

Working Paper
**Maternal Health
Financing Profile:
Tanzania**

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- ▲ *Design and implementation of health information systems for disease surveillance.*
- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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Abstract

This paper attempts to identify the key financing issues and constraints for accessing maternal health services in Tanzania. Access to the services is of concern because, despite high use of antenatal care, the 1990s saw an appreciable decline in the number of births that take place in a health facility (currently 44 percent) and in the number of births attended by skilled health workers (36 percent). The current analysis finds that the great majority of women who access antenatal care services do not pay for the services nor do they pay for drugs and transportation related to the services. While many delivery services (and related drugs and transportation) also are free of charge, a greater number of women who access the services do pay something. Costs are particularly high for caesarian-section delivery-related supplies.

Evidence is mixed on the impact of user fees, instituted in 1993, and especially on their impact on the use of maternal health services. Enrollment in the prepayment-oriented Community Health Fund (CHF), begun in 1996, is low and thus far available in only 23 districts; an exemption policy is inconsistently applied, so many members are still charged user fees. Evidence is not yet available to evaluate the effect on access of the more recent, and still limited, financing efforts of national health insurance and decentralization.

Given that financing barriers may play a role in preventing access to maternal health services, the paper recommends that further research on user fees be undertaken to help guide health policy implementation. The findings could solidify support for the country's national waiver and exemption policy and help determine which key maternal health-related expenses should be waived. The paper also suggests that expanding the CHF and the national health insurance program could help reduce financial barriers and promote greater equity in access to these services. The Sector Wide Approach also has potential to improve efficiency of external funding by eliminating the duplication of efforts among donors and providing a single policy for the government to implement.

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Acronyms

| | |
|-------------|-------------------------------------|
| AIDS | Acquired Immune Deficiency Syndrome |
| CHF | Community Health Fund |
| GOT | Government of Tanzania |
| HIPC | Highly Indebted Poor Country |
| HIV | Human Immunodeficiency Virus |
| HSR | Health Sector Reform |
| PRSP | Poverty Reduction Strategy Paper |
| SWAp | Sector Wide Approach |
| TFR | Total Fertility Rate |
| Tsh | Tanzanian Shilling |

Conversion Rate:

The exchange rate of the Tanzanian shilling to the U.S. dollar varied from Tsh 763 to Tsh 800 per US \$1.00 in the earlier studies cited in this paper.

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1. Introduction

This profile summarizes key health financing data for Tanzania in the context of the broader health system and economic trends, with a view toward identifying financing issues and constraints for accessing maternal health services in the country. It first looks at health indicators and, in particular, maternal health indicators. Then it provides an overview of the health sector and recent health reform to finally draw conclusions on the implications for maternal health services.

2. Overview of Economic Development and Health Indicators

Tanzania's total population in 1999 was 33 million with an annual growth rate of 2.8 percent. The majority of the population is live in rural areas; only 32 percent resides in urban centers. In 1999, life expectancy was 44 years for males and 46 years for women. This is lower than the average for sub-Saharan Africa (49 years for men and 52 years for women).

Throughout its four decades of independence, Tanzania has remained one of the 10 poorest countries in the world. It is estimated that more than half of the Tanzanian population lives below the poverty line of US\$ 0.65 per day. Tanzania's per capita gross national product of US\$265 is lower than the sub-Saharan average of US\$500 (World Bank and Government of Tanzania [GOT], 2001). The average gross domestic product (GDP) growth rate has been 3.7 since independence despite an average population growth rate of about 3 percent over the same period (World Bank and GOT, 2001).

Adding to the economic development problem is the rate of HIV infection, which, in 2001, was estimated to have reached 7.8 percent (UNAIDS, 2001). The HIV/AIDS pandemic has shortened life expectancy and is depleting the productive and skilled segment of its population (World Bank and GOT, 2001).

According to the 1999 Reproductive and Child Health Survey (Tanzania National Bureau of Statistics and Macro International Inc., 2000), infant mortality is estimated at 99.1 deaths per 1,000 live births and the mortality rate of children under 5 years of age is estimated at 146.6 deaths per 1,000 live births.

The total fertility rate (TFR) in Tanzania for women aged 15-49 is 5.6. However, there are rural/urban differences – the TFR for rural women is almost twice that of urban women: 6.5 vs. 3.2 respectively. Similarly, there are differences between educated (TFR 4.9) and non-educated women (TFR 6.5) (Tanzania National Bureau of Statistics and Macro International Inc., 2000).

There is a high rate of utilization of antenatal care in Tanzania. Antenatal care is used in nine out of 10 births (Tanzania National Bureau of Statistics and Macro International Inc., 2000). Among women who give birth, the majority (60.9 percent) in urban areas seeks care from a nurse/midwife; most rural women (50.1 percent) seek care from a health aide (Tanzania National Bureau of Statistics and Macro International Inc., 2000).¹ Overall, health aides provide a slightly greater share of antenatal care (44 percent) than do nurses and midwives, who provide 43 percent.

Despite high levels of access to antenatal care, only 44 percent of women delivered at a health facility in 1999. This rate has steadily declined since 1992 (53 percent) and 1996 (47 percent). Thirty-

¹ This report defines "skilled birth attendants" as trained medical personnel – doctors, nurses, and midwives. "Health aides" are medical aides and maternal-child aides. "Birth attendants" are trained birth attendants, traditional birth attendants, and village health workers.

six percent of births are attended by trained medical personnel. This proportion also has declined since 1991–92, when it was 44 percent. Overall, relatives and friends provide the greatest proportion of assistance at delivery (29 percent), while nurses and midwives assist 28 percent, less-skilled birth attendants assist 18 percent, medical aides assist 8 percent, and doctors assist 7 percent. (Seven percent of births are reported to be unattended.) Attendance at birth significantly differs by location of residence. More than three-fourths of births in urban areas are attended by trained medical personnel in comparison to 26 percent in rural areas.

Use of postnatal care is also low. Only 38 percent of the women who delivered at home and half of the women who delivered in a health facility received postnatal care.

Table 1: Select Indicators of Health System Performance, Tanzania, 1999

| Indicator | |
|--|------------------|
| Infant mortality rate | 99.1 per 1,000 |
| Maternal mortality rate | 529 per 100,000* |
| Deliveries in facilities | 44% |
| Contraceptive use: ever use, any modern method | 29.9% |
| Fully immunized child* | 68.3% |
| Population growth rate | 3%** (2001) |
| Adult female illiteracy rate | 33.5%*** (2000) |
| GDP per capita | \$265** |

Sources: Tanzania National Bureau of Statistics and Macro International, 2000

* Tanzania National Bureau of Statistics and Macro International, 1997

** World Bank and GOT, 2001

*** World Bank 2000

3. Overview of Health Sector

Overall, Tanzania has a well-established health care system. Prior to independence, Tanzania's health system was concentrated in urban areas and services were essentially curative in nature (GOT, 2001). In 1967, the Arusha Declaration stated that the government would finance and provide free medical care to all of its citizens. As part of the declaration, an expansion strategy for facilities, especially in the rural areas was adopted. Results of the strategy were impressive – by 1978, a clinic was located within 10 kilometers of 90 percent of the population (Benson, 2001). In line with its free-health-for-all policy, private for-profit health services were banned in 1971. Private non-profit health facilities operated by nongovernmental organizations, however, continued to provide a large share (currently about one-third) of the health services in the country with subsidies from the government. Despite inadequate revenues, the government adhered to these policies throughout the 1970s and 1980s. Underfunding led to shortages in supplies and drugs, deterioration of facilities, low staff morale, and poor quality of care (Ministry of Health of Tanzania, 1998).

The importance of a private sector in health service delivery and the move towards market-based economic reforms resulted in the re-establishment of private medical and dental services with the approval of the Ministry of Health in 1991 (GOT, 2002). In July 1993, under pressure from the World Bank and the International Monetary Fund, the government started a phased implementation of user fees for certain health services in its referral, regional, and district hospitals. To ensure that the poor and those who needed care most would not be barred from accessing care because of inability to pay, the Ministry of Health developed waiver and exemption guidelines (Mubyazi, Massaga, Njunwa, et al., 2000).

The demand for better services and the need to improve the population's health status, particularly the rural poor, led to the development of Health Sector Reform (HSR) proposals in 1994. By 1996, a health sector reform strategy was approved by the government – the HSR Plan of Action for 1996-1999. The action plan included six strategies: decentralization, improvement of central health systems, health management, financing, human resources, and partnership. In 1999, the HSR Programme of Work 1999-2002 and Action Plan was developed. This document increased the strategies from six to eight to enable the HSR plans to explore new options for health financing such as the Sector Wide Approach (SWAp) Framework, a national insurance scheme, community health funds, and cost sharing.

4. Willingness to Pay for Maternal Health Services

The current analysis on willingness to pay for antenatal care and delivery services used data obtained from the 1996 Tanzania Human Resource Development Survey, a national survey fielded by the Population and Human Resources Division of the Eastern Africa Department of the World Bank in collaboration with the University of Dar es Salaam and the Tanzania Planning Commission.² The survey is national in scope and covers a total of 4,953 households in the 20 regions of mainland Tanzania as well as 230 households in Zanzibar. Forty-four percent of the households are rural and 56 percent urban.

4.1 Willingness to Pay for Antenatal Care Services

According to Human Resource Development Survey data, 95 percent of the women who had given birth within the year prior to the survey had accessed antenatal care services, with no significant difference based on location of residence. The majority of these women (92 percent) received antenatal care services free of charge and, again, no significant difference existed based on location of residence. Of the women who accessed antenatal care services and paid for them, 6 percent paid between 1 and 499 Tanzania shillings (Tsh), 1 percent paid between Tsh 500 and Tsh 999, and only 2.5 percent paid Tsh 1,000 or more.³

Government facilities played the largest role in providing antenatal care services. They made up 86 percent of the services provided, while missions made up 11 percent, private providers 2 percent, and employer-owned facilities 1 percent. Antenatal care services provided through government facilities or missions are most often offered at no cost (Table 2). As expected, high-end services were provided mainly by the private sector. Nonetheless, 57 percent of antenatal care services provided by the private sector were free-of-charge.

² Data analysis was performed using Stata. Data were weighted to obtain nationally representative statistics that reflect census-type results.

³ The exchange rate of the Tanzanian shilling to the U.S. dollar varied from Tsh 763 to Tsh 800 per US \$1.00 in the earlier studies cited in this paper.

Table 2: Costs of Antenatal Care Services, by Type of Provider

| Type of provider | Cost (in shillings) | | | | |
|-----------------------|---------------------|-------------|-----------|-------------|---------------|
| | Free | 1–499 | 500–999 | 1,000–9,999 | 10,000–40,000 |
| Government facilities | 95% n=576 | 4% n=21 | 0% n=3 | 1% n=8 | 0% n=1 |
| Mission | 71% n=41 | 22% n=16 | 3% n=2 | 4% n=5 | 0% n=0 |
| Private | 57% n=14 | 5% n=4 | 9% n=5 | 16% n=9 | 13% n=7 |
| Employer owned | 100% n=5 | 0% n=0 | 0% n=0 | 0% n=0 | 0% n=0 |

Uncorrected chi2 = 150.5930
P= 0.0000⁴

Costs related to antenatal care services include the costs of drugs and of transportation. Overall, most women who accessed antenatal care services did not spend money on either. The majority of women who accessed antenatal care services (83 percent) received drugs, pharmaceuticals, vitamins, potions, and/or medical supplies as part of these visits and most of them (90 percent) received the items free-of-charge (Table 3). Similarly, most women (90 percent) did not pay for transportation costs related to their antenatal care visits (Table 4). Living in a rural area increased the likelihood that women who access antenatal care services will not pay for drugs or transportation.

Table 3: Payment for Medicines by Women Accessing Antenatal Care Services

| Location of residence | Cost (in shillings) | | | | |
|-----------------------|---------------------|------------|-----------|-------------|---------------|
| | Free | 1-499 | 500-999 | 1,000-9,999 | 10,000-45,000 |
| Rural | 91% n=266 | 4% n=14 | 3% n=9 | 2% n=8 | 0% n=0 |
| Urban | 88% n=241 | 8% n=18 | 0% n=2 | 3% n=16 | 1% n=5 |

Uncorrected chi2 = 12.6381
P=0.0229

⁴ The Pearson χ^2 statistic was used for all tests of independence. A 5 percent confidence interval was assumed.

Table 4: Payment for Transportation by Women Accessing Antenatal Care Services

| Location of residence | Cost (in shillings) | | | | |
|-----------------------|---------------------|------------|------------|---------------|--------------|
| | Free | 1-499 | 500-999 | 1,000 – 4,999 | 5,000-20,000 |
| Rural | 91% n=330 | 4% n=13 | 4% n=12 | 1% n=6 | 0% n=0 |
| Urban | 82% n=284 | 6% n=22 | 4% n=14 | 4% n=30 | 4% n=3 |

Uncorrected chi2 =25.4020

P=0.0311

4.2 Willingness to Pay for Delivery Services

The majority of women in the sample received free-of-charge delivery services and drugs, medical supplies, and medical equipment related to the delivery (Tables 5 and 6). Most women also did not pay for transportation related to the delivery (Table 7). The type of delivery, however, did play an important role in determining the type of costs incurred by women and the level of these costs. While delivering by caesarian section did not impact the costs incurred for delivery services, it did increase the likelihood of incurring costs for drugs, medical supplies, and medical equipment, as well as transportation. Only 7 percent of women delivered by caesarian section. Of these women, 47 percent incurred costs for drugs, medical supplies and medical equipment (versus 24 percent for vaginal deliveries) and 50 percent incurred costs for transportation (versus 10 percent for vaginal deliveries). Location of residence only impacted transportation costs incurred by women who had vaginal deliveries. A greater portion of women in rural areas who had vaginal deliveries spent no money on transportation versus women in urban areas.

Table 5: Payment for Delivery Services

| Type of delivery | Cost (in shillings) | | | | |
|------------------|---------------------|-------|---------|-------------|--------------|
| | Free | 1-499 | 500-999 | 1,000-4,999 | 5,000-40,000 |
| Vaginal | 84% | 5% | 3% | 7% | 1% |
| Caesarian | 77% | 9% | 2% | 8% | 4% |

Table 6: Payment for Drugs, Medical Supplies, and Medical Equipment Related to Delivery Services

| Type of delivery | Cost (in shillings) | | | | |
|------------------|---------------------|------------|------------|-------------|--------------|
| | Free | 1-499 | 500-999 | 1,000-4,999 | 5,000-40,000 |
| Vaginal | 76% n=278 | 8% n=22 | 8% n=23 | 8% n=36 | 0% n=1 |
| Caesarian | 53% n=22 | 20% n=3 | 7% n=2 | 10% n=6 | 10% n=5 |

Uncorrected chi2 = 40.1553
P= 0.0000

Table 7: Payment for Transportation Related to Delivery Services

| Type of delivery | Location of residence | Cost (in shillings) | | | | |
|------------------|-----------------------|---------------------|-------------|--------------|-------------|---------------|
| | | Free | 1-999 | 1,000-4,999 | 5,000-9,999 | 10,000-30,000 |
| Vaginal | Rural | 85% n=310 | 7% n=23 | 8% n=26 | 0% n=2 | 0% n=1 |
| | Urban | 61% n=149 | 10% n=38 | 24% n=116 | 3% n=16 | 2% n=5 |
| Caesarian | Not significant | 50% n=27 | 21% n=9 | 17% n=14 | 8% n=8 | 4% n=2 |

Uncorrected chi2 = 36.0581
P=0.0061

Few women are reimbursed through health insurance or their employer for costs incurred from antenatal care and delivery. However, women in urban areas are more likely to have costs reimbursed than are women from rural areas (3 percent versus 0.4 percent). Health insurance is also more likely to cover costs associated with caesarian section deliveries (5 percent of women reimbursed) as opposed to vaginal deliveries (1 percent reimbursed). Reimbursement rates are high, though, for women who receive these benefits. Sixty-three percent of women who are reimbursed receive between Tsh 12,000 and Tsh 40,000.

Women in urban areas were more likely to receive financial assistance from outside the household (8 percent of urban women versus 2 percent of rural women) and received, overall, higher levels of assistance (Table 8). The majority of all women who received external assistance did not have to repay these loans.

Table 8: Financial Assistance Received from Outside Household Based on Location of Residence

| Location of residence | Amount of financial assistance (in shillings) | | |
|-----------------------|--|-------------|--------------|
| | 1–1,000 | 1,000–4,000 | 4,000–12,000 |
| Rural | 43% n=7 | 17% n=3 | 40% n=4 |
| Urban | 3% n=1 | 60% n=8 | 37% n=6 |

Uncorrected chi2 = 8.5254
P= 0.0389

Finally, a large portion of the expenses funded within the household came from available cash (44 percent) and only a small portion from the sale of livestock and poultry (3 percent) or of valuable assets (1 percent).

5. Reforms in Health Sector Financing

Based on the 1999 National Health Accounts estimation, total expenditure in the health sector was Tsh 275.5 billion (US\$361 million) in Tanzania. Households provide the largest portion of funding (47 percent). The government of Tanzania and donors provide equal proportions of funding, 22 percent and 23 percent respectively. For 1999/2000, total health spending by the Ministry of Health amounted to Tsh 51.5 billion (US\$67.5 million). Total annual health expenditure averages US\$11.34 per capita, with households spending an average of US\$5.35, districts US\$2.22 and the Ministry of Health US\$2.12 per capita annually.

Overall, 53 percent of total annual health expenditure is directed towards hospitals and 19 percent towards health centers and dispensaries. Public sector providers receive up two-thirds of these expenditures. More than half of the expenditures were spent on inpatient care (56 percent) while 25 percent was spent on outpatient care and 19 percent was spent on prevention.

The health sector in Tanzania has faced budget shortages for many years. To address the under funding of health services, a number of strategies have been introduced. These include user fees, community prepayment schemes, and the development of a health insurance scheme for civil servants.

5.1 User Fees

As mentioned earlier, in 1993, the GOT, which previously had provided services free of charge, instituted user fees in phases beginning with district hospitals in order to generate additional revenue to supplement declining government expenditures. A national waiver and exemption policy was developed for the poor, children under five, pregnant women, patients with epidemic diseases as well as for specific services such as family planning services. There is mixed evidence on whether the introduction of user fees are linked to a decline in service utilization. National cost sharing guidelines were developed outlining the charges for services at all levels of the public health care system. One year after the introduction of user fees in the public sector, the number of outpatient visits to public hospitals declined by 53 percent (Hussein and Mujinja, 1997). However, the utilization of private health services remained constant during the same time period. Hussein and Mujinja suggest that further research is necessary to determine whether the drop in utilization of public services represents a lack of access by the poor to these services.

Another study finds that the fall in the number of births attended by a skilled birth attendant during this same period is a result of the introduction of user fees (Kwast and Vickery, 1998). In a survey of 30 districts, the main reason for women giving birth at home was the prohibitive costs of giving birth in a health facility. Women were required to purchase drugs and supplies as well as fund health procedures during complicated deliveries (Muhimbili University College of Health Sciences, 1999). A study in Zanzibar also finds that costs were the main reason for not attending health facilities. These costs ranged from Tsh 2,000 (US\$2.50) to Tsh 20,000 (US\$25) and included the purchase of drugs, gloves, needles, and syringes (UNICEF, 1998).

On the other hand, a government evaluation conducted in 1998 concluded that user fees did not affect attendance or pattern of utilization of services in public hospitals. However, the shortage of drugs and medical supplies continued to exist. Furthermore, the evaluation found that the policy on waivers and exemptions had been variably applied across public hospitals (GOT, 2001).

5.2 Community Health Fund

The Community Health Fund (CHF) was established in 1996 with one pilot district (Igunga) and subsequently rolled out to nine other districts in 1999. 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 (Chee, Smith, and Kapinga 2002).

CHF is a community prepayment scheme allowing contributors to access a basic package of curative and preventive 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. The CHF is implemented differently by different districts: while in most districts the CHF covers primary care services at health centers and dispensaries, the CHF in Songea district offers three levels of membership and allows members to pay for different levels of care, including outpatient and inpatient treatment at mission hospitals (Chee, Smith, and Kapinga, 2002). Contributions are set by the community and made by households on an annual basis. Households that contribute to the scheme are exempted from fee-for-service payments at dispensaries and health centers. Those community members who do not belong to the CHF are required to pay fees when seeking care. CHF membership fees are pooled at the district level and are currently being matched by the central government. User fees are also added to this pool. The District Health Board along with the CHF Ward Committee then determine how to allocate the funding. An exemption policy exists to ensure that families who cannot afford to pay the membership fees obtain a free CHF card.

The Ministry of Health and the World Bank have conducted several evaluations of the CHF. The results from these evaluations have been mixed. Most notably, in 1999, the World Bank conducted an in-depth evaluation of the Igunga district in order to make recommendations for improvements prior to rolling out to other districts. Select recommendations from the evaluation are as follows: improve the attitudes of health workers, a key determinant in the community's decision to join; increase health workers' understanding of the CHF program; ameliorate the referral system; increase CHF members' representation in management and administrative activities as well as decision making about use of funds; and increase communities' understanding of the exemption system (World Bank, 1999).

A recent evaluation conducted in a nearby district (Hanang) reveals ongoing problems with level of membership fees in relation to benefits, financial management, and record keeping. The evaluation also found that enrollment rates are low. User fee revenues continue to exceed pre-payment revenues. Furthermore, member households used health centers and dispensaries, on average, 32 times during an 11-month period. As enrollment rates rise, the health system incurs greater costs because revenues from enrollment do not cover the value of the services used. Raising user fees to increase the sustainability of the scheme and increase the incentives for households to enroll in the CHF may not benefit the poor because this group already cannot afford the enrollment fee. According to many users and health personnel, however, quality has improved in terms of drug supply and other structural measures (Chee, Smith, and Kapinga, 2002).

A recent analysis of the CHF by the World Bank Institute cites three key criteria that contributed to the success of the CHF: an affordable prepayment membership fee, financial incentives for people to join, and effective social mobilization (Shaw, 2002). However, Shaw also finds that: user fees are probably not high enough to make prepayment attractive; the limits on curative care at district hospitals and the absence of alternative public providers within the area undermine the appeal of the benefits; management autonomy is not fully achieved; and the exemption policies undermine the financial sustainability and membership pool of the scheme.

5.3 National Health Insurance

A national health insurance plan was introduced in July 2001 to cover all civil servants for inpatient and outpatient care (Chee, Smith, and Kapinga, 2002). Its planned expansion will include all formal sector employees. Contribution rates have been set at 6 percent of salary with the employee and employer each contributing 3 percent. The plan will give members access to a pre-established package of services from any public or private institution that has been accredited by the Insurance Fund (a semi-private institution). Currently, contributions are being withheld from government employee salaries and public facilities are providing services under the plan (GOT, 2001).

5.4 Decentralization

The health sector reforms are closely linked with Local Government Reforms, which aim to decentralize personnel, planning, and financing decisions of service delivery to the districts, and Civil Service Reforms. As of January 2000, 35 districts had been decentralized. Forty-five more districts were to be decentralized by January 2001 and the remaining ones by January 2002 (GOT, 2001). Districts will be responsible for staffing decisions and will set service priorities. District health plans will be funded through block grants, in addition to donor funding provided through the basket financing mechanism. A significant emphasis has been placed on human resource development to ensure adequate planning and budgeting of services. Until now, districts have had difficulty in taking greater responsibility for service delivery, integrating health services with other district managed services, and building local capacity. Coordination between local government and health sector reform programs has also been weak. Implementation of health plans will be monitored and additional funding will be withheld if standards of achievement are not accomplished. The Ministry of Health will retain control of policy, regulatory, and strategic functions and will also continue to provide certain essential services including immunizations, family planning, and the treatment of chronic illnesses, tuberculosis, and leprosy.

6. New Directions in Development Assistance

Over the past two years, Tanzania has worked towards establishing a solid economic performance record. In 2000, the government developed the Tanzania Assistance Strategy, which provides a broad strategic framework for more effective use of resources to combat poverty, and the Poverty Reduction Strategy Paper (PRSP), which details benchmarks and actions for poverty reduction in the medium and long term. In November 2001, Tanzania became the fourth highly indebted poor country (HIPC) to reach the “completion point” under the enhanced HIPC initiative⁵ and had its debt burden reduced by 54 percent (International Monetary Fund, 2001). Reducing the maternal mortality rate from 529 deaths per 100,000 live births to 450 per 100,000 by 2003 is cited in the PRSP as one target, as is increasing coverage of births by trained personnel to 80 percent of all births. The PRSP progress report from August 2001 states that coverage by trained personnel attendants did not increase substantially in 2001 but is expected to accelerate following the preparation and adoption of District Health Plans in 82 of 114 districts. Other health targets include reducing the infant mortality rate from 99 per 1,000 in 1999 to 85 per 1,000 by 2003 and reducing under five mortality from 158 to 127 per 1,000 by 2003. By 2010, the PSRP aims to contain the number of seropositive pregnant women between 6 percent and 27 percent, restore life expectancy to 52 years, and reduce the death rate of children under five due to malaria to eight.

SWAps

A Health Sector Wide Approach was adopted to support Tanzania’s HSR Programme of Work. The goal of the health SWAp is to pool or “basket” non-earmarked resources (government and donor) to support the program. Seven donors have signed up to provide funds for the health basket (the British Department for International Development, Ireland Aid, NORAD (Norwegian Agency for Development Cooperation), Danida (Danish International Development Agency), Swiss Development Corporation, the World Bank and the Netherlands). The level of donor funds under SWAp arrangements have increased by almost 150 percent from 1999 to 2000 (Kamuzora and Toner, 2002). The GOT would welcome more donors but for some agencies (United Nations, European Union, U.S. Agency for International Development) rules and procedures preclude them from participating in such an arrangement (Brown, 2000).

⁵ This means that the country has implemented key, predefined structural reforms. At such time, countries receive their full package of debt relief.

7. Implications for Maternal Health Financing Policies

The decline in births occurring in health facilities as well as the decline in the number of skilled attendants at birth are two worrisome factors contributing to the high maternal mortality rate in Tanzania. Further research to understand this decline would be beneficial, in addition to research on factors affecting the shift in provision of antenatal care from nurses and midwives to less well trained health personnel (Tanzania National Bureau of Statistics and Macro International, Inc., 1999).

As one step towards improving these outcomes, the inclusion of maternal health indicators in the PRSP shows a clear commitment towards improving maternal health, particularly by increasing attendance at birth. SWApS also have potential for success in reducing maternal mortality rates in that they eliminate duplication of efforts by donors and provide a single policy for governments to implement. Tanzania has included an impact indicator on the maternal mortality rate to monitor the HSR Programme of Work, which the health SWAp supports. For the period 2001-2002, donors supporting the health sector through basket funding have pledged Tsh 86.5 billion. However, these pledges were largely targeted at district health services focusing on malaria, childhood diseases, HIV/AIDS, tuberculosis, leprosy, and malnutrition. There has been no mention of maternal health.

Financial barriers to access antenatal care services do not seem to be a factor in Tanzania. The high rate of access to antenatal care could largely be a result of these services being provided free of charge to a majority of women. The low cost burden of drugs and transportation related to receiving antenatal care also contributes to the high accessibility of these services.

While a majority of women who deliver in a health facility receive delivery services, drugs, and transportation free of charge, the percentage that does incur some delivery-related expense is appreciably higher than the percentage that incurs an antenatal care-expense. That is, among women who had vaginal deliveries, 16 percent paid for delivery services, 24 percent paid for drugs and medical supplies, and 20 percent paid for transportation. These percentages are even higher for women who delivered by caesarian section: 22 percent paid for delivery services, 46 percent paid for drugs and medical supplies, and 44 percent paid for transportation.

The findings from this data analysis are similar to those from other studies, which found that the costs of drugs and emergency transportation prohibit access to delivery services in health facilities. For example, current Tanzanian policy requires that maternal health services such as deliveries are to be free. However, the World Bank's evaluation of the CHF in Igunga district found that some women, despite being members of the CHF, are charged between Tsh 2,000 and Tsh 5,000 for delivery services. Many of these women are referred to regional hospitals and pay between Tsh 50,000 to Tsh 70,000 for transportation. Women also reported having paid for drugs and/or supplies.

Further research would be beneficial to determine the extent to which financial costs can explain the low level of delivery in health facilities and, more broadly, to contribute to the body of knowledge on the impact of user fees on service utilization. Findings could solidify support for a national waiver and exemption policy, determine which key costs incurred by pregnant women should be waived to

improve access to delivery services and skilled attendance at birth, and push for the policy's more consistent application.

Given that risk pooling is currently low and households provide the greatest proportion of funding in the health sector, the expansion of the CHF to cover all districts by 2003 could prove to be another key mechanism for improving access to delivery services. The CHF, by waiving membership fees for families who are unable to afford them, contributes to improving equity in access to services. In terms of maternal health services, this policy directly targets poor women who are less likely to deliver in a health facility and less likely to have skilled birth attendants. As exemplified in the data analysis, insurance or employer reimbursement is very low and could be improved through both the roll-out of the CHF as well as the expansion of the national health insurance scheme, which currently covers only government employees. From the data analysis, given that the level of repayment is high in comparison to the costs incurred by women for antenatal and delivery services, insurance schemes would significantly reduce the financial burden incurred by women delivering in health facilities.

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