsh. 10,000.

The fee was set without very much community input – information about the CHF and the fee was not widely disseminated from the onset. According to the DMO, only after the District Council had approved of the Tsh. 10,000 fee were ward and village-level meetings held to tell community members about the CHF, including the membership fee. Nonetheless, there was general acceptance of this fee.

Like other districts that had introduced the CHF, Hanang district relied on its ward executive officers to collect the fees. In evaluations of Igunga and Singida districts, problems were found with this system, most notably that some of the funds were being diverted toward uses not related to CHF. In addition, because WEOs also serve as tax collectors, some community members misunderstood the CHF fee to be part of the general taxation rather than prepayment for health services. Although the assessment team did not see formal documentation of these problems in Hanang, the collection system in Hanang was changed in early 2000 so that only health facilities collected the CHF fees.

Although the CHF was officially established in 1998, substantive promotion and marketing did not occur until May/June 1999. It was after these mass information and mobilization campaigns that enrollment reached its peak, with over 5,000 members joining in 1999.

Based on accounts from DHMT members, including the DMO, 5,000 memberships (totaling Tsh. 50 million) in 1999 were paid by a “good Samaritan.” This policy was put in place to generate goodwill and trust in the CHF and to allow people to join even though they might not have the Tsh. 10,000 in cash available at enrollment time. The procedure was that any person who wanted to enroll could do so, with their first year's fee paid by the “good Samaritan.” People who enrolled in this way were urged to pay their fee when they had the funds.

It was difficult to verify the exact procedures by which the “good Samaritan” policy operated. CHF cards for such members were not always available at the health facilities – many of these members were probably not given official CHF member cards. It is also unclear whether these members were allowed

membership for the full year – in some facilities it was said that after several months, if these members did not pay their fees, they were no longer considered members. Lastly, none of the members who were interviewed by the assessment team verified that they first joined in 1999 under such terms. All the members or former members interviewed said they paid the fees themselves when they first joined.

There has been no systematic promotion of the CHF since the promotion campaigns in 1999. DHMT officials had intended to conduct additional campaigns, but none ever took place. There did not appear to be significant resource constraints, other than limited staff time and availability. Both DHMT officials and health facility staff generally recognize the need to improve promotion of the CHF to regenerate interest and increase enrollment.

7.2 Membership Rules and Fees

A household⁴ joins the CHF through payment of an annual fee of Tsh.10,000 per household, or by approval for a free CHF card by the district council, if the family is deemed unable to pay the CHF membership fee. To date, however, few families have been exempted from membership or user fees. The official policy also allows the CHF membership fee to be paid in installments although few people are aware of this option. Of the people who paid in installments, most paid in two equal installments of Tsh 5,000. Table 3 details the CHF and user fees established from the onset.

Table 3: CHF Membership and User Fee Structure

Service/Facility	Fee (Tsh)	Services Included
CHF fee	10,000	All primary care services for family members for one year, including consultation, drugs, laboratory services
Health center user fee	1,500	Consultation, drugs, laboratory services
Dispensary user fee	1,000	Consultation, drugs, laboratory services

CHF membership is voluntary for all residents with the initial exception of civil servants. From 1998 to 2001, prior to the introduction of National Health Insurance in July 2001, CHF membership was compulsory for civil servants and the fee was automatically deducted from their salaries. As of July 2001, NHI covers all civil servants for health care services, and the associated fees are deducted from their salaries. At the time of the assessment, civil servants in Hanang claimed that CHF fees were still being deducted and, thus, they were double-paying for health care.

7.3 Benefits

CHF membership provides member households with unlimited access to outpatient services at CHF-participating facilities. The CHF in Hanang district operates out of MOH facilities and private dispensaries serving parastatal farms in the district. The parastatal dispensaries became part of CHF gradually, with only one dispensary enrolling members in 1999, five enrolling members in 2000, and seven in 2001. None of the mission dispensaries and health centers are part of the CHF, that is, they do not enroll members nor do they provide free services for CHF members.

⁴ A household consists of a head of household, spouse, and dependent children under the age of 18. In polygamous situations, each wife constitutes a separate household.

There is no limit on the number of visits per year by a CHF member household or individuals within the household. The policy is that CHF membership also covers referrals to Dareda Hospital in Babati district, although few people know of the policy and it appears to be applied only on a selected basis. It is the intention of the district to cover services at the Hanang District Hospital once it is operational. If the policy of covering hospital services is applied in a widespread manner, it could have significant negative impact on the CHF's financial status.

8. CHF Membership and Utilization in Hanang District

Information on CHF membership and health service utilization was gathered by visiting facilities to examine their records and interview health staff, reviewing district and national CHF reports, and speaking with district officials, including DHMT members and the District Accountant.

8.1 CHF Membership Registration and Recording System

8.1.1 Facility Level

There are four sources of information on CHF membership status at the facility level: the CHF log book, CHF member cards, facility receipt books recording cash received from patients, and deposit receipts recording CHF deposits made to the district CHF account.

The CHF log book records the names of CHF members and the date of enrollment. The information is entered in the log upon receipt of the CHF membership fee of Tsh. 10,000. In cases where people are paying in installments, the status of payment may be tracked in the CHF log books as well. In five of the seven CHF-participating facilities visited, the CHF log books were used as a means of recording the names and status of members. The logs, however, were not always updated on a regular basis. In one facility visited, the CHF log book was used to record not only the names of CHF members but of villagers who had expressed, but never acted on, their interest in joining the CHF. There was no indication, however, of which people were actual members.

CHF member cards are provided to all CHF-participating facilities by the district (see Annex D). The member cards contain two parts, separated by a perforation. After the membership fee is paid in full and the information requested on the card is filled out, the health facility gives the CHF member one part of the card, which must be presented upon seeking treatment, and retains the other part for the facility records.

The part of the CHF member card retained by the facility lists the name and address of the household head, and the names, ages, and sex of the spouse and dependents. In most cases, this section was filled out, although in one facility, about 25 percent of the cards did not list individual household members. The facility portion also contains the date of enrollment, a member identification number, and space for a passport-sized photograph.

The part of the CHF card given to the member contains the name and address of the household head, the membership period, member ID number and space for a photograph. It does not contain a listing of the household members, other than the head of household. Very few cards kept at the facility or with the member actually had attached a photograph of the household head, and none had a picture of the entire family covered under the household's CHF membership.

When a CHF member renews a membership, the renewal date is to be indicated on the member and facility cards. In most of the facilities visited, the membership cards were separated by year, but not ordered alphabetically or by membership number. This makes it time-consuming for health staff to retrieve a card to enter a renewal date – or to verify a person’s membership status. As a result, not all cards kept at the facility had renewal dates indicated on them.

The CHF deposit receipts track the date and amount of deposits made to the CHF district bank account. Fees collected from user and CHF membership fees are deposited into the same district CHF account. In-charges at the health facilities typically make deposits at least once a month, but the frequency depends largely on the amount collected in a particular month. Deposits are made at the district accountant’s office or via a DHMT member during monthly supervisory visits to the facility. In some cases, the DHMT members do not have a receipt book with them, so the deposit amount and date is marked on the user fee or CHF member receipt books currently being used at the facility. The CHF deposit slips appeared to be filed with little care at most of the facilities visited. At two facilities, in-charges admitted that they were missing several receipts.

8.1.2 Reporting to the District and National Level

CHF-participating facilities are required to submit a monthly CHF reporting form to the district. The form records the number of new, continuing, and renewing members, and presents the total number of active members for that month.

The district accountant uses these monthly CHF reporting forms to prepare quarterly and annual CHF reports for the MOH. However, the number of active members reported on the monthly forms often does not match the CHF deposits made to the district CHF account by each ward/facility. In cases when there are discrepancies, the number of members reported to the MOH is based on CHF deposits received at the district level.

Both the quarterly and annual district CHF reports present CHF and user fee information by ward. Cumulative amounts of the following are included in the reports: number of CHF member households, CHF funds collected, matching funds received, funds not receiving matching funds, user fees collected to date, total funds collected, and the balance of the district CHF account. The reason that the data is calculated on a cumulative basis is to track the total amount of CHF funds eligible for the matching grant and the amount in matching funds received to date.

8.1.3 Inconsistencies in CHF Membership Data

The reliability and organization of the CHF log books, member cards, and deposit receipts varied by health facility. In most facilities, the logs and member cards appeared to be relatively well documented and the majority of deposit receipts were available. Upon reviewing them, however, various discrepancies in the CHF registration and recording system were found. All facilities visited exhibited inconsistencies in the number of current members recorded in the ledgers, the number of CHF cards indicating current membership, and the number of members according to CHF deposit receipts. In addition, the CHF membership numbers reported in the quarterly and annual district CHF reports did not match the number of current members recorded at the facilities visited.

There are several possible reasons for these discrepancies. Health facility staff are required to fill out a large amount of often time-consuming paperwork on a regular basis for their own facility’s records, the HMIS, and the CHF program. This poses many challenges for the small staff at most

facilities, particularly the clinical officer in-charge, who is responsible both for ensuring that all of the records are being maintained and forms filled out and for treating patients.

In addition, the staff at most facilities visited had received very little training from the DHMT about how to maintain an effective CHF registration and recording system, including how to fill out the ledger and forms. Most of the in-charges had a very limited understanding of the CHF recording system and its uses. For example, when asked to explain how to complete the monthly CHF reporting forms submitted to the district, only one in-charge, among those at the seven CHF-participating facilities visited, could do so in a complete manner.

Lastly, there is no mechanism for in-charges to reconcile their records. Much of the data recorded is not referred to at a later date, so periodic errors tend to be compounded over time.

8.2 CHF Membership Rates

It is important to note that Hanang district officials calculate the CHF enrollment rates using the number of households according to the 1988 census, not the projected number of households for each year. As a result, the membership rates reported by the district are overestimated if the number of households in Hanang has increased since 1988.

The membership rates presented in this report are calculated based on the Hanang district official 2001 population estimate of 180,895 and an average household size of seven persons for Arusha region.⁵

8.2.1 District Level

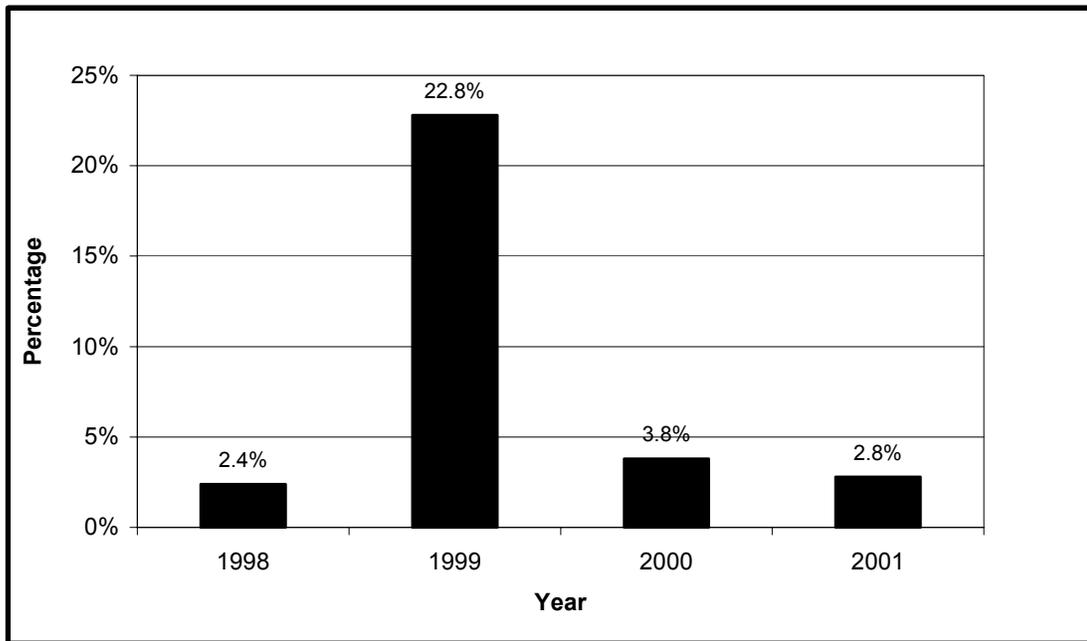
According to the annual district CHF reports based on CHF deposits to the district account, CHF membership for the district increased from 2.4 percent of households during the last quarter of 1998, when the CHF was implemented in Hanang, to a peak of 22.8 percent in 1999. CHF membership rates declined significantly in 2000, to 3.8 percent, and appear to have dropped even further in 2001, to 2.8 percent, as of October 31, 2001 (see Figure 1).

It was not possible to examine changes in membership over time at the ward level due to recent changes in the way CHF membership fees are collected. As stated above, prior to 2000, CHF membership fees were collected by the WEOs. In 2001, Hanang district implemented a new policy stating that all CHF fees were to be collected at the health facility only.

Due to this change in the CHF collection policy, district-level membership data was based from 1998–2000 on ward-level deposits made by the WEOs and from 2000 to the present on facility-level deposits made by in-charges. Each facility serves more than one ward. As a result, it is only possible to trace changes in membership numbers at the ward level from 1998–2001 by reviewing all membership cards from 2000–2001 to obtain the ward in which all members reside. Due to time constraints, the assessment team was not able to do this.

⁵ See http://www.act-intl.org/appeals/appeals_2000/AFTZ02.html

Figure 1: CHF Membership Rates for Hanang District, 1998–2001



Source: District CHF Reports

8.2.2 CHF Membership in Facilities Visited

The 2001 CHF membership data reported by the district for the facilities visited could not be verified at the facility level. Table 4 presents the total number of CHF members according to the best available facility-level records and the district CHF reports. The average membership rate for the seven CHF-participating facilities visited during the assessment was 5.1 percent, and ranged from 1.5 percent to 13.0 percent. The enrollment rate was also calculated excluding Katesh Health Center and Bassotu Plantation, resulting in an enrollment rate of 2.2 percent. Katesh was excluded because it is the only health center in the sample and thus attracts patients from outside its catchment area. Bassotu Plantation was excluded because the majority of its memberships are paid for by farm management.

In some cases, discrepancies between facility- and district-level data can be explained by the lag between when membership fees are collected and deposited at the district level. For example, in the case of Getanuwas, membership fees for the period from September to November were being deposited at the district level in early December.

In other cases, the difference between membership levels recorded at the facility and district level may be due to inconsistencies in accounting for the fees paid by health staff. Although the policy is to deduct the membership fee from health staff salaries, they may not be included in the District Accountant's calculations of total CHF deposits. Given that the District Accountant ultimately calculates membership figures in the district reports based on CHF deposits made to-date, this could account for some of the difference.

Table 4: 2001 Membership in CHF-participating Facilities Visited

Health facility	Pop. of catchment area in 2000	No. of HH in catchment area	2001 CHF members (as of 10/31/01)		% of CHF households in service area, according to facility membership records
		Avg. HH size=7	Facility ledger/CHF cards	District CHF report	
MOH Health Facilities					
Bassotu Ziwani *	10,299	1,471	27	22	1.8
Endasak	23,370	3,339	66	82	2.0
Dawar	4,060	580	33	14	5.7
Getanuwas	11,392	1,627	4	0	0.3
Katesh Health Center	21,091	3,013	393	297	13.0
Sirop	6,044	863	13	0	1.5
Private/Mission Facilities					
Bassotu Plantation	2,145	306	39	20	12.7
Total	78,401	11,199	575	435	5.1
Total Excluding Katesh and Bassotu Plantation	55,165	7,880	173	118	2.2

Source: DHMT service population data, facility records, district CHF reports

* The district CHF report shows that there were 76 members as of 10/31/01. However, this is inconsistent with the CHF member fees reported on the same form, which indicated that there were 22 members in Bassotu Ziwani.

In the case of Bassotu Plantation, the farm management pays the CHF membership fee for 36 workers. As of October 31, 2001, farm management had paid directly to the District Accountant Tsh. 5,000 each for 36 farm workers. The balance was not paid until December 2001. Thus, although 36 workers are legitimate CHF members, with cards at the facility, the fees collected from them total only Tsh. 180,000 as of October 31, 2001. Since the district-level data is based on total CHF funds deposited, the District Account would have calculated that 18 households had paid in full for CHF membership.

8.3 Characteristics of CHF Members and Non-members

As mentioned above, in the seven CHF facility catchment areas visited during the assessment, CHF members account for 5.1 percent of all households and non-members for 94.9 percent. Limited information on the characteristics of members and non-members was obtained by examining CHF log books and member cards, interviewing health facility staff and DHMT members, and conducting focus group discussions and exit interviews with members and non-members.

8.3.1 Household Size and Location

Upon reviewing active CHF cards, the average size of CHF member households at the facilities visited was calculated to be eight persons, which is higher than the Arusha regional average of seven persons. The average member household size in the facilities visited ranged from an average of five persons in Bassotu Plantation to 10 persons in Getanuwas (see Table 5).

The vast majority of CHF member households are located in the village in which the ward health facility is located.

Table 5: Household Size of Active CHF Members, 2001 (as of 1 December 2001)

HH size	Dispensary						Total
	Bassotu Plantation	Bassotu Ziwani	Dawar	Endasaki*	Getanuwas**	Sirop	
1	2	0	0	16	0	0	2
2	2	0	1	0	0	0	3
3	10	0	1	0	0	0	11
4	3	0	1	4	0	1	9
5	8	0	0	8	0	1	17
6	6	1	2	7	0	1	17
7	5	3	2	10	0	1	21
8	1	4	8	3	0	1	17
9	2	5	7	7	1	2	24
10	0	6	6	7	1	1	21
11	0	11	4	0	2	5	22
12	0	0	1	0	0	0	1
Total member HHS	39	30	33	62	4	13	181
Average HH size	4.7	9.5	8.4	7.1	10.3	8.7	8.2

Source: CHF member cards

* The 16 CHF cards with information only on the head of the household were considered incomplete, and thus were excluded in calculation of the average HH size. only

** Getanuwas dispensary has been operational only since September 2000. Thus, the number of CHF members is very low and may be unrepresentative of HH likely to join the CHF in Getanuwas.

8.3.2 Socioeconomic Status

Most of the in-charges at the facilities visited believe that community members from different socioeconomic groups join CHF, not just the wealthy. However, two in-charges noted that the majority of CHF members were relatively wealthy households. Given the original policy that required civil servants to join the CHF, a large percentage of the CHF members tend to be civil servants, and thus relatively wealthier and well-educated. Most of the in-charges also believe that few of the very poor would have the ability to pay the CHF membership fee.

Some in-charges noted that, generally speaking, CHF members tend to be more informed and involved in community-level activities.

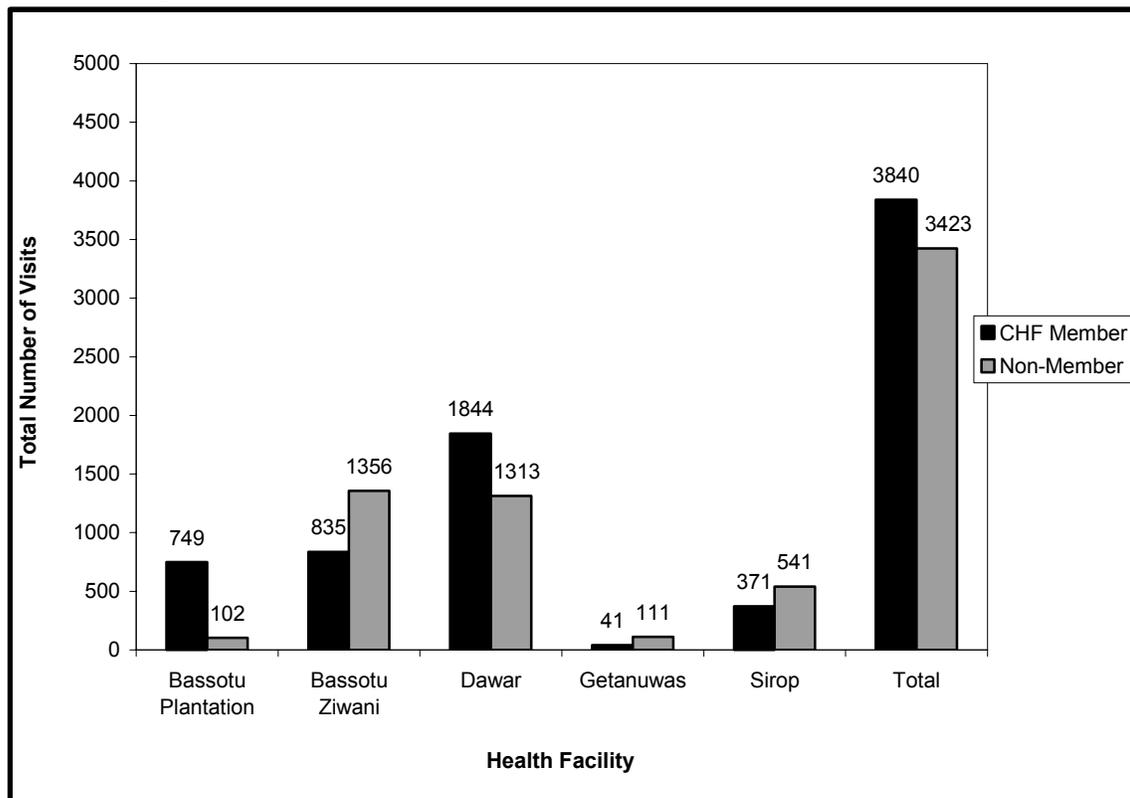
8.3.3 CHF Member vs. Non-member Utilization

The in-charges at the facilities visited believe that CHF members do not overuse health services by coming to the health facility for minor conditions. Most of the in-charges, however, feel that CHF members may seek care more readily when ill because they have prepaid for services.

The in-charges do not believe that members are sharing their cards with non-members. In many facilities, the in-charges said that they recognize CHF members, including individual members of CHF households. However, health facility staff rarely consult the CHF member cards kept at the facility to verify a patient's CHF membership status. In addition, the in-charges noted that the CHF Act prohibits sharing of cards, and the warning posted in some facilities provides sufficient discouragement of this practice.

Figure 2 presents the number of visits by CHF members and non-members for the period January–November 2001. In two of the CHF-participating facilities with the largest service populations and volume of patients, Katesh and Endasak, the patient registry books did not indicate whether or not the patient was a CHF member. Thus, information on member vs. non-member utilization was only available for five of the seven facilities visited.

Figure 2: CHF Member and Non-member Utilization, Jan–Nov 2001



Source: CHF and non-CHF patient registries

Across the five facilities, CHF member visits account for 53 percent of total utilization from January to November 2001 (Table 6). However, CHF members represent only 2.4 percent of total households in the facility catchment areas.

Table 6: CHF Member Utilization, Jan–Nov 2001

	Health Facility					Average
	Bassotu Plantation	Bassotu Ziwani	Dawar	Getanuwas	Sirop	
CHF member visits as % of total visits	88.1%	38.1%	58.4%	27.0%	40.7%	52.9 %
CHF members as % of total HH in service area	12.7%	2.0%	5.7%	0.3%	1.5%	2.4%

The average number of visits per CHF member household varied significantly by service area, ranging from 10 in Getanuwas to 56 in Dawar. Similarly, the average number of visits per individual ranged from one to seven. The team could not identify an explanation for the unusually high average number of visits by members at the Dawar dispensary. The average across all facilities was 32 visits per CHF member household and four per individual.

Table 7: Average CHF Household and Individual Member Visits, Jan–Nov 2001*

Dispensary	CHF member visits	No. of HH	Total no. of HH members	Average visits per HH/year	Average visits per member/year
Bassotu Plantation	749	40	185	19	4
Bassotu Ziwani	835	30	285	28	3
Dawar	1844	33	278	56	7
Getanuwas**	41	4	41	10	1
Sirop	371	13	113	29	3
Total	3840	120	902	32	4

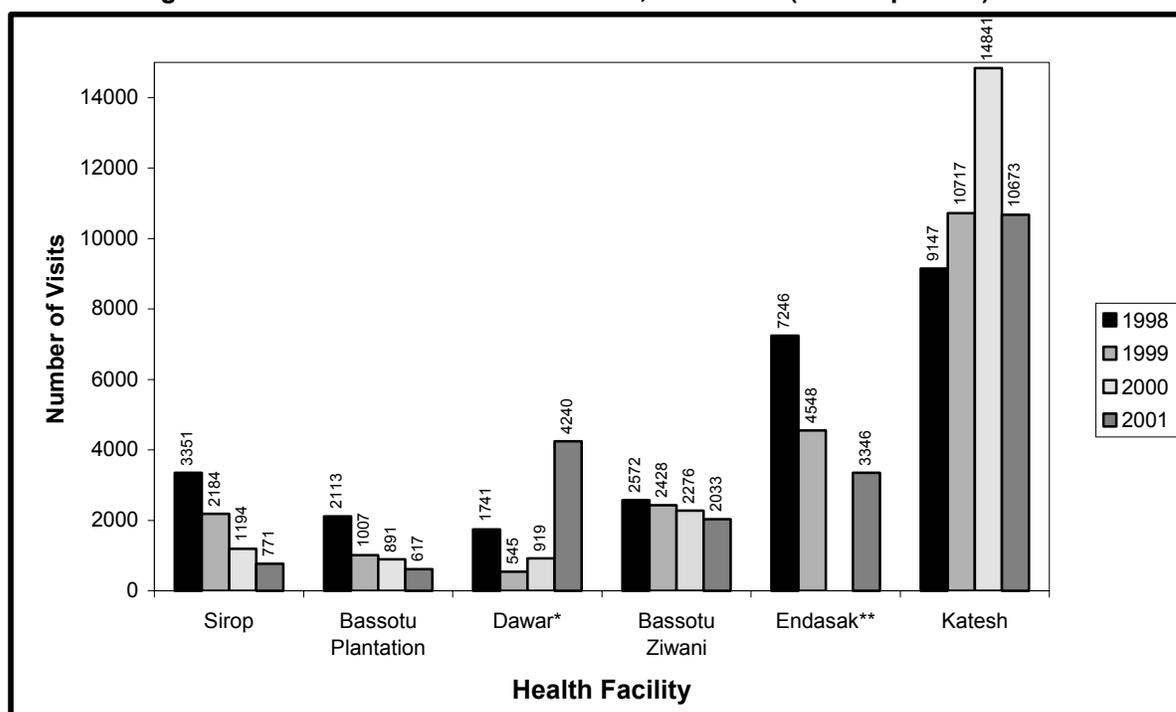
* CHF and non-CHF patient registries were not kept at Katesh Health Center or Endasak.

** Getanuwas dispensary opened in September 2001.

8.4 Health Service Utilization Before and After Implementation of CHF and User Fees

Information on service utilization before and after implementation of the CHF was gathered from the Health Management Information System records (Book 2) kept at the facilities. Utilization data were not available prior to 1998. While the CHF was established in September 1998, user fees did not go into effect immediately. Thus, 1998 utilization figures provide a good indication of preCHF utilization levels. It should be noted that the HMIS data for 2001 is only available for the period from January–September 2001.

Figure 3: Total Visits to Health Facilities, 1998-2001 (Jan–Sept 2001)



Source: HMIS records (Book 2)

* The HMIS data at Dawar dispensary is included in order to maintain consistency in the data source used for utilization trends at facilities visited. However, the assessment team found systematic errors in the HMIS records, which resulted in significant underestimations of the number of visits to the facility from 1998-2000.

** 2000 HMIS data was not available at Endasak dispensary.

Figure 3 presents total utilization from 1998 to 2001 at six of the seven CHF-participating facilities visited.⁶ In four of the six facilities (Sirop, Bassotu Plantation, Bassotu Ziwani, and Endasak), utilization dropped significantly from 1998 to 1999, as much as 37 percent as in the case of Endasak. In those four facilities, utilization has continued to decline through 2001. One of the explanations given for the decline in utilization is that implementation of user fees reduced the number of people who sought care for minor illnesses or who visited the facility only to collect drugs for future illness or to sell for profit.

⁶ The HMIS Book 2 was not available in Getanuwas.

The utilization patterns in Katesh health center are difficult to interpret. In the case of Dawar dispensary, systematic errors in the way utilization data was entered into the HMIS books from 1998 to 2000 have resulted in significant underestimations of total visits to the facility during that period. While the Dawar HMIS records were used to maintain consistency in the data source across facilities, the assessment team deems the historical utilization numbers for Dawar to be unreliable.

During the focus group sessions, CHF members were asked if they tend to go to the health facility more or less frequently since they joined the CHF. Most responded that it is “easier” to seek care at the health facility when ill with a CHF membership card because services are “free.” However, CHF members did not feel that they overuse services by going to the health facility for minor illnesses.

Non-CHF members were asked if they tend to go to the dispensary/health center more or less frequently now that user fees are charged at MOH health facilities. Most non-members said that the implementation of user fees had not affected their utilization of health facilities. One person noted that “you can’t stop going to the dispensary just because of Tsh. 1,000.”

Some non-members, however, believe that since the establishment of user fees, more people prefer to do directly to the pharmacy and buy prescription drugs, which may be less expensive than the user fee. They noted that some commonly prescribed drugs are not always available at the health facility, so many people end up paying the user fee and for the prescription drugs. Thus, some people believe that it is less expensive to bypass the health facility and go directly to the pharmacy.

Several non-members noted that only for medical emergencies or other exceptional circumstances are health services provided without payment, so lack of funds does prevent some people from going to the health facility. In the case of medical emergencies, patients are still required to pay the health facility for services rendered when funds are available.

9. CHF Organizational and Management Structure

Information on the organizational and management structure of the CHF was gathered through focus groups and exit interviews with Hanang district CHF members and non-members, interviews with in-charges, and discussions with ward councilors, DHMT members, the DMO, and the District Accountant.

9.1 Organizational Structure

The CHF organizational and management structure was integrated into existing administrative structures at the central, district, and ward levels. At the central level, the MOH and the Ministry of Regional Administration and Local Government play a limited management and oversight role in the CHF program. The primary role of the MOH is to promote and provide technical assistance for the implementation of the CHF, and to monitor and evaluate CHF performance. The Ministry of Regional Administration and Local Government also supports the implementation and operations of the CHF, mainly through its oversight of the district council.

The CHF is a district-based program, managed and administered by the district health board, which acts as the CHF board, and is guided by the district council. The district health board is responsible for implementing the CHF, and for authorizing and monitoring the use of CHF funds. At the local level, the ward CHF health committee is responsible for the management, administration, and promotion of the CHF. Community participation in the CHF is primarily through elected members of the district health board and WHC.

Under the Community Health Fund Act of 2001, the district health board is to be replaced by a district council health services board, whose composition and role will differ slightly from that of the district health (CHF) board. As of 2001, in order for a non-CHF district to begin implementation of the CHF program, a CHSB must be established. At the time of the assessment, however, a CHSB had not been established in Hanang district, although preparation for this board had begun. The Hanang District Health Board and WHCs had been created in accordance with the CHF Operations Guidelines prepared and distributed to district authorities by the MOH. The composition and responsibilities of the health board and WHCs set forth in the Hanang District 2001 Health Plan adhere to the Operations Guidelines. Box 1 presents the composition and functions of the district health board, DHMT, and WHC.

9.2 Introduction and Promotion of the CHF

The CHF was introduced to Hanang district through an initial visit by MOH officials to inform district leaders about the design, operations, and management of the CHF, and to provide technical assistance to promote the implementation of the CHF. The District CHF Health Board, however, was responsible for the district- and ward-level introduction and implementation of the CHF.

The CHF was officially launched in Hanang district in September 1998. The District Council and CHF Board held meetings at the district administrative headquarters in Katesh with WEOs and ward councilors to introduce the CHF program. The CHF membership fee was decided upon at these meetings, largely among District Health Board and council members, without direct input from community members.

The role of the ward leaders and composition and responsibilities of the ward health committees were also discussed at the initial CHF introduction meeting in Katesh. Ward leaders were then responsible for educating village leaders and members about the CHF, establishing WHCs, and mobilizing community members to join.

In response to low rates of enrollment during the first nine months of the program, district authorities, assisted by Tanzanian Food and Nutrition Center personnel, launched a district-wide sensitization and mobilization campaign in May/June 1999. District authorities, including the District Executive Officer, met with ward and village leaders, health providers, and community members to discuss the CHF. Meetings were held in the central ward villages, with community leaders and members from all villages in the ward invited to attend the CHF meetings. Most people who attended these meetings, however, lived in or near the central ward village. CHF promotional materials, such as posters, hats, t-shirts, and bags, were distributed.

While DHMT members are encouraged to promote the CHF during monthly supervisory visits to health centers, the district has not carried out any organized promotional campaigns since 1999. According to DHMT members, funds were available for further promotional activities in 2000–01, but they had not been carried out due to limited staff time and availability.

According to community members and in-charges at facilities visited, village and religious leaders have not been adequately involved in efforts to mobilize community members to join the CHF. In addition, few local leaders in the wards visited were active CHF members at the time of this assessment.

Box 1: Responsibility and Composition of CHF Administrative Bodies

(Operations Guidelines, 1999, p.22; Hanang District 2001 Health Plan, p. 17-18).

Responsibilities

District Health (CHF) Board

- > Responsible for overall routine monitoring of CHF operations
- > Works in consonance with the DHMT to ensure quality care and professionalism
- > Administers, mobilizes funds and opens bank account
- > Sets exemption policy and targets for CHF
- > Reviews reports from ward committees and other sources
- > Monitors and makes verification upon collection, expenditure, and control of funds

District Health Management Team

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

Ward CHF Health Committee

- > Mobilizes communities to join CHF
- > Prepares membership lists and supervises the collectors of fees
- > Reviews specific cases and situations in their own communities and resolves the problem or makes recommendations to the District Health Board
- > Monitors the number/proportion of CHF members in the community
- > Monitors the level of contributions and user-fee revenues
- > Reviews CHF operations, makes recommendations, and takes remedial actions
- > Implements and monitors the community health plans
- > Attends biannual general meetings of members

Composition

District Health (CHF) Board: 15 members, 8 representing each division and 3 women.

- > Chairperson - elected by District Council among the CHF members
- > Chairperson of District Social Services Committee
- > Two (2) members from each division as recommended by the ward committees
- > District Executive Director
- > Three (3) women members elected by the District Council as recommended by ward committees

Ward CHF Health Committee

- > Chairperson elected by members amongst themselves
- > Ward Councilor
- > Ward Executive Officer
- > Clinical Officer or Assistant Clinical Officer In-charge
- > Health teacher from a primary school located in the ward
- > Two (2) members elected by ward community
- > Secretary nominated by the community amongst its members

9.3 Management and Supervision of the CHF Program

9.3.1 Role of District Health (CHF) Board

The District Health Board is responsible for (1) monitoring CHF operations, (2) collaborating with the DHMT; (3) administering and mobilizing CHF funds, (4) setting and implementing the CHF exemption policy, and (5) reviewing CHF reports from the WHC and other sources. The board is composed of representatives from the district and division levels, as well as three women representatives (see Box 1). The District Medical Officer serves as the Secretary of the District Health Board.

The District Health Board plays a role in overall monitoring of the CHF program, particularly the use at the ward level of funds in the district CHF account. To request use of CHF funds (which includes membership and user fees and the matching grant), the WHC submits a Ward Health Plan or minutes from a committee meeting to the District Health Board, which outlines the proposed use of CHF funds. The plan or minutes must be signed by three members of the WHC: the Chairman of the WHC, the WEO, and the in-charge at the health facility. The District Health Board must approve the proposed CHF expenditures before CHF funds are released to the WHC.

9.3.2 Role of the District Health Management Team

The District Health Management Team is responsible for (1) supervising the CHF program, (2) providing technical assistance to WHCs to manage CHF and develop ward health plans, and (3) responding to problems regarding the CHF at the facility or ward level.

The DHMT makes monthly supervisory visits to every MOH health facility in Hanang. Mobile clinic visits are made to wards without facilities. The DHMT monthly visits are conducted according to a supervisory checklist, which outlines specific areas and activities to be examined and monitored. They include the following:

- ▲ Administration activities
- ▲ MCH activities
- ▲ EPI (Expanded Program on Immunization) diseases
- ▲ Prescription drugs (distribute essential drug kits, reviewing existing stock, etc.)
- ▲ Outcome measures
- ▲ CHF
- ▲ Laboratory, if applicable
- ▲ Pharmacy
- ▲ Environmental sanitation

With regard to the CHF, DHMT members are required to monitor and supervise:

- ▲ CHF membership register
- ▲ Membership renewals

- ▲ Inventory of CHF membership cards
- ▲ Social mobilization
- ▲ Cash box utilization
- ▲ Cash receipts and money collected in CHF and user fees

At the end of each visit, the DHMT submits a report to the DMO which records; (1) the date of supervision, (2) problems and causes identified during the visit, (3) recommendations, (4) person responsible for follow-up action, and (5) date of follow-up action.

According to in-charges at facilities visited, DHMT members typically spend one hour reviewing all facility records and speaking with staff members during the monthly supervisory visits. The time spent at each facility is insufficient to adequately cover all of the areas included in the supervisory checklist above. Given these time constraints, DHMT members generally conduct a rapid review of CHF records and reports. Due to the time-consuming nature of such a task, DHMT members do not examine internal consistency in the CHF registration and recording system by comparing CHF register entries, membership fees collected, and active membership cards. During the visit, in-charges usually deposit CHF membership and user fees collected via the DHMT members.

While membership renewal and social mobilization are specifically listed as areas to be examined during supervisory visits, these areas are only superficially touched upon during visits. DHMT members generally do not meet with or monitor the activities of the WHC. One of the roles of the DHMT is to assist in the development of ward health plans, which are incorporated into the District Health Plan and the district health budget. According to the DMO, all wards submitted a ward health plan in 1999; however, the assessment was only able to locate four plans at the time of the assessment. Few wards have submitted health plans since 1999.

9.3.3 Role of the Ward CHF Health Committees

The Operations Guidelines state that the WHC is to be composed of eight members, including the Ward Councilor, WEO, a member of the Ward Development Committee, one primary school teacher, the clinical officer in-charge at the health facility, and two members of the community. All members of the WHC must be CHF members. The main functions of the WHC are: (1) to mobilize the community to join the CHF, (2) monitor the CHF program and use of funds at the local level, (3) organize CHF meetings among committee and CHF members, and (4) develop Ward Health Plans.

At the time of the assessment, WHCs were generally not performing these key functions. The WHC was functioning in one of seven wards visited – Endasak. As mentioned above, WHCs have not been preparing health plans, which would detail the use of CHF funds. In most wards visited, the in-charges at the health facility assumed responsibility for managing the CHF at the local level, largely on their own. Where the WHC was not functioning, in-charges would prepare an annual ward budget or other request for the use of CHF funds and obtain required signatures from WHC members.

Under the Operations Guidelines, WHCs are required to hold biannual general meetings of CHF members. With the exception of Endasak, most CHF members in the wards visited had never been invited to or attended a meeting for CHF members. Many CHF members said that they would appreciate feedback on a quarterly or annual basis on the use of CHF funds. Despite the absence of general CHF member meetings, many CHF members and some non-members were aware that the

WHC was responsible for the local management of the CHF. However, they were not well informed about the formation or composition of the Committee, or its specific roles and responsibilities.

One of the reasons that WHCs do not always function as intended is that many WHC members are no longer CHF members, which disqualifies them from holding positions on the WHC. In one facility, the CHF committee members had been receiving allowance for attending meetings. When that allowance was eliminated in 2000, members stopped attending meetings. Many of the in-charges at facilities had called WHC meetings on one or more dates, but in many cases few or no committee members attended.

9.3.4 Community Participation in Management

In most wards, the participation of community members in the management of the CHF is limited to the elected officials and community members who sit on the District Council, District Health Board, and the WHC. Many members and some non-members were aware that a WHC existed and played some role in the management of the CHF. However, they were not informed about decisions made or actions taken by the committee with regard to the CHF. Most believed that the in-charge played the greatest role in the management of the CHF and decisions regarding the use of CHF funds.

As noted above, most CHF members had never attended a meeting among CHF members to discuss the program or use of CHF funds, or voice suggestions or complaints regarding the CHF. Most CHF members did not know whom they should inform of problems concerning their CHF membership or the CHF program.

10. Financial Results and Financial Management

Information on CHF financial management was collected at the national, district and facility level. It was important not only to document the amount of fees collected from CHF and user fees and how the fees were used, but also to examine the procedures for administering the funds collected, and the data maintained about the CHF. This information allowed the assessment team to analyze the financial status of the CHF and the efficiency of the record-keeping system, and to provide recommendations regarding management improvements. Reliable data on utilization and finances are important for assessing the impact of the CHF on expanding access to high-quality, affordable services and mobilizing financial resources for health services.

Financial information collected at the national level included reports of CHF and user fees collected for all CHF districts, Hanang district CHF reports sent to the central CHF coordinator, and data from interviews with central officials. At the district level, the District Medical Officer and District Accountant were interviewed, and various CHF reports were reviewed, including CHF reports of funds collected by facility and ward, and the ward CHF ledger. At the facility level, the facility in-charge and other staff were interviewed, and records reviewed. The key records reviewed included CHF member cards, the CHF log book, the HMIS Book 2, the facility receipt books, receipts from the District Accountant for funds deposited, and patient registries.

10.1 CHF Fees and User Fees Collected

Information about funds collected through CHF fees and user fees for Hanang district as a whole was gathered from the national level. At the district level, annual and quarterly district CHF reports sent to the central CHF Coordinator and the ward CHF ledger were reviewed. At the facility, data on fees collected was assembled by compiling information from receipts to patients and receipts from the district for deposit of funds. There were inconsistencies between the different data sources that could not be reconciled.

The most current national level data available was from 1998 through October 2000. Based on data from the central CHF Coordination office, the funds collected through CHF fees and user fees totaled Tsh. 79,640,060 (Table 8).

Table 8: CHF Fees and User Fees – Inception (1998/99) to October 2000

	1998	1999	2000	Total
CHF Fees	6,110,000	50,790,000	7,760,000	64,660,000
User Fees	4,090,000	5,901,600	4,988,460	14,980,060
Total	10,200,000	56,691,600	12,748,460	79,640,060

Source: CHF Financial Position October 2000 (MOH/CHF Coordination Office)

District data could not be compared precisely with the national level data because of the timing of reports available. Table 9 shows available national- and district-level data for CHF and user fees collected from the inception of the CHF in 1998 through 2000.

Table 9: Comparison of National and District Data on Funds Collected, 1998-2000

	National-level data (through Oct 2000)	District CHF report (through Dec 2000)	Ward CHF ledger (through Dec 2000)
CHF Fees	64,660,000	74,900,000	62,407,500
User Fees	14,980,060	33,131,200	33,895,500
Total	79,640,060	108,031,200	96,303,000

Source: CHF financial position October 2000 (Mmuni)
Ward CHF financial trend as of 31 December 2000

The district figures for user fees collected through 2000 – from both the district CHF reports and ledger – differed significantly from the national-level data, while the figures for CHF fees were more compatible. The discrepancy between national and district user fee data may be partially explained by the different time periods covered by the data available. There were also discrepancies between the district-level records, particularly in the amount of CHF fees collected. The assessment team was not able to identify reasons for the inconsistencies in the district-level data.

Unless otherwise noted, data sent from the district CHF reports to the central CHF coordinator, rather than the CHF ledger, will be used for subsequent analysis of funds collected at the district level. The district CHF reports represent the final and official compilation by the district of CHF funds collected and, thus, will serve as the primary source of district-level data in this report.

The team also reviewed facility-level data on CHF and user fees collected. Data at the health facility was gathered by either compiling the data from receipt books (receipts issued to patients), or from deposit receipts issued to facilities by the DHMT. This data was not complete at all facilities. Further, where data was available, it was only for 2000 and 2001.

Table 10 compares CHF and user fee data for 2000 and 2001 at the district and facility level. In most cases, district data show higher amounts of funds collected than do facility data. One possible reason for the discrepancy is incomplete records at the facility. There were two instances of higher fees based on facility records – Sirop Dispensary records show higher CHF fees than the district report for 2001, and Endasak Dispensary reported higher user fees collected for 2001. This may be due to a lag between when CHF and user fees were paid at the facility and when they were deposited, and/or a lag in the compilation of data at the district level by the District Accountant.

Table 10: Comparison of District and Facility Records on Funds Collected

	CHF		User fees		TOTAL		Difference
	District CHF rpts	Facility	District CHF rpts	Facility	District CHF rpts	Facility	
2000							
Sirop	110,000	66,000	323,000	273,000	433,000	339,000	-22%
Endasak	480,000	390,000	1,420,000	1,330,000	1,900,000	1,720,000	-9%
Dawar	250,000	40,000	436,000	259,000	686,000	299,000	-56%
Bassotu Ziwani	100,000	60,000	753,000	566,000	853,000	626,000	-27%
2001 (through October)							
Sirop	0	90,000	385,000	368,000	385,000	458,000	19%
Endasak	825,000	675,000	3,821,000	4,245,000	4,646,000	4,920,000	6%
Dawar	140,000	220,000	1,124,000	574,000	1,264,000	794,000	-37%
Bassotu Ziwani	220,000	220,000	1,050,000	220,000	1,270,000	440,000	-65%

10.2 Trends in CHF Fees and User Fees Collected

For Hanang district as a whole, fees from CHF membership have decreased significantly from 1999 to 2001, while total user fees have increased moderately over that same period.

Table 11: Trends in CHF Fees and User Fees Collected

Year	CHF Fees	Percent change	User fees	Percent change	Total	Percent change
1999	65,070,000		15,926,800		79,996,800	
2000	9,830,000	-85%	16,827,400	6%	26,688,400	-67%
2001	6,740,000	-31%	22,248,800	32%	28,482,800	9%

The fees collected from CHF memberships have declined dramatically, in 2001 representing only 10 percent of the peak in 1999 of Tsh. 65 million. This decline reflects the one-time impact of the “good Samaritan” in 1999, as well as a general decline in interest due to lack of promotion efforts. Even adjusting for the “good Samaritan” effect, which accounted for Tsh. 50 million of the 1999 income, there has been a 45 percent decline in CHF membership. Staff and community members attributed the decline to recent droughts affecting the cash income of farmers.

At the same time, income from user fees continues to grow, increasing 6 percent from 1999 to 2000. For the first 10 months of 2001, user fees already show an increase of 32 percent over the whole of 2000. User fees are becoming a more important source of revenue, while the contribution from CHF membership fees is declining.

The increase in user fees collected is inconsistent with the general decline in utilization. One potential reason for the inconsistency is that more patients are willing to pay because of better services,

or fewer exemptions are being given. Another reason may be related to improved financial management, so that more of the funds paid are being recorded and deposited.

10.3 Procedures for Collecting CHF Fees and User Fees

CHF fees and user fees are collected at the health facility. This procedure has been in place since 2000. Prior to that, the WEOs collected the CHF membership fees, but the procedure was changed as there was concern over whether all the funds were being deposited to the CHF account. All the facilities maintained separate receipt books for CHF fees and user fees. In the dispensaries, there are only two open receipt books at any give time, as noted, one for CHF and one for user fees, although more than one person per shift may collect money and issue receipts. At Katesh health center, which has a higher volume of patients, one person is responsible for collecting funds at each shift, and she maintains her own receipt books while she is on duty.

The standard procedure for the facilities located far away from the district administrative headquarters in Katesh is to make user fee deposits to the district account once a receipt book is filled up. Each receipt book has 50 receipts, which represents Tsh. 50,000 in user fees collected. The procedure for CHF fees is less standard, since the rate of memberships tends to occur in spurts, and just a few memberships would leave a facility with a substantial sum of money. Generally, money from CHF fees is deposited whenever user fees are deposited, which may mean deposits from Tsh. 10,000 up to Tsh. 150,000 at one time. In one facility, however, the in-charge specifically said that he was not allowed to keep more than Tsh. 100,000 at the facility.

Generally, the facility in-charge travels to the District Council headquarters in Katesh and deposits fees collected at the District Accountant's office. For those facilities far from Katesh (some facilities are 40–50 kms from town), the DHMT officials also collect funds during monthly supervision visits. Although there was no specific evidence of problems with this system, there is not always careful record-keeping to follow-up on these collections. In some cases, DHMT members do not have CHF deposit receipts with them during supervisory visits and, thus, informally sign the back of a patient receipt instead of issuing an official receipt. The facility staff also have no way to ensure that the CHF funds deposited were credited to their district CHF sub-account, since they do not keep their own records of their facility sub-accounts.

10.4 Record-keeping Procedures

The record-keeping procedures and the level of accuracy of data varied among facilities. Within each facility, and between the facility and the district, there were inconsistencies in basic data such as the amount of funds collected, the number of CHF members, and total utilization.

None of the facilities visited maintained their own records of deposits or expenditures, relying solely on the reports from the District Accountant. Even facilities that maintained their district deposit receipts in an orderly fashion never calculated the total funds deposited. Given that CHF funds are not accessed frequently (since they are used to pay for larger expenditures), it would not be difficult for the facilities to maintain a simple system to calculate the balance of CHF funds available. Only one facility knew the approximate amount of funds available for the facility or ward.

The procedures for recording utilization were also inconsistent from facility to facility. It is more difficult for the larger facilities to maintain complete records due to the number of people responsible for the task, the volume of work, and the concurrent use of multiple patient registers and receipt books.

The assessment team found inconsistencies between patient registers and the HMIS Book 2, which, in some cases, appeared to be due to calculation errors.

10.5 Comparison of Actual Funds Collected with Expected Collections

The assessment team analyzed the total funds actually collected and the funds that would be expected to be collected based on facility-level information on utilization and number of CHF members. The expected CHF fees collected were calculated based on the number of active CHF members. The amount of user fees expected was calculated based on non-CHF member utilization. These amounts were then compared with records of actual funds collected. Due to limitations in data availability, this comparison could only be made for three of the seven facilities visited (Table 12).

Table 12: Comparison of Actual and Expected Funds Collected, Jan–Oct 2001

	Sirop	Dawar	Bassotu Ziwani
Actual CHF Fee	90,000*	220,000*	250,000
Expected CHF Fees	130,000	330,000	270,000
% Difference	-30.8%	-33.3%	-7.4%
Actual User Fees	414,000	1,124,000	1,050,000
Expected User Fees	493,000	1,580,000	1,356,000**
% Difference	-16.0%	-28.9%	-22.6%
Total Actual Collected	504,000	1,344,000	1,300,000
Total Expected	623,000	1,910,000	1,626,000
% Difference	-19.1%	-29.6%	-20.0%
**			

Source: Ward CHF Income Schedule as at 31 October 2001 (District CHF Report), except as noted

* Denotes data from facility record review, which showed higher figures than district data

** The dates of patient visits entered in the patient registries at Bassotu Ziwani dispensary were not entered correctly for October and November. Total utilization for January–November 2001 could be calculated. However, the assessment team was unable to calculate the exact number of visits for October–November. Thus, this table shows expected user fees for January–November 2001.

In all three facilities, the actual funds collected, based on the higher of district or facility records, were lower (by 19 percent–30 percent) than the expected collections based on utilization and CHF membership data. There is a need for improved financial management to ensure that all funds are properly collected, recorded, and deposited into the CHF account.

11. Impact of CHF in Hanang District

The CHF does appear to have positively impacted health services in Hanang district. However, the procedures in place for facilities to access the CHF funds are not always followed and some facilities and wards are more pro-active in using the funds than others. In accordance with general usage in Hanang district, “CHF funds” in this section refers to funds from CHF membership fees, the central-level matching funds, and user fees.

11.1 Procedures for Budgeting and Accessing CHF Funds

According to the policies in place, the WHC should submit annual plans that indicate its health needs. Based on those plans, the WHC meet each quarter to approve expenditures for the quarter. The minutes of this meeting are then sent to the District Health Board, and serves as the documentation that releases the funds. Although this is the stated procedure, the assessment team learned that no WHC has submitted an annual plan since 1999, the first year of the CHF program.

In actuality, the process of accessing the CHF funds is somewhat haphazard and seems quite different from facility to facility. Some facilities have active WHCs that do meet regularly and approve expenditures, without the use of an annual plan. In several wards, however, the WHCs were not functioning at the time of the assessment. In two cases, facility in-charges said that they had not been able to hold a WHC meeting for almost a year because committee members would not show up at the scheduled meeting time. Even without a functioning WHC, some in-charges have been able to access CHF funds. One in-charge, for example, said that he could send a letter to the DMO describing a specific need, and, if approved by the DMO, CHF funds could be used for that purpose.

After receiving approval from the district for use of CHF funds, facilities may experience delays in receiving CHF funds or requested materials to be purchased by the district using CHF funds. At the time of the assessment, one facility had an approved plan for use of CHF funds to renovate the dispensary, but construction has not yet begun six months after approval.

11.2 Use of CHF Funds

Information on expenditures of CHF funds by ward was obtained from the ward CHF ledger. The ledger had not been updated since December 2000. Thus, expenditure data was only available from inception (1998/99) through 2000. Table 13 shows how CHF funds were used during this period.

From 1998 to 2000, the majority of CHF funds (59 percent) was used for the construction of the district hospital, though the percentage of total CHF expenditures used for hospital construction declined from 73 percent in 1998/99 to 20 percent in 2000. The amount that each ward contributed to construction was determined and withdrawn from the CHF account by the district – and was the largest single expenditure in most wards. In 2000, all wards contributed the same amount, regardless of facility size or total CHF funds collected at the facility. In 1998/99, however, there was some variation in the

contribution amount by ward, but hospital construction accounted for 80–100 percent of CHF expenditures in all wards, except Katesh.

Table 13: Use of CHF Funds 1998–2000 (% of total CHF expenditures)

	1998/99	2000	Total
District Hospital Construction	42,619,000 (72.8%)	4,374,930 (20.4%)	46,993,930 (58.7%)
Drug Procurement	8,651,110 (14.8%)	5,890,720 (27.5%)	14,541,830 (18.2%)
Refurbishing Facility *	3,011,200 (5.2%)	2,126,714 (9.9%)	5,137,914 (6.4%)
Petty Cash	1,292,700 (2.2%)	1,555,000 (7.2%)	2,847,700 (3.6%)
Medical Equipment and Supplies**	-- (0.0%)	1,500,000 (7.0%)	1,500,000 (1.9%)
CHF Board Allowances	150,000 (0.3%)	1,791,950 (8.4%)	1,941,950 (2.4%)
Cholera Epidemic	-- (0.0%)	2,785,380 (13.0%)	2,785,380 (3.5%)
Other (bank fees, transport, misc.)	2,849,048 (4.9%)	1,428,000 (6.6%)	4,277,048 (5.3%)

* Includes installation of electricity, general maintenance, repairs, and furniture purchases

** In most cases, microscopes and related supplies were purchased

Drug procurement represents the second largest CHF expenditure item (18 percent) through 2000 for the district as a whole. However, only three facilities are actually using CHF funds to purchase additional drugs. Katesh health center, for example, accounts for 95 percent of all drug purchases from 1998 to 2000. Most other facilities did not require additions to the drug kits and sometimes DHMT officials were even able to collect overstocks for use in other facilities.

CHF funds have also been used for facility renovations (including the installation of electricity, furniture, and general repairs) (6 percent), petty cash to be used at the facility's discretion (4 percent), and to provide allowances for CHF board members (2 percent). In 2000, CHF funds were also used to respond to a cholera epidemic (13 percent) and for the purchase of medical (diagnostic) equipment and supplies (7 percent).

While CHF funds are being used to improve district health services, only half of the the total CHF funds collected between 1998 and 2000 were used by facilities/wards by the end of 2000. Katesh accounted for almost half of all CHF expenditures in 2000 for the district as a whole. During 2000, most wards expended less than 20 percent of CHF funds collected in 1998 and 1999, and had significant unused balances in their district CHF sub-accounts by January 2001.

For two facilities, Endasak and Dawar, data on planned use of CHF funds in 2001 was available. It appears that a significant portion of unused CHF funds collected from 1998 to 2000 were being accessed and used by these two facilities in 2001 (Table 14). Nonetheless, the balance of unused CHF funds continues to increase.

Table 14: CHF Funds Collected Compared with Planned Use*

	2000 CHF account balance	CHF funds collected Jan–Oct 2001	2001 planned use of CHF funds	Expected balance Oct 2001
Endasak Dispensary	5,141,678	5,471,000	3,991,000	6,621,678
Dawar Dispensary	3,758,478	1,404,000	1,370,000	3,792,478

Source: Ward CHF Financial Trend as of 31 December 2000 (District CHF Report), Ward CHF Income Schedule as of 31 October 2001 (District CHF Report)

* CHF funds collected include CHF member fees, user fees, and matching grant contributions

In most wards without health facilities, CHF funds collected from 1998 to 2000 (the period in which WEOs collected CHF membership fees) have only been used for hospital construction and allowances for district CHF board members. In one ward without a health facility, CHF funds were used to build a health post. In general, however, wards without health facilities have not requested use of the CHF funds in their district CHF sub-account.

Due to the change in the CHF collection policy in 2000 mandating that CHF membership fees be collected only at the health facility, no further deposits will be made to the sub-accounts of wards without health facilities. However, WHCs in wards without facilities can request use of all funds collected between 1998 and 2000. Since the facility in-charge often leads the WHC and is the most active advocate for using CHF funds, it is unlikely that WHCs in wards without facilities will plan to use their CHF funds without other facilitation. Given this situation, if assessments to support hospital construction continue to be made equally in all wards, the wards without facilities will see their funds depleted without receiving benefits at the community level.

While all WHCs within a health facility service area are to be involved in decisions regarding the use of CHF funds collected at the health facility, the extent to which this occurs appears to vary by service area. In most service areas, decisions regarding the use of CHF funds tend to be facility-based and made by the WHC in the central ward where the health facility is located.

11.3 CHF Contribution to District Health Budget

The total budget for health services in Hanang district in 2001 was Tsh. 358 million. While the central government and basket funds provide the large majority of the total budget, the CHF funds do make a significant contribution to the overall budget.

The CHF funds (including the CHF membership fees and user fees) collected for January to October 2001 represent 8.0 percent of the district 2001 annual budget. (Table 15) If one includes the contribution from the matching grant (providing an additional Tsh. 6,740,000), then the CHF represents 9.9 percent of the district budget. After the basket funds and central government funds, CHF is the most significant source of funds for Hanang district. The majority of CHF funds (6.1 percent) represents user fees with CHF membership fees representing 1.9 percent of the budget.

Table 15: CHF Funds as Percent of District Health Budget, Jan–Oct 2001

	Amount (Tsh.)	Percent of Total
District Budget*	358,088,529	100.0%
CHF Membership Fees	6,740,000	1.9%
Matching Grant	6,740,000	1.9%
User Fees	21,871,800	6.1%
Total CHF Contribution	28,611,800	9.9%

*District health budget is for the whole year.

11.4 Relative Impact of CHF Membership Fees and User Fees

While the total contribution from CHF membership fees and user fees together is significant, user fees contribute the majority of these funds and continue to grow as a share of total funds collected. In 1999, 80.3 percent of total fees generated in the district came from CHF memberships. The financial contribution from CHF memberships has declined each year since, representing 36.9 percent of fees generated in 2000, and 23.3 percent of fees generated for the first 10 months of 2001 (Table 16).

Table 16: Trends in Contribution from CHF Membership and User Fees

	CHF Members	User Fees	Total
1999	65,070,000	15,926,800	80,996,800
	80.3%	19.7%	100.0%
2000	9,830,000	16,827,400	26,657,400
	36.9%	63.1%	100.0%
2001*	6,740,000	22,248,800	28,988,800
	23.3%	76.7%	100.0%

*Represents Jan–Oct 2001 only.

The relative impact from membership fees and user fees is even more striking if the fees generated are compared with the volume of service delivery. Facility-level data for this comparison was available for three dispensaries.

While the CHF membership fees account for a small portion of total fees collected (0-17.3 percent), CHF member utilization accounts for 38.1 percent to 57.8 percent of total utilization (Table 17). CHF members are using a larger proportion of health facility resources than non-CHF members, relative to their financial contribution.

Table 17: Comparison of CHF and Non-CHF Fees and Utilization Jan–Oct 2001

Facility		CHF	Non-CHF	Total
Sirop	Fees	0	385,000	385,000
	% of Total	0.0%	100.0%	100.0%
	Utilization	371	541	912
	% of Total	40.7%	59.3%	100.0%
Dawar	Fees	140,000	1,124,000	1,264,000
	% of Total	11.1%	88.9%	100.0%
	Utilization	2,280	1,667	3,947
	% of Total	57.8%	42.2%	100.0%
Bassotu Ziwani	Fees	220,000	1,050,000	1,270,000
	% of Total	17.3%	82.7%	100.0%
	Utilization	835	1,356	2,191
	% of Total	38.1%	61.9%	100.0%

Source: Fees collected from Ward CHF Income Schedule on 31 October 2001.

11.5 Patient Perceptions of Changes in Health Services

Most CHF members and non-members who knew of the CHF believed that the program has had a positive impact on the quality and range of services offered at CHF-participating facilities. The vast majority said that the CHF program has improved the accessibility of drugs, noting that in the past, stock-outs of most drugs commonly occurred within a week of receiving the essential drug kits. However, the data shows that, except in Katesh, the CHF cannot be credited with the increase in drug availability.

At three facilities, CHF funds had been used to purchase a microscope and other supplies necessary to provide basic diagnostic services that were not previously available. Community members believed that the diagnostic services had improved the accuracy of diagnosis at the health facility, leading to an increase in the quality of care and patient satisfaction. In the two facilities offering diagnostic services, however, the lab technicians were not being paid. Community members believed that MOH or CHF funds should also be used to pay for a lab technician.

While many people noted that the CHF has improved the supply of drugs, several members and non-members noted that sometimes prescribed drugs are still not available. At Katesh health center, a common complaint among CHF members was that, in addition to the CHF membership fee, they had to pay for syringes, and often times commonly prescribed drugs were not available.

Even though community members acknowledged improvements in health services and facilities, many noted that the quality of health services still could be improved. Several people claimed that the health providers often misdiagnose their illnesses and/or give ineffective drugs. Almost all community members mentioned quality diagnostic services as a key component of improving the quality of care at public health facilities

12. Exemption Policies

12.1 Exemption from User Fees

To ensure access to health services for the poor, the government of Tanzania has established national exemption policies. Some categories of exemptions include:

- ▲ Children under five years of age
- ▲ Pregnant women
- ▲ Family planning services
- ▲ Tuberculosis
- ▲ Leprosy
- ▲ Other chronic diseases

The districts implementing the CHF are not exempting children under five, except for immunization.⁷ The rationale for overriding the national policy was because it was agreed that if children under five were exempted from user fees, there would be no incentive for the family to join the CHF. This policy was verified in Hanang district.

Providers were questioned regarding the number of exemptions requested and granted. The facilities had limited data on the exemptions granted. Except for one facility, most providers said that the number of exemptions was very low – most said only a few (2-3) people per month would request exemptions. At Katesh health center, data from May and June 2000 showed that 12 people were unable to pay for inpatient services. One facility did mention a much higher exemption rate of 20-30 people per week. It is unclear whether that area has a poorer population or whether there is lower acceptance of user fees and less willingness to pay.

12.2 Free CHF Membership

As part of the CHF Act and the original design, there was a provision to provide a free card to families who could not afford CHF membership fees. The design specified that communities would identify families eligible for free cards. In Hanang district, lists of families proposed for free cards were submitted to the District Health Board more than 18 months ago. No one has been approved for a free card to date, because it was felt that the lists submitted included too many people.

Few people are being exempted from user fees or CHF membership fees in Hanang district. One of the reasons for the limited number of exemptions is because district officials do not adhere to the

⁷ Interviews with Dr. Bura (11/28/01) and Mr. Shirima (12/6/01).

national exemption policies. There was also a general perception among the DHMT officials that there are very few people who cannot afford to pay – it is believed that although some are reluctant to pay, most people in the district are well off. Although this assessment did not seek to investigate ability to pay, it can conclude that the policies in Hanang district are insufficient to protect the poor from the burden of health costs.

13. Knowledge of and Attitudes toward the CHF Program

This section presents community members' understanding and perceptions of the CHF program. Information in this section was gathered through focus groups conducted with members and non-members at five CHF-participating health facilities and exit interviews at five CHF-participating and one non-participating facility.

13.1 Community Knowledge of the CHF Program

Most CHF members and non-members participating in focus groups or exit interviews had heard of the CHF program. However, many non-members (who had never been members) indicated that they had heard of the program only after being assisted by the interviewer or other focus group participants. In two non-member focus groups, only one or two participants could explain any aspect of the CHF program.

Of the people who had more than a superficial knowledge of the program, there was little difference in the responses to questions between CHF members and non-members. Knowledge of the CHF concept and the program itself is relatively high among current and former CHF members and non-members who live in the village where the health facility is located. Most learned about the CHF program through the district-wide CHF promotional campaign that took place in May/June 1999. The campaign was organized by the District Health Board and DHMT to inform people about CHF and mobilize them to join the program. The rallies were mainly held in the central ward village where the facility is located. Others learned about the CHF from family members, neighbors, the health facility staff, and, to a lesser extent, ward leaders. Few community members had learned about the CHF through village or religious leaders.

13.1.1 CHF Program Benefits

Members and non-members who know of the program understand the CHF to be a prepayment scheme whereby a household pays Tsh. 10,000 per year and household members receive unlimited services at any CHF-participating facility for one year. They also know that there is a matching grant component to the program. The name for the CHF program in Swahili is *tele kwa tele*, which translates in English to "one-for-one." District and ward officials appeared to emphasize to potential members that for every membership fee of Tsh. 10,000 paid, the ward would receive Tsh. 10,000 from a major – and generally unknown – donor. A few members cited the matching grant component as one of the benefits of the program.

Most non-members and several CHF members are not aware that the membership fee included referrals to Dareda hospital, with presentation of a referral letter from the in-charge and a CHF membership card. Those CHF members who know that referral services were covered were unclear about whether or not transportation expenses to the hospital were also covered.

Few members and non-members are aware that the CHF membership fee could be paid in installments. Payment by installment appeared to be more common in some facilities than others.

13.1.2 Reasons for the Creation of the CHF Program

When asked why the CHF was created by the MOH, the most common responses among members and non-members who knew of the program were:

- ▲ To improve health services and health status by ensuring the availability of drugs, supplies, and equipment
- ▲ To increase access to health services by ensuring that people can afford services throughout the year, particularly those whose incomes are highly seasonal
- ▲ To get the community to assist the government in paying for health services, equipment, and drugs.

People were not aware of the CHF Act passed in April 2001. When told of the act, several CHF members expressed a desire to learn about what the act contained, as well as CHF policies and procedures about which they may not be informed.

13.1.3 Management of the CHF Program and Funds

CHF members and non-members are not well-informed about how the CHF program and funds are managed, particularly how decisions are made regarding the use of funds. Most believe that CHF funds were being used to buy drugs, medical supplies, and/or equipment and to make improvements to the health facility. Some know that the WHC was in charge of managing the CHF, and others seem to assume that the in-charge made most of the decisions concerning the use of funds. In general, most members and non-members know very little about the organizational and management structure of the CHF.

Many CHF members complain that they have never been invited to a meeting for CHF members to discuss, in detail, the benefits and management of the program, or to be informed about how the CHF funds would be spent. In addition, they are not aware of where or to whom they could ask questions or voice their complaints about the CHF program.

13.2 Community Attitudes toward the CHF

13.2.1 Benefits

Most CHF member and non-members have positive attitudes toward the program. Most believe that the CHF program has led to an increase in the supply of drugs and improved services at participating facilities. All CHF members believe that the cost of health services used by their household in a year exceeded the annual membership fee of Tsh. 10,000, and, thus, that the benefits of the program outweigh the cost.

It should be noted that improvements in drug supplies since the implementation of CHF in 1998 is only partially attributable to the CHF program. At some facilities, CHF funds are being used to

supplement the supply of essential drugs in the monthly drug kits supplied by the district, or to purchase additional drugs and supplies not contained in the kits. However, even at facilities where CHF funds have not been used to purchase drugs, CHF members and non-members attribute the increase in availability of drugs to the CHF program. All facilities in Hanang district have experienced an increase in the stock of essential drug supplies due to improvements in the packaging of essential drug kits, which has greatly reduced pilfering of drugs from the kits during the distribution process. In addition, the implementation of user fees and recognition of increased drug stocks seems to have reduced the run on drugs at the beginning of every month by community members who feared stock-outs or wished to sell the drugs.

At the facilities where CHF funds had been used to make improvements in the health facility, such as by installing electricity and buying diagnostic equipment and furniture, community members noted that one of the benefits of the CHF program is that it generates funds to pay for these improvements.

Many members felt that one of the greatest benefits of CHF is that it ensured unlimited access to health care by the whole family. Others considered it a positive form of savings for future, unpredictable illnesses.

A few members cited the matching grant component as one of the major benefits of the CHF.

13.2.2 Shortcomings

When asked what could be done to improve the CHF program, the most common answers among CHF member and non-members were:

- ▲ Improve the quality of services and infrastructure at MOH facilities;
- ▲ Expand the range of services offered to include diagnostic services, which are not offered at most MOH dispensaries;
- ▲ Increase promotion and marketing of the CHF program to increase knowledge of CHF and membership levels;
- ▲ Consider payment-by-installment to enable more community members to join the program; and
- ▲ Expand coverage under the CHF program to include access to mission hospitals located in neighboring districts, or mission dispensaries and health centers located in Hanang district.

Many CHF members believe that the community should be more informed about and involved in decisions regarding the management and use of CHF funds. Most CHF members have never attended a CHF meeting and know little about the managerial structure of the program.

Several members noted that having one card per household makes it difficult for all members to have access to health services if one member of the family is traveling within the district and would like to take the CHF member card with him/her.

A few members mentioned that the definition of household should be expanded to include certain household members over the age of 18, including unmarried women or students who do not earn an income and still act as dependents within the household.

Providers emphasized the importance of increased mobilization and sensibilization efforts, particularly by district, ward, and village leaders.

13.2.3 Reasons for Joining, Not Joining, and Dropping Out of the CHF

13.2.3.1 Reasons for Joining

The reasons for joining are closely related to the perceived benefits of the program (see Section 13.2.1). The most commonly cited reasons for joining were:

- ▲ To ensure that family members have access to health care all year;
- ▲ To improve health services; and
- ▲ To gain the benefits of the matching grant.

13.2.3.2 Not Joining and Dropping Out

The most common reason given for not joining or renewing CHF membership was inability to pay. Many claimed that it was easier to find Tsh. 1,000/1,500 for each visit than to pay Tsh. 10,000 at one time. Few were aware that the CHF fee could be paid in installments.

When asked if they would join or renew if they could pay by installment, many said that they would prefer to pay Tsh. 1,000/1,500 per visit. They feel that they and other members of their family do not fall sick enough to justify paying such a large sum of money in advance. Many note that there is no reason to join if your family is healthy because you would just lose the money.

Many non-members feel that the program was not beneficial to individuals or small households, or to those who lived in villages that are far from the health facility. In addition, several people noted that in polygamous family situations, it is difficult for the husband to be able to purchase a separate membership for each wife.

During exit interviews at one mission dispensary, two patients said that they had not joined because CHF membership does not cover services at mission facilities, which they considered to be of better quality than services at MOH facilities.

Two former CHF members at Katesh health center said that they had not renewed their membership because they ended up having to pay for drugs and syringes in addition to the CHF fee.

13.3 Provider Attitudes toward the CHF

All of the in-charges interviewed at CHF and non-CHF facilities believe that CHF is a beneficial program. In-charges at CHF-participating facilities said that it had enabled them to purchase additional drugs, supplies, and equipment, and make needed improvements in the health facility. In addition, many providers feel that the CHF program has benefited relatively poorer households who cannot afford to pay Tsh. 1,000/1,500 per visit to the dispensary/health center. They do not believe the CHF has led to over-use of health services, but rather has enabled community members to seek care immediately when ill rather than wait until the illness has become serious.

When asked how the CHF program could be improved, in-charges said that district, ward, and village leaders need to increase efforts to educate community members about the CHF and mobilize them to join the program. In-charges noted that the health staff informs patients about CHF when they come to the facility, but that the staff does not have time, or the means of transportation, to travel to households or villages that are far from the facility to inform community members about the CHF. At one facility, the in-charge gives health education talks every morning, during which the in-charge promotes the CHF.

Several in-charges believed that the CHF could also be strengthened by improving health services. At Dawar dispensary, for example, the in-charge noted that enabling the facility to perform deliveries or diagnostic services would likely increase community members' incentive to join the CHF.

14. Conclusions and Recommendations

14.1 Conclusions

The CHF has made progress in meeting its original objectives, although there are many areas for improvement. In accordance with the three main objectives outlined in the CHF Act, the broad findings are:

1. *To mobilize financial resources from the community for the provision of health care services to its members:* The CHF is mobilizing resources (both CHF membership and user fees) from the community for health care services. The majority of the contribution for the last two years is from user fees.
2. *To provide quality and affordable health care services through a sustainable financial mechanism:* The CHF has improved the quality and range of services in Hanang district. While the CHF can continue to be sustainable as a complementary financing mechanism, it is not designed, nor is it able, to recover the full cost of services.
3. *To improve health services management in the communities through decentralization by empowering the communities in making decisions affecting their health:* The CHF has a decentralized management structure, which seeks to promote involvement of the communities, but in practice community participation is limited. In some cases, ward leaders are actively involved in CHF management. WHCs, however, are not always functional.

The framework of the assessment was not specifically designed to evaluate CHF success in meeting objectives of the CHF Act, but rather to review overall performance and identify areas for improvement. In that vein, the more specific conclusions are:

- ▲ Enrollment rates are fairly low. It is estimated that 2.8 percent of households in Hanang district are currently enrolled in the CHF, and CHF membership fees contribute less than 20 percent of total fees collected. At the same time, CHF members use approximately half of all services in the facilities visited.
- ▲ Financial management and information systems require improvement. The assessment team found many inconsistencies between data at the national and district level, district and facility level, and records within the facility. Assistance to rationalize and simplify the record-keeping at the facility and district level is needed. Eventual computerization of the records would improve overall management information.
- ▲ The involvement of the WHC in management of CHF funds varies from ward to ward. In many cases, the WHC does not function, and facility in-charges and the DMO make decisions about the use of CHF funds.
- ▲ In practice, the DHMT has the primary responsibility for supervision of the CHF. Given its other responsibilities, there is a need to develop mechanisms to allow the DHMT to improve its supervision procedures.

- ▲ Although there are sometimes obstacles or delays in accessing the funds, CHF funds have improved health facilities and services through the purchase of additional drugs and equipment and refurbishment of facilities. From 1998 to 2000, however, the majority of CHF expenditures (59 percent) was used for construction of the district hospital.
- ▲ While CHF funds are being used to improve district health services, most wards/facilities have significant balances of unused CHF funds. In the wards that do not have health facilities, there is generally no plan for using the funds collected in the first two years of the CHF, except for district-wide assessments, such as for hospital construction. In some wards with facilities, inactive WHCs constrain the timely use of CHF funds.
- ▲ People believe that the CHF has led to an increase in the supply of drugs and improved services at participating facilities. However, data shows that, except in Katesh, the CHF cannot be credited with the increase in drug availability.
- ▲ The most common reason cited for not joining was that it was difficult to pay Tsh. 10,000 all at once. Many thought it was easier to pay Tsh. 1,000 when one is sick. Patients who lived far from a facility are less likely to join than patients who live close to the facility.
- ▲ Community members have little understanding of, or participation in, the management of the CHF. Some communities felt that they were represented in the management of the CHF, although their representation is limited to their elected leaders who are on the CHF Board.
- ▲ The national-level exemption policies are not being implemented in Hanang district. More specifically, Hanang district does not exempt children under five for curative services and does not provide free CHF cards to the poorest. Currently, there are no mechanisms to ensure that the poor have access to care.

14.2 Recommendations

Based on the findings of this assessment, the following recommendations are offered for the short term (six to nine months) and longer term (the following 12 months):

Short Term

- ▲ The goal of the CHF should not be focused solely on maximizing enrollment rates, but rather on improving overall management.
- ▲ 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.
- ▲ 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.

Longer Term

- ▲ 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. Education should also be targeted to those communities far from a health facility.
- ▲ Analysis of the financial impact of covering hospital-based services is needed to ensure that hospital care does not deplete CHF funds.

- ▲ 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.
- ▲ Implementation of an exemption policy is required to ensure that the poor are not excluded from accessing services.
- ▲ Strengthening capacity of the DHMT is required to ensure improved supervision and technical support of the CHF.

In addition, several broader policy and structural issues need to be addressed:

- ▲ More consideration should be given to the role of the CHF within the overall health financing framework – relative to other sources of funding such as basket funding or national health insurance. Study of the impact of the new National Health Insurance scheme on CHF participation may be useful, since many CHF members are civil servants now required to participate in NHI.
- ▲ Support and guidance to districts implementing the CHF is needed to ensure that the relationship between user fees, CHF membership fees, and the CHF benefits package is appropriate given the goals of the CHF.
- ▲ While the CHF itself is not self-financing, its long-term sustainability should be addressed, since it is currently being subsidized through a World Bank loan.
- ▲ Non-governmental organizations play a significant role in health care provision in Tanzania, so increased efforts toward involving them in the CHF may increase access to health care for a large segment of the population.

Annex A: Community Health Fund Act

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*THE UNITED REPUBLIC OF TANZANIA
ACTS SUPPLEMENT*

No. 1

6th April, 2001

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**THE COMMUNITY HEALTH FUND ACT, 2001
ARRANGEMENT OF SECTIONS**

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FIRST SCHEDULE

SECOND SCHEDULE

THE UNITED REPUBLIC OF TANZANIA



No.1 OF 2001

I ASSENT,

BENJAMIN W. MKAPA,

President

6th APRIL, 2001

**An Act to provide for the mechanism of establishment of
Community Health Fund and to provide for the constitution
of the management organs, and the administration of the
Fund and other related matters.**

[.....]

ENACTED by the parliament of the United Republic.

PART I
PRELIMINARY PROVISIONS

1. This Act may be cited as the Community Health fund Act, 2001 and shall come into operation on such date as the Minister may by notice published in the *Gazette*, appoint.

Title and commencement

2. This Act shall apply to local government authorities specified in the First Schedule to this Act, and such other local government authorities as the Minister may from time to time declare by order, published in the *Gazette*.

Application

Interpretation	<p>3. In this Act, unless the context requires otherwise –</p> <p>"Board" means a Council Health Services Board established by the respective Council;</p> <p>"card" means a community health fund card;</p> <p>"collector" means a person appointed for the purpose of collecting Community Health Fund contributions;</p> <p>"community" means a group of households organised in a recognised government administrative structure;</p> <p>"contribution" means an annual voluntary contribution to the Fund;</p> <p>"Council" means –</p>
Act No. 7 of 1982	(a) a District Council established under the Local Government (District Authorities) Act, 1982; or
Act No. 8 of 1982	<p>(b) an Urban Council established under the Local Government (Urban Authorities) Act, 1982;</p> <p>"Council Health Management Team" means the Council Health Management Team established by the respective Council;</p> <p>"Fund" means the Community Health Fund established by a local government authority in accordance with the provisions of this Act;</p> <p>"health-care provider" means a government health care facility or a private registered health care facility;</p> <p>"health care facility" means government or private health facility and includes any other facility established or organized for purposes of delivering health services;</p> <p>"health plan" means a council or ward health plan;</p> <p>"household" means-</p> <p style="padding-left: 2em;">(a) a mother, father and children under the age of eighteen years; or</p> <p style="padding-left: 2em;">(b) a member who has attained the age of eighteen years or more with or without children under the age of eighteen years;</p> <p style="padding-left: 2em;">(c) an institution;</p> <p>"hospital" means a district hospital or a designated district hospital providing level 1 referral medical services;</p> <p>"Member" means a contributing household to the Fund;</p> <p>"Minister" means the Minister responsible for health matters;</p> <p>"local government authority" means-</p>
Act No. 7 of 1982	(a) in relation to a district, a district council established under the provisions of the Local Government (District Authorities) Act, 1982; or

- (b) in relation to an urban, an urban council established under the provisions of the Local Government (Urban Authorities) Act, 1982; Act No. 8 of 1982

"user fee" means a fee charged by a health care facility for services rendered;

"Village council" means a council of a village registered in accordance with the provisions of the Local Government (District Authorities) Act, 1982, or existing as such in accordance with the provisions of the Local Government (Urban Authorities) Act, 1982;

"Ward Health Committee" means the Ward Health Committee established by the respective Council.

PART II COMMUNITY HEALTH FUND

4. (1) There shall be a Community Health Fund which is a voluntary community based financing scheme whereby households pay contributions to finance part of their basic health care services to complement the Government health care financing efforts. Community Health Fund
- (2) A local government authority may establish a Community Health Fund in respect of its area of jurisdiction.
- (3) The Community Health Fund established by a local government authority shall be, managed and administered in accordance with the provisions of this Act.
5. The objectives of the Fund shall be Objectives of the Fund
- (a) to mobilize financial resources from the community for provision of health care services to its members;
- (b) to provide quality and affordable health care services through a sustainable financial mechanism ; and
- (c) to improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health.

PART III MEMBERSHIP, CONTRIBUTIONS AND HEALTH SERVICES

6. All contributing members shall be registered with the Fund and shall be issued with a membership card. Registration
7. membership shall be restricted to a paid up household except for exemptions as may be issued by the Council from time to time under the provisions of this Act. Membership

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| Contribution level | <p>8. (1) Every Council shall determine after consultation with, members of that community, the level of annual contributions to be paid by respective Council; each household depending on whether the contribution is for outpatient or inpatient health care services.</p> <p>(2) The level of annual contributions may be varied from time to time by the Council after consultations with the members of that community.</p> <p>(3) The Government may through the respective Council, contribute to the Fund any specified amount of money.</p> |
| Health care services
To members | <p>9. Subject to the provisions of this Act, every members' household shall be entitled to medical services of its choice which have: been prepaid for at a preselected health care facility within the respective district.</p> |
| Exemptions | <p>10. (1) The powers to issue exemptions to pay Community Health Fund annual contribution to any person shall, be, vested into the. Ward Health Committee after receiving recommendations from the Village Council and the Council shall authorize that-person to obtain a Community Health Fund card.</p> <p>(2) The exempting authority shall seek alternative means of compensating the Fund.</p> <p>(3) Notwithstanding subsection (1) of this section, the Minister after consultations with the respective Council,, may by order published in the <i>Gazette</i> issue exemptions as he may deem fit.</p> |

PART IV
MANAGEMENT AND ADMINISTRATION OF COMMUNITY
HEALTH FUND

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| Management
and administration | <p>11. (1) At the national level the Ministry responsible for health and the Ministry responsible for local government shall:</p> <p style="padding-left: 40px;">(a) provide advice and technical support to the Fund; and
(b) monitor and evaluate the activities of the Fund.</p> <p>(2) The management and administration of the Fund shall vest</p> <p style="padding-left: 40px;">(a) at district level, to the Council, through a Council Health Service Board;
(b) at ward level, to the Ward Development Committee through the Ward Health Committee.
(c) at village level, to the Village Council through the Village Social Services Committee.</p> |
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| <p>12. The Functions of Council shall be</p> <ul style="list-style-type: none"> (a) to provide operational guidelines for health activities to the Board; (b) to provide guidelines that facilitate management of the Fund; (c) to receive Fund management report; (d) to ensure that the Board works harmoniously with other implementing agencies; (e) to ensure that funds are available for health development activities in the council and essential drugs, medical supplies and vaccines are timely available; and (f) to make by-laws for the Community Health Fund | <p>Functions
of a Council</p> |
| <p>13. (1) he Board shall be composed of the following members, namely</p> <ul style="list-style-type: none"> (a) four community service users of whom at least two shall be female; (b) one representative each from a non-profit voluntary agency Board and a private for profit health care facility, appointed by the Council from amongst health care facilities which have entered into a service agreement with the Board; (c) the head of the Council Social Services Committee; (d) the Council Planning Officer; (e) the District Medical Officer who shall be the Secretary to the Board; (f) one representative from the hospital; and (g) one representative from the Regional Health Management Team. <p>(2) The Chairman shall be elected from amongst members specified under paragraph (a), (b), and (c) of subsection (1) of this section.</p> <p>(3) Members specified under paragraphs (a), (b), and (c) other than members specified under paragraphs (d), (e), (f), and (g) of subsection (1), shall have voting rights in any decision of the Board.</p> | <p>Composition of
Council Health
Services Board</p> |
| <p>14. (1) Members of the Board who have voting tights under subsection (3) of section 13 shall each hold office for a period of three years and may be re-elected for another one term only.</p> | <p>Tenure of office</p> |
| <p>15. (1) The functions of a Council Health Services Board shall be</p> <ul style="list-style-type: none"> (a) to provide district health services and monitor Community Health Fund operations and activities; (b) to work in consultation with the Council Health Management Team to ensure quality health care and professionalism; (c) to mobilise and administer funds for Community Health Fund; (d) to set exemption criteria for users of the health care services provided by the Fund; | <p>Functions of a
Council Health
Services Board</p> |

- (e) to set targets for the Fund;
- (f) to review reports from Ward Health Committees or any other source;
- (g) to monitor and make verification on collection, expenditure and control of funds; and
- (h) to design an annual health plan for approval by the respective Council.

- (2) The provisions of the Second Schedule shall have effect as to the tenure of its members, quorum, meetings and proceedings and such other matters in relation to the Council Health Services Board.

Functions of
Council Health
Management Team

- 16. (1)** The functions of Council Health Management Team shall be
- (a) to monitor activities of both private and public health facilities In relation to the Fund;
 - (b) to advise the Committee responsible for health matters regarding the Fund;
 - (c) to set mechanisms of monitoring and evaluation of the Community Health Fund;
 - (d) to assure quality assurance of the health care services provided.
- (2) The provisions of the Second Schedule shall have effect as to the quorum, meetings and proceedings and such other matters in relation to the Council Health Management Team.

Composition of
Ward Health
Committee

- 17. (1)** Members of the Ward Health Committee shall be-
- (a) the councillor of the respective ward;
 - (b) the ward executive officer;
 - (c) one head teacher from a primary school located in the ward who shall be appointed by the Ward Development Committee;
 - (d) two members from the community elected, by the community of which one of whom shall be a female;
 - (e) a clinical officer or an assistant clinical officer in charge of a health care facility, who shall be the secretary to the committee;
 - (f) one member appointed by the Ward Development Committee from amongst persons proposed by the village councils within the area of that Ward; and
 - (g) one representative from a community based organisation appointed by the Ward Development Committee;
- (2) The Chairman and Vice-Chairman of the Committee shall be elected by their number from amongst the members.

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| 18. Members of the Committee shall each hold office for a period of three years and may be re-elected for a further period of three years. | Tenure of office |
| 19. (1) The functions of a Ward Health Committee shall be-
(a) to mobilise the community to be members of the Fund;
(b) to prepare the list of members and monitor the number of members in the community;
(c) to supervise the collectors of annual contributions;
(d) to monitor the level of contributions and user-fee revenue;
(e) to review Fund's operations, make recommendations and take remedial actions;
(f) to initiate and coordinate community health plans;
(g) to organize general meetings and any other meetings of members of the Fund.

(2) The provisions of the Second Schedule shall have effect as to the quorums meetings and proceedings and such other matters in relation to the Ward Health Committee. | Functions of Ward Health Committee |
| 20. The Fund requires a Council and a Ward Development Committee to ensure the following
(a) compliance with their own plans and budget;
(b) careful procurement in a transparent and open manner using acceptable government procedures;
(c) keeping of accurate records of income and expenditure of the resources of the Fund; and
(d) holding of regular meetings by the established Committees. | Requirements for Councils and Ward Development Committees |
| 21. (1) No private health care facility shall provide health care services to Community Health Fund members unless that facility is registered under the relevant law.

(2) A registered private health care facility shall enter into a service agreement with the Board for the provision of health care services in the respective community.

(3) Before a Board enters into a service agreement with any health care facility for provision of health care services, the Board shall first afford an opportunity to the public and privately owned health care facility established within its area of operations to bid competitively for the provision of health care services to members. | Health care Facility |
| 22. The Minister may amend the Second Schedule by an order published in the Gazette. | Amendment of Second Schedule |

PART V
FINANCIAL PROVISIONS

- Sources of Fund **23.** The funds and resources of the Fund shall consist of -
- (a) all moneys received in respect of contributions paid by members;
 - (b) user fees payable for using a government health centre or dispensary;
 - (c) Government contributions;
 - (d) grants from councils, organisations or any other donor;
 - (e) any other money lawfully acquired from any other source.
- Uses of the Fund **24.** The money accrued to the Fund shall be used for the following purposes namely –
- (a) health related purposes specified in the health plans and approved by the Board; and
 - (b) any other essential health purposes or activities as may deem relevant from time to time and approved by the Board.
- Financial Management **25.** (1) The Board shall keep proper accounts and other records in relation thereto and shall prepare in respect of each financial year of the Council statement of accounts as the Council may direct.
- (2) The accounts of the Fund shall be audited by competent and qualified auditors in accordance with regulations governing auditing of Council's accounts.
- (3) The Board shall as soon as practicable after the end of each financial year of the Council prepare a full report on the performance of its functions during that financial year, and one copy of; such report together with a copy of the audited accounts shall be submitted to the Council and the Ministry responsible for health matters:

PART VI
COMPLAINTS AND DISPUTE SETTLEMENT

- Dispute settlement **26.** A mechanism of dispute settlement shall be as prescribed by regulations made under this Act.
- Grounds for complaints **27.** (1) The following acts shall constitute valid grounds for complaints Between a Board and a health care facility.
- (a) the quality of health care services not in line with the granted fees;
 - (b) fee levels is smaller than the agreed amount;
 - (c) delay in payment for provision of health care services.

(2) In the case of a member and a Board, the following constitutes valid grounds for a complaint -

- (a) provision of low quality health care services;
- (b) any other act or omission that undermines the purposes of the Community Health Fund.

(3) In the case of a member and a health care facility, the following constitutes valid grounds for a complaint -

- (a) the quality of health care services provided by the health care facility;
- (b) unjustifiable denial of certain health care services by health care facility;
- (c) delay in the provision of a required health care service;
- (d) poor attitude to beneficiaries of health care services under the Fund.

28. Any member, Board or health care facility may lodge a complaint to the Ward Health Committee, or to the Board or to the Council as the case may be, in accordance with the dispute settlement mechanism prescribed by regulations made under this Act.

Complaints

PART VII GENERAL PROVISIONS

29. Any person who -

penalties

Offences and

- (a) for the purpose of obtaining a health care service -
 - (i) knowingly makes any false statement or representation or produces or causes to be produced any document or information which he knows to be false in any material particular;
 - (ii) presents a forged card or document.
- (b) fails to disclose any material fact as a result of which he obtains the health care services which he is not entitled to, commits an offence and is liable on conviction to a fine not exceeding one hundred thousand shillings or to imprisonment for a term not exceeding one year or to both that fine and imprisonment.

30. (1) The Minister may after consultation with the Minister responsible for local government affairs make regulations for the better carrying out of the objects of this Act.

Regulations

- (2) Without prejudice to the generality of subsection (1) the Minister may make regulations -

- (a) regulating the Community Health Fund;
- (b) providing for the mechanism of dispute settlement;
- (c) providing for the manner of payment and collection of contributions and user-fees;
- (d) providing for criteria and procedures of exemptions;
- (e) prescribing the selection procedure of members to the Board.

By-Laws

31. A Council may make by-laws to provide for establishment of Community Health Fund in its respective areas of jurisdiction or operations and running of the Fund.

FIRST SCHEDULE

(Section 2)

- (1) Hanang District Council.
- (2) Igunga District Council.
- (3) Iramba District Council.
- (4) Iringa District Council.
- (5) Kilosa District Council.
- (6) Mbinga District Council.
- (7) Nzega District Council.
- (8) Singida District Council.
- (9) Songea District Council.
- (10) Songea Town Council.

SECOND SCHEDULE

(Sections 15(2); 16(2); 19(2))

PROCEEDINGS OF THE COUNCIL HEALTH SERVICES BOARD,
COUNCIL HEALTH MANAGEMENT TEAM, AND
WARD HEALTH COMMITTEE

Interpretation

1. In this Schedule -

"chairman", "vice-chairman" and "member" means the chairman vice-chairman and member as the case may be of the –

- (i) the Council health Services Board;
- (ii) the Council Health Management Team; and
- (iii) the Ward Health Committee.

Vacation of office

2. The office of a member shall become vacant –

- (a) on his or her death;
- (b) upon resignation;

- (c) if the member without sufficient cause fails to attend three consecutive ordinary ; meetings;
- (d) if the member becomes in any manner disqualified from membership;
- (e) if the member is declared in accordance with any written law to have body or mental infirmity;
- (f) if the member has ceased to, hold the post which entitles him or her to be a member.
- 3.** (1) An ordinary meeting shall be held once alter every three months and convened by the Chairman and the notice of the meeting shall be sent to each member in , not less than fourteen days before the date of the meeting. Meetings
quorum
- (2) The Chairman, or in his absence the Vice Chairman, shall be bound to convene a special meeting upon receipt of a request signed by not less than five members, and not less than two days' notice of the meeting shall be given to the members.
- (3) One half of the total number of members shall firm a quorum for any meeting.
- (4) There shall preside at any meeting-
- (a) the Chairman;
- (b) in the absence of tire Chairman, the Vice-Chairman;
- (c) in the absence of the chairman and the Vice-Chairman, such member as may be elected by other members for the purpose of that meeting.
- 4.** (1) At any meeting a decision of the majority of the members present and voting shall be deemed to be the decision of that meeting. Voting
- (2) In the event of equality of votes the Chairman of that meeting shall have a , casting vote in addition to his deliberative vote.
- 5.** A decision may be made without a meeting, by circulation of the relevant papers to all members and the expression in writing of their views, but a member may require that any such decision shall be deferred until the matter is considered at another meeting. Decision by
Circulation of
papers
- 6.** Minutes in proper form of each meeting shall be kept and shall be confirmed by the members at the next meeting and signed by the Chairman and the Secretary of the meeting. Minutes
- 7.** Members may act notwithstanding any vacancy in its composition of membership. Vacancy

- Validity of proceedings **8.** The validity of any proceedings shall not be affected by any defect in the appointment of any member.
- Orders and directions **9.** All orders, directions, notices or other documents made or issued shall be signed by –
- (a) the Chairman; or
- (b) the Secretary or any officer authorized in writing in that behalf by the Secretary.
- Proceedings **10.** Subject to the provisions of this Schedule, members shall have power to regulate proceedings of their meetings.

Passed in the National Assembly on the 7th February, 2001.

KIPENKA M. MUSSA
Clerk of the National Assembly

Annex B: Scope of Work

SCOPE OF WORK

Partners for Health Reform *plus* Project REDSO/ESA Community Based Health Financing Assessment of the Community Health Fund in Tanzania Task Direction No. 512A

Overview

USAID/REDSO/ESA has requested that the Partners for Health Reform *plus* (PHR *plus*) project in collaboration with the Commonwealth Regional Health Community Secretariat (CRHCS) provide technical assistance to strengthen and improve the sustainability of existing community-based health financing schemes in the East and Southern Africa (ESA) region. The first activity as part of the assistance plan is to conduct an assessment of the Community Health Fund (CHF) and to implement a plan to improve management of the CHF in Hanang District of Tanzania. This SOW will cover the Hanang CHF assessment and development of a plan for strengthening the CHF. Follow-on implementation assistance is anticipated and will be detailed in a future SOW.

Background

The Tanzanian CHF was established by the Ministry of Health on a pilot basis in Igunga District in December 1995. Its purpose was to ensure the availability of quality health services at affordable prices. The design of the project was based on the assumption that the essence of strong community involvement is for the community to take on the responsibility for generating, using, and controlling financial resources to run an efficient health service. The principal objectives of the CHF were to increase access and control costs. It is essentially a pre-payment scheme targeted at the rural population and the informal sector. Currently, the CHF is made up almost exclusively of public sector facilities. However, the intention of the scheme (and the government health reform plan) is to include private sector and mission providers in districts where they exist.

At the time of introduction of the scheme, user fees were implemented in the same districts and an exemption policy introduced for potential CHF members. User fee amounts are established by the community and fees collected go into the CHF along with premiums paid and matching funds (equal to the premiums collected in the district) from the central government. In-kind payments are also accepted in most districts. The exemption policy includes under fives, pregnant mothers, poor elders, and those others unable to pay. The fund's primary financial support (matching fund) has come from the World Bank.

Although membership has remained very low, the government expanded the CHF to 10 districts in 1998. Hanang District established its CHF in this initial phase of expansion. In 2001, the Community Health Fund Act was passed establishing the CHF as the official health plan at the local/community

level. The CHF is now being rolled out on a national basis. There is political pressure to expand to up to 38 districts in 2001 or as soon thereafter as possible. A study has been conducted looking at how CHF might also include the urban informal sector.

Problems experienced by the CHF and identified in previous evaluations of CHF include:

- ▲ low enrollment
- ▲ inadequate community awareness about the CHF
- ▲ inadequate community involvement and ownership
- ▲ poor quality of care and lack of accountability to community (bad provider attitude/poor treatment of patients)
- ▲ minimal use of exemption program
- ▲ “leakages” or loss of premiums collected
- ▲ overuse of services by CHF members
- ▲ misuse of membership cards

At the same time the MOH is promoting and expanding the Community Health Fund, the Tanzania government is moving ahead with the development of a National Health Insurance Scheme (NHIS) for the formal sector. The expectation is that these two plans, CHF and NHIS will be linked at the District level.

Specific Objectives

- ▲ To conduct an assessment of the CHF in the Hanang district. Information will be collected on the organization and administrative structure of the CHF, management of funds, data collection and reporting systems, exemption policy, membership and utilization trends, resource mobilization, and member and non-member perceptions of the CHF, among others.
- ▲ To provide recommendations to assist REDSO/ESA, CRHCS and Tanzanian health officials to develop a plan of action to increase membership and utilization of the CHF in targeted districts in Tanzania.
- ▲ To work with CRHCS and the Hanang CHF to develop a plan for implementing the recommended changes with PHR*plus* assistance.

Description of Activities

1) Assessment of Hanang CHF

PHR*plus* will conduct an assessment of the CHF in Hanang district and develop recommendations to improve the CHF management (marketing, operations, service delivery). The assessment will be conducted at all levels of the CHF (central, district, ward, and village). Visits will be made to all types of service facilities included in the CHF – district hospitals, health centers, and dispensaries. The assessment will also include data collection from facilities and individuals not currently participating in the CHF. The assessment aims to identify the strengths and weaknesses of the CHF and will include a review of problems previously identified in World Bank and MOH evaluations in other districts, and by CHF/MOH officials in Dar es Salaam.

The wards, village and health facility sites included in the assessment will be selected in collaboration with CRHCS and Hanang District health officials by considering: socioeconomic characteristics of the population, population density, CHF membership rates, and type of health facility (public, private, participating in CHF or not). It is proposed that the team visit 3-4 wards in the district, each of which would have a MOH health center. Within each ward, the team would visit two villages that have MOH dispensaries. Focus group discussions would be held with community members in those villages. Thus, 3-4 wards and MOH health centers, and 6-8 villages and MOH dispensaries would be included in the assessment. In addition, a number of non-participating health facilities will be included.

Information will be gathered through semi-structured interviews with individuals involved in the administration of the CHF at all levels, and providers and managers at participating and non-participating health facilities. Focus groups discussions will be conducted at the village and subvillage (Kitongoji) level with CHF members and non-members.

Central Level

At the central level, the assessment will include semi-structured interviews with central CHF officials, including:

- ▲ Mr. Rogatian M. Shirima, CHF Coordinator, MOH
- ▲ Mr. Maximilliam Mapunda, Economist/Head Insurance Implementation Team, MOH
- ▲ Dr. F.N. Njau, Head Health Sector Reform Secretariat, MOH

Information at the central level will be gathered on:

- ▲ The history of the CHF in Tanzania
- ▲ Tanzania's health sector reform vision/strategy and how CHF fits in
- ▲ Role of districts in the CHF design and policy
- ▲ Organizational structure of the CHF – current and proposed new structure
- ▲ CHF Act of 2001 and plans for roll-out to all districts
- ▲ Differences in CHF experiences in 10 districts
- ▲ National level IE&C
- ▲ CHF and national exemption policy and practice

District and Ward Level

At the district level, the assessment will include semi-structured interviews with the following officials:

- ▲ District Health Board
- ▲ District Health Management Team
- ▲ District Medical Officer
- ▲ District CHF Board

At the ward level, the assessment will include semi-structured interviews with the Ward CHF Committee.

Information will be gathered at the District and Ward level on:

- ▲ Socio-demographic characteristics of the district/ward population
- ▲ Administrative and management structure of CHF
- ▲ Responsibilities of District Council/District CHF Board/Ward CHF Committee
- ▲ Establishment of CHF membership fees
- ▲ Number of CHF members
- ▲ Characteristics of CHF members
- ▲ Data collection and recording systems
- ▲ Funds flow and management
- ▲ Exemption policy, procedures and practices
- ▲ Private sector involvement
- ▲ CHF and user fees collected in 2000 and in last month
- ▲ Community involvement in management of CHF and use of CHF funds
- ▲ Member and non-member attitudes toward the CHF
- ▲ Promotion and marketing of the CHF

Village Level

At the village level, the assessment will include semi-structured interviews with the Village Health Committee members and other community members. In addition, 4-6 focus group discussions (each with 8-10 participants) will be held with community members – separate FGDs will be held for CHF-members and non-members.

Focus group discussions will gather information on:

- ▲ Community awareness of CHF policies and procedures
- ▲ Knowledge about exemption policy, procedures, and practices
- ▲ Attitudes towards the CHF and health care services
- ▲ Reasons for joining or not joining the CHF
- ▲ Ability and willingness to pay for health services
- ▲ Community involvement in CHF planning, management and use of funds

Participating Facilities

At the facility level, semi-structured interviews will be conducted with health care providers and administrators at the district hospital, 3-4 health centers, and 4-6 dispensaries to gather information on:

- ▲ Services provided
- ▲ Schedule of fees charged
- ▲ Sources of funding
- ▲ Availability of drugs and other supplies
- ▲ Provider knowledge and perceptions of CHF
- ▲ Procedures for managing CHF premiums and user fees
- ▲ CHF premiums and user fees collected in 2000 and in last month
- ▲ Promotion and marketing of CHF at the facility level
- ▲ Other facility-level concerns regarding CHF

Non-Participating Facilities

Information from facilities not participating will also be gathered using semi-structured interviews with health providers and administrators. A private mission hospital, 3-4 parastatal dispensaries, and 2-3 private dispensaries will be visited to gather information on:

- ▲ Services provided
- ▲ Schedule of fees charged
- ▲ Sources of funding
- ▲ Availability of drugs and other supplies
- ▲ Provider knowledge and perceptions of CHF
- ▲ Interest in joining the CHF
- ▲ Reasons for not joining the CHF

It is anticipated the data collection will be completed in approximately three weeks. A draft report of findings and recommendations will be prepared approximately one month after data collection is completed. This report will be disseminated to the MOH, CRHCS, REDSO/ESA and officials in Hanang district for comments before finalization.

2) Development of Implementation Plan

After the assessment report has been circulated, PHR*plus* will convene a meeting with representatives from the CHF/MOH, CRHCS, the Hanang DHMT, and communities to review the findings and recommendations and to agree on an action plan for implementing the recommendations from the assessment. During this meeting, it is anticipated that appropriate technical expertise and funding will be identified to support implementation of new practices. Based on the agreements from this meeting, PHR*plus* will prepare an Implementation Plan, which will be circulated for comments. Once the Implementation Plan is finalized, it will be circulated widely together with the Assessment Report, to ensure that other districts in Tanzania can benefit from the experience in Hanang district.

Personnel

Jack Galloway, Africa Regional Coordinator
Grace Chee, Team leader

Charlotte Leighton, Senior Technical Advisor
Kimberly Smith, Technical Officer
Natasha Hsi, Task Manager
Janet Edmond, CBHF Advisor
Allison Kelley, CBHF Advisor

Deliverables and Due Dates

- Assessment Report – January 2001
- Implementation Plan – February 2002

Annex C: Questionnaires

Tanzania Community Health Fund Assessment

CHF Facility Questionnaire

Date:

Name:

Title:

Years in current position:

A. Health Services

1. What health services does this facility provide?
2. Do you have a fee schedule for these services – can we see it?

B. Financial Management and Accounting

3. Please provide for 1998-2000 the following information:
 - Total enrollment in CHF
 - Premiums collected
 - User fees collected
 - Total clients – utilization
 - Number of exempt patients
 - Budget for the facility
4. What are the different sources of funding for this health center/dispensary?
5. How are CHF membership fees and user fees established?

6. Have the fees changed since the implementation of the CHF/user fees in 1998?
7. What are the procedures at the village and facility level for collecting, recording and managing funds collected through CHF member contributions and user fees?
8. Who decides how the CHF money is spent? What input do health providers at this facility provide for the ward health plans?
 - 8a. (If not answered) Does the district (DMO) purchase CHF goods and services on behalf of the wards (to take advantage of bulk purchasing)?
9. How does the CHF money get back to the ward and facility level for the purchase of small and unique goods and services, such as kerosene or facility maintenance?
 - 9a. Who decides how much can be spent on ward and facility-specific goods and services?
10. Is there a separate bank account for each facility at the district level?
11. How are CHF expenditures recorded and tracked at the facility level?
 - 11a. Is a budget prepared and expenditures compared against the budget?
12. What do you do if someone is ill and cannot pay? Does that happen often?

C. CHF Membership and Member Characteristics

13. Why did the health center/dispensary decide to participate in the CHF program?

14. When can community members join the CHF? How do they join?
15. Have you noticed any particular differences between CHF members and non-members? Do CHF members tend to be of a particular socio-economic group or in poor health?
16. Do members tend to come to the facility more?
17. Do you think people share cards? Do you think that is okay? What can be done to prevent this?

D. Supervision and Monitoring

18. Has the DMO visited this site since it decided to participate in the CHF?
19. What was the purpose of the visit(s)?
20. What was done by the DMO during these visits?
21. What is in cases of financial irregularities of CHF funds? Have you had these problems?

E. Drugs and Medical Supplies

22. Do you experience drug shortages on a regular basis?
23. Are CHF funds used to purchase drugs and related supplies?
24. Has the implementation of the CHF had an impact on the availability of drugs?

25. Has the implementation of the CHF had an impact on the availability of essential medical supplies?

F. Staff Attitudes Toward CHF

26. Do you know why the CHF was created?
27. What do you think of the CHF?
28. How do you think the CHF could be improved?
29. Do you hold meetings with the community to discuss CHF issues? When was the last meeting? What was discussed?

G. Promotion and Marketing of CHF

30. What role does the health center/dispensary play in the promotion and marketing of the CHF?
31. Does the health center/dispensary have a particular marketing strategy for the CHF?
32. Do you think more can be done to increase knowledge and utilization of the CHF?
33. Why don't more people join?

Tanzania Community Health Fund Assessment

Village Level Questionnaire CHF Member Focus Group

Village:

Kitongoji:

Distance from nearest health facility:

Number of focus group participants:

A. Utilization of Health Services

1. Where do you go for health services? How often did you attend the dispensary/health center last year?
2. Do you tend to go to the dispensary/health center more or less frequently now that you are a CHF member?
3. Do you get good treatment at that facility?

B. Knowledge of the Community Health Fund (CHF)

4. Can you please describe what the CHF is? How does it work? What are the costs and benefits?
5. Do you know why the CHF was created by the Ministry of Health?
6. Why did you join the CHF?
7. Where can you get health services for no fee with your CHF membership card?

8. Are all services covered by the CHF? What services are covered?
9. Do you know how the money collected from CHF membership contributions is used?
10. Do you know about the CHF exemption policy and procedures? If yes, how does the exemption system work?

C. Attitudes Towards the CHF

11. What do you think about the CHF? Do you think it is a good plan?
12. Do you think the CHF has had an effect on the supply of drugs or quality of health services at the health center/dispensary? In what way?
13. Can you explain what insurance is and how it works? (probe for understanding of risk pooling)
14. Does the CHF premium that you pay cover the costs of the health services you receive? Is that okay?
15. Have you heard of people sharing their cards with their relatives or neighbors?
16. Is that accepted by the community? Do you think its okay?

D. Community Involvement/Ownership

17. Have you attended any CHF meetings?
 - 17a. If yes, what was discussed at the meeting(s)?

18. Do you know to whom you can voice complaints or suggestions regarding the CHF, or the use of CHF funds?

19. Do you think the community is adequately involved in the management of the CHF?

20. Do you have any suggestions on how to improve the CHF?

E. Promotion and Marketing of the CHF

21. How did you learn about the CHF?

22. Do you encourage other members of the community to join the CHF?

23. Have the village or religious leaders encouraged community members to join?

24. Do you feel that the health providers at the health center/dispensary support the CHF and encourage patients to join?

Tanzania Community Health Fund Assessment

District Level Questionnaire

Date:

Name:

Title:

Years in current position:

A. Socio-Demographic Information

1. What is the total population of the Hanang District?
2. How many wards and villages are there in the District (if necessary)?
3. Please provide a list of the hospitals, health centers, and dispensaries in the district.

B. Financial Management and Accounting

4. Please provide for 1998-2000 the following information:
 - ▲ Total enrollment in CHF
 - ▲ Premiums collected
 - ▲ User fees collected
 - ▲ Total clients – utilization
 - ▲ Number of exempt patients
 - ▲ Budget for the district
5. When is the budget for the DHMT developed, by whom?
6. How are CHF membership fees and user fees established? Are they set at the District or does each facility determine the fees?

7. Have the fees changed since the implementation of the CHF/user fees in 1998? What are the fees?
8. Please describe the procedures at the village, ward and district level for collecting, recording and managing funds collected through CHF member contributions?
9. How are CHF bank accounts opened and maintained? Is there just one account for all of the District funds, or is there a separate account for the CHF funds? Can we see the bank statements or ledger for the account?
 - 9a. Are there particular requirements for depositing and withdrawing CHF money?
10. Who decides how the CHF money is spent – is it based solely on ward health plans?
 - 10a. (If not answered) Does the district (DMO) purchase CHF goods and services on behalf of the wards (to take advantage of bulk purchasing)?
11. How does the CHF money get back to the ward and facility level for the purchase of small and unique goods and services, such as kerosene or facility maintenance?
 - 11a. Who decides how much can be spent on ward and facility-specific goods and services?
12. How are CHF expenditures recorded and tracked?
 - 12a. Is a budget prepared and expenditures compared against the budget?
13. In the Operations Manual (p.12), it states that the DMO recommends the amount of matching grant for each ward to District Health Board, which then forwards the request for a matching grant to the CHF National Coordinator at the MOH. How is the amount of the matching grant decided upon? How do you access the money?

14. What is the policy for exempting those who can't afford to pay?

C. Membership and Utilization

15. When can community members join the CHF? Where do they join the CHF?

16. How much in CHF fees were collected in 1998-2000?

16a. In the last month? this year?

17. How much in user fees was collected in 1998-2000?

17a. In the last month? this year?

18. Do you have data on membership by ward or by village?

19. What reports are the wards or dispensaries, hospitals required to give you? How frequent are these reports?

D. Supervision and Monitoring

20. How many site visits to CHF-participating wards has the DMO conducted since 1998?

21. What was the purpose of these visits – general supervision or to respond to requests for assistance from a CHF committee or facility?

22. What was done by the DMO during these visits? Is there a supervision report or checklist?

23. Does the DMO make supervisory visits to participating dispensaries, health centers, or hospitals?
24. Does the DMO submit monthly, quarterly or annual progress and/or financial reports? Do you have copies of these?
25. What is done in cases of financial irregularities with of CHF funds? Have you had these types of problems?
26. Does the Regional Medical Office provide support in your implementing the CHF? Do they visit to monitor how things are going? What is your relationship with them?

E. Financial Sustainability

27. Do most districts receive a matching grant equal to the amount of money raised by the district through CHF contributions (Operations Manual, p. 6, states maximum matching grant will be in 1:1 ratio)?
28. How do you get these funds? Do you have to make a request?
29. Do you think that this level of government contribution is sustainable?

F. Promotion and Marketing of CHF

30. What role does the district play in the promotion and marketing of the CHF?
31. Does the district have a particular marketing strategy for the CHF?
32. Do you think more can be done to increase knowledge and utilization of the CHF?

33. How do you think the members/patients feel about the CHF?
34. Why don't more people join?
35. Do you think the CHF works well?
36. What are some of the problems with the CHF or areas for improvement?

Tanzania Community Health Fund Assessment

Exit Interview with Patients at CHF Facilities

Village:

Kitongoji:

Health facility:

1. Are you a CHF member?
2. How long have you been a member?
3. Why did you come to the HC/dispensary today (what is the illness)?
4. When was the last time you visit the HC/dispensary?
5. How many times have you come this year?
6. Are you satisfied with the treatment at this facility?
7. Are you satisfied with the CHF – do you get good benefits for your premium?
8. How did you learn of the CHF?
9. Why did you join?
10. Would you recommend CHF membership to others?
11. What can be done to improve the CHF?

Tanzania Community Health Fund Assessment

Village Level Questionnaire CHF Member Focus Group

Village:

Kitongoji:

Number of focus group participants:

A. Knowledge of the Community Health Fund (CHF)

1. Can you please describe what the CHF is?
2. Why did you join the CHF?
3. Are you able to acquire health services for no additional fee at other nearby health facilities with your CHF membership card?
4. Do you know how the money collected from CHF membership fees is used?
5. Do you know about the CHF exemption policy and procedures? If yes, how does the exemption system work?

B. Attitudes Towards the CHF

6. What do you think about the CHF?
7. Do you think the CHF has had an effect on the supply of drugs or quality of health services at the dispensary?

C. Utilization of Health Services

8. How often do you attend the dispensary/health center last year?

9. Do you tend to go to the dispensary/health center more frequently now that service fees are covered under your CHF membership?

D. Community Involvement/Ownership

10. Have you attended any CHF meetings?

11. Do you know to whom you can voice complaints or suggestions regarding the CHF?

12. Do you have any suggestions on how to improve the CHF?

E. Promotion and Marketing of the CHF

13. How did you learn about the CHF?

14. Do you encourage other members of the community to join the CHF?

15. Have the village or religious leaders encouraged community members to join?

16. Do you feel that the health providers at the dispensary support the CHF and encourage patients to join?

Tanzania Community Health Fund Assessment

National Level Questionnaire

Date:

Name:

Title:

Years in current position:

A. History of CHF and Health Sector Reforms in Tanzania

1. Can you please describe the CHF concept, the specific objectives of the CHF, and how it fits in to the overall health reform vision/strategy in Tanzania?

2. Who was involved in the design of the CHF and the Community Health Fund Act of 2001?
 - 2a. To what extent have the districts participated in the design and policies of the CHF?

3. Has the success of the CHF differed among the districts in which it has been implemented?
 - 3a. What are some of the “lessons learned” from each of the districts?

4. What is the process by which the CHF will be rolled out to all districts? How many districts are implementing the CHF currently? When do you plan to be national?
 - 4a. Is participation of the CHF at the ward level voluntary? (Operations Manual, p.2)

5. Can you please explain the CHF exemption policy and procedures?

5a. Are they fully compatible with national exemption policies, procedures and practices?

5b. Do facilities set their own fees/exemption policies?

B. Management and Organizational Structure

6. Can you please describe the organizational structure of the CHF and how it builds on the existing MOH structure or that proposed under on-going structural reforms?

7. What role does the MOH/central level play in the operations and management of the CHF?

7a. Does the MOH have a supervisory or monitoring role?

8. What authority do districts have in shaping CHF policies and procedures at the district level?

9. What is the role of the Regional Medical Officer in shaping policies and supervising and monitoring the districts?

C. Financial Sustainability

10. Can you provide information for all districts available:
 - ▲ Total enrollment in CHF
 - ▲ Total premiums collected
 - ▲ User fees collected
 - ▲ Exemptions granted

11. Who within the MOH compiles that information? What does the MOH do with that information?

12. What are the reports expected from the Districts regarding the CHF?

13. Do most districts receive a matching grant equal to the amount of money raised by the district through CHF contributions (Operations Manual, p. 6, states maximum matching grant will be in 1:1 ratio)? What is the procedure for transferring those funds?
 - 13a. Do you think that this level of government contribution is sustainable over the long-term? Does the government plan to continue this long term?

D. Promotion and Marketing of CHF

14. What role does the MOH/central level play in the promotion and marketing of the CHF?

15. Do you think more can be done at the national level to increase knowledge and utilization of the CHF?

Tanzania Community Health Fund Assessment

Non-CHF Facility Questionnaire

Date:

Name:

Title:

Years in current position:

A. Health Services

1. What health services does this facility provide?

2. Do you have a fee schedule for these services – can we see it?

B. Financial Management and Accounting

3. What are the different sources of funding for this health center/dispensary?

4. When were user fees introduced? How are user fees established?

5. Have the fees changed since the inception of the user fee system? How often do they increase?

6. How much in user fees was collected in 2000?
 - 6a. In the last month? This year?

7. Is there a prepayment plan or a system for insurance?

C. CHF Membership

8. Do you know what the CHF is?

9. Do you know why it was created?

10. Is the health center/dispensary interested in participating in the CHF program?

11. Why or why not?

Tanzania Community Health Fund Assessment

Ward Level Questionnaire

Date:

Name:

Title:

Ward:

Years in current position:

A. Socio-Demographic Information

1. What is the total population of the ward?
2. How many villages are in the ward (if necessary)?
3. Please provide a list of the health centers, and dispensaries in the ward.

B. CHF Organization and Management

4. What is the role of the Ward Health Committee in the management of the CHF? Do you visit participating facilities? Do you address issues raised by the community?

C. Financial Management and Accounting

5. What are the procedures at the village and ward level for collecting, recording and managing funds collected through CHF member contributions?

6. How is the fee collector at the ward and village level chosen?
7. Who is involved in the development of the ward health plan and budget?
8. How does the CHF money get back to the ward and facility level for the purchase of goods and services?
9. How are CHF expenditures recorded and tracked?
 - 9a. Is a budget prepared and expenditures compared against the budget?
10. What is the policy for exempting those who can't pay?

D. Membership and Utilization

11. Why did the ward decide to participate in the CHF? Are there some wards that do not participate?
 - 11a. Who was involved in that decision and how was it made?
12. When can community members join the CHF? Where do they go to join?

13. How much in CHF fees were collected in 1998-2000?

13a. In the last month? This year?

14. How much in user fees was collected in 1998-2000?

14a. In the last month? This year?

E. Supervision and Monitoring

15. How often does the Ward Health Committee meet to discuss the CHF?

16. Who usually attends these meetings?

17. How many site visits to this ward has the DMO conducted since 1998?

18. What was the purpose of these visits – general supervision or to respond to requests for assistance from a CHF committee or facility?

19. What was done by the DMO during these visits?

20. Has the DMO conducted any trainings for ward officials or providers regarding the operations and management of the CHF?

F. Promotion and Marketing of CHF

21. What role does the ward level play in the promotion and marketing of the CHF?
22. Does the ward have a particular marketing strategy for the CHF?
23. Do you think more can be done to increase knowledge and utilization of the CHF?
24. How do you think the members/patients feel about the CHF?
25. Why don't more people join?
26. Do you think the CHF works well?
27. What are some of the problems with the CHF or areas for improvement?

Annex D: CHF Membership Card



UCHANGIAJI GHARAMA ZA MATIBABU
MFUKO WA AFYA WA JAMII
WILAYA YA HANANG'

Namba ya kadi ya Matibabu **03059**
(CHF Card No.)

Jina la mwenye familia
Sahihi
Jina la Mjumbe
Kata
Kijiji



Picha ya mwenye familia.

Maelezo ya Familia

	Majina ya Familia	Uhusiano	Umri	Jinsia
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Michango ya CHF

Tarehe	Fecha aliyolipa	Fecha iliyosalia	Sahihi ya Mpokeaji	Risiti Na.

WILAYA YA HANANG'
KADI YA MATIBABU
KADI NA: **03059**

JINA: _____
ANWANI: _____
SAHIHI YA MGENYETI: _____
MIWAKA: _____

PICHA

KADI HII NI MALI YA MFUKO WA AFYA WA JAMII (CHF) - WILAYA YA HANANG' - HAIRUHUSIWI KUBADILISHA JINA AU KURUZA. KAMA UKIOKOTA, TAFADHALI IPELEKE KWENYE OFISI YOYOTE YA CHF, AU ITUME KWENYE ANWANI IFUATAYO:

MKURUGENZI MTENDAJI WA WILAYA
S.L.P. 2
KATESHI, HANANG',
ARUSHA.

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