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EXECUTIVE SUMMARY

This work articulates the objectives identified by YAV to examine issues of cost sharing in health care provision specifically on levels of accessibility and affordability to health care services by various groups of services users and their degree of ownership and management of health care services at the same time reflecting on service providers' accountability and transparency in health service provision in Kinondoni, Ilala, Temeke and Kibaha district councils.

Through surveys and in-depth interviews conducted with both service users and service providers the study found that levels of affordability and accessibility to health care services by most service users are very minimal. Exempted groups of pregnant women, children under five years and the poor have limited access to health care services because in some situations told to pay for services or to buy necessary medical items which are supposed to be provided by the government. As confirmed by both service users and service providers the source of great discrepancy between theory and practice with regard to exemption and waiver is the unwillingness and lack of commitment by the government to provide required financial resources.

The sense of community ownership of health services and management of the same is very low among service users. Still there are strong feelings among service users that health care provision is the responsibility of the government. Most service users are not even aware of the modality of community representation in health boards and committees and thus they feel they are not involved in the whole process of health care provision. However, this study found that service users are well represented in management boards and committees, the only problem is that the representatives do not feel moral obligation to communicate what transpires in boards and committees to community members.

The level of accountability and transparency by service providers in health services provision is not sufficient. Lack of accountability by health providers is partly the result of lack of enough financial and human resources to take good care of service users. Transparency level is very low due to poor communication of information between health care providers and service users and no enough efforts that have been made to put in place mechanisms for efficient flow of information between the two parties. Mechanism of communication through community representatives is still ineffective. Less than half of health facilities involved in this study displayed any information regarding revenue, expenditure and planning of health facility/hospital on notice boards. Lack of transparency is the source of service users to accuse service providers for embezzlement financial resources but the fact is that the government is not providing enough funds.

LIST OF ABBREVIATIONS

CHF …… Community Health Fund

DANIDA……. Danish International Development Agency

HIV/AIDS …….. Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome

MDGs..... Millennium Development Goals

MKUKUTA..... Mkakati wa Kukuza Uchumi na Kupunguza Umaskini

OPD …… Out- Patient Department

SPs …… Service Providers

SUs …… Service Users

TGNP..... Tanzania Gender Networking Programme

TOR ……. Terms of Reference

URT ……. United Republic of Tanzania

WHO…… World Health Organization

YAV ……. Youth Action Volunteers

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1. Introduction and Background

In 1948, in its constitution, the World Health Organization (WHO) defined health as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. The definition was updated in the 1986 WHO "Ottawa Charter for Health Promotion" to say health is a "resource for everyday life, not the objective of living" and "health is a positive concept emphasizing social and personal resources, as well as physical capacities". Health is considered a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest standard of health conducive to living a life in dignity[1].

Like many Sub Saharan African governments, the government of the United Republic of Tanzania embarked on health sector reforms in the early 1990s following the global and national economic recession in the end of 1970s and early 1980s. Since then there has been a number of health reforms and multi- sectoral framework implementations which witnessed the need for involving community members (services users) to contribute part of their funds as part of cost sharing and user fees as an alternative way of improving provision and access of health services.

These efforts have also focused on enhancing accountability and transparency with the rationale that if community members contribute they can own, control, and influence better changes that would address their health needs. In this course, therefore, some community members in different districts have been informed to incur their own costs to join community health funds under schemes such as prepaid community health insurance commonly known as Community Health Fund (CHF). In Tanzania this has been the case in districts such as Igunga and Songea Rural. Some have been automatically granted waivers[2] and exemption[3], and processes towards implementation are still going on.

A cost sharing operationalisation tool has been in place since 2002. Although this manual has accounted five years, the problems of waivers and exception are increasingly stated. The government of the United Republic of Tanzania is very optimistic[4] that community contributions can enhance availability of quality health

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[1] The South African Human Rights Commission in 2007 cited this Article as a *General comment* No.14 (2000) The Right to Highest Attainable Standard of Health (Article 12 of the International Covenant of Economic, Social and Cultural Rights), for further clarification read for example, NUN Committee on Economic, Social and Cultural Rights, 2000, paragraph 1

[2] A waiver is granted to those patients who do not automatically qualify for statutory exemption but are in need of the same, and classified as 'unable to pay, in the operationalisation manual. See for example, Tanzanian Review of Exemptions and Waivers, February 2006, submitted to Ministry of Health and Social Welfare, p. 6

[3] An exemption is a statutory entitlement to free health care services, granted to individuals who automatically fall under the categories specified in the cost sharing operationalisation manual; MCH services, including immunization of children in all Grade III services; children of 5 years of age and below; patients suffering from TB, leprosy, paralysis, typhoid, cancer and HIV/AIDS; cholera, meningitis, plague, and long term mental disorder (according to CHF design manual)

[4] The Act for establishment of Health Boards Section 8 No 7 of 1982 has this core objective as it works in line with local government reforms and decentralization of health services at grassroots levels. Read also Mwongozo wa Utekelezaji wa Sera ya Wananchi Kuchangia Gharama za Huduma za Afya Katika Hospitali, 2nd Edition, December 1997, p.1

services and in due course, this can increase degree of good governance particularly transparency and accountability in participation that would address poor people's health care needs. The government through health board and committee members in districts and wards understands that specific people entitled under these services will be identified and their needs will be presented in respective health bodies. These service providers have also the roles of recommending any other sick people who might be in critical ill situation to get the same health services. Exemptions are automatically granted to all maternity services, children under five years and particular diseases such as TB/Leprosy, HIV/AIDS, cholera, sickle cell anaemia, and some chronic diseases that could drain substantial income from the patients if they were asked to pay. While waivers cover cases that are in need of exception, for example the "poor" but do not automatically qualify. However if patients are noted in the latter service they follow the same channel of services (Tanzania Review of Exception and Waivers, 2006, p.19).

While there are some levels of success on some of these schemes and regulations, but it is largely stated that these schemes and regulations above seem to have proved failure[5] in most areas where they operate due to lack of balance of people's income capacity and the nature of services being provided at health facility level. Failure of community health funds in urban areas is a good example, and drop out of some community members from CHF in rural areas where CHF has taken off in about 78 rural districts is another good case to argue for. Another very important scenario is that majority people with insecure income in both rural and urban cannot either afford user fees or share the associated health service costs. When they try to meet those charges they don't access important health services like drugs at health facility. Some have argued that due to abject poverty (low per capita income) the majority poor in urban and rural areas lack ability to afford those costs. Moreover, it is stipulated that some health services for people who fall under waiver and exemption have more or less marginalized and stigmatized the service users respectively[6].

At another point in this era of reforms the discourse has revolved around relationship between the position of service users (the community members) and accountability and transparency of the funds that is managed by different health service provider (the government, health boards and committees) and drawing the relationship of the service users (the community members) participation at various levels. Moreover there has been a question that reflects the roles and possibilities of these actors in supporting the poor people and health facilities in their areas of jurisdictions toward protection and promotion of their health rights for service users under waiver and exemption and other people. All these remain as paradoxical issues as the government keeps on reforming health service delivery systems in urban and rural areas.

In that milieu therefore, there is a great discourse going around in the public health sectors on the state of cost sharing, user fees, waivers and exemption in relation to

[5] The URT government despite of these notable lessons and challenges still insists promotion of these services. Speaking during Health Financing Workshop on 3rd May 2005, held at Golden Tulip Hotel Dar es Salaam, the then Deputy Minister of Health, Dr. Hussein Mwinyi noted that these schemes empower community members regain more power to influence and demand good governance-transparency and accountability in their communities.

[6] See for example "Save the Children" in the report titled The unbearable cost of illness; Evidence from Lindi District, 2005

provision of quality health care services. These debates cannot be taken for granted as majority poor people who face many health problems (diseases) need better access and affordable quality health services at their health facilities in their community and society levels from the fact that access to quality health services for all citizens is their fundamental right[7]. This position is highly informed in the government health reforms since 1993[8] to ensure that during implementation of new financial systems the poor people and vulnerable groups' needs will be protected to ensure that they have access to quality health services. It was under these auspices that this study was designed so as to be able to contribute to approaches, strategies and multi-sectoral framework implementation in place, which aim to improve quality health services at community level for the betterment of all people.

1.1 Problem Statement

In a way of adhering to article 16 of African charter on Human rights, Tanzania initiated cost sharing in public hospitals in 1993 with the intent of reducing the financial gap, improving availability and quality of health services and increasing ownership, demand and community participation. At all public health facilities primarily financed by government and donors, income from user charges are retained locally to complement government resources (DANIDA 2005 & http://www.diplomacy.edu/africancharter/acharter_rights.asp)

There has been a plethora of literature showing a significant discrepancy between theory and practice since the implementation of cost sharing. There is a general agreement in the literature on the existence of practical weakness of cost sharing but again there are dissensions on the root causes of the inefficiency of the program (Jaffari, 2004). This study, among other issues was geared towards addressing the gap between theory and practice of cost sharing in provision of health care services and subsequently devising down-to-earth recommendations.

1.2 Objectives of the Study

Objectives of this study were prescribed by the Terms of Reference for the work (attached in Annex 1) and categorized as General and Specific Objectives.

1.2.1 General Objective

The study aimed at examining the relationship between cost sharing, user fees and waiver and exemption as alternative service provision approaches towards improved

[7] Service Client Charter 2004 issued by Ministry of Health and Social welfare states very clearly on the mission and vision of the URT government. The need is to reduce all health problems, first by recognizing that all community members need equal treatment in health services but second to meet the National Development Vision 2025 and Millennium Development Goals 2015 on the objective of health. The above action goes parallel with other established and implementation of various health guidelines like CCHP, HIV/AIDS multicultural frameworks, MKUKUTA approaches, etc.

[8] Mwongozo wa Utekelezaji wa Sera ya Wananchi Kuchangia Gharama za Huduma za Afya Katika Hospitali, 2nd edition, December 1997, p.1

quality health services among the poor people in urban and rural areas and to contribute to the new approaches towards realization of National Vision 2025 and Millennium Development Goals 2015.

1.2.2 Specific Objectives

The following are specific objectives of the study;

i. To examine the relationship between cost sharing, waiver and exemption to accessibility, affordability and provision of quality heath services at health facility level.

ii. To examine the relationship between cost sharing, waiver and exemption on ownership and management of health service provision by users

iii. To examine the relationship between cost sharing, waiver and exemption on service providers accountability and transparency in healthy service provision to users

iv. To critically discuss recommendations (based on respondents and key informants) on measures to enhance quality health service provision and transparency and accountability at health facility level.

2. LITERATURE REVIEW

Tanzania initiated cost sharing in public hospitals in 1993 with an intention of reducing the financial gap, improving availability and quality of health services and increasing ownership, demand or community participation. Cost sharing has been introduced at lower level public facilities in some municipalities (including Dar es Salaam), and beginning in 1998 it has been rolling out at district level together with the introduction of Community Health Fund (CHF). By March 2005, 42 districts had initiated cost sharing for facilities below hospital level (DANIDA, 2005).

Cost sharing in health service delivery was part of Structural Adjustment Programmes (SAPs) which were started in 1980 by the World Bank. Before 1980, finance by the World Bank was project finance, which was a very long duration loan concentrating on infrastructural projects. In 1980, the World Bank changed its emphasis from project finance to Structural Adjustment Programmes, which are quick disbursing loans to avoid balance of payment deficits and to enable the adjusting countries to meet their debt obligations (Muneef, 1996).

Mapunda (2005) states that in an effort to stem the deterioration of the health system and address systemic financing, service delivery and management concerns, a Health Sector Reform (HSR) program was initiated in 1995/96 including a move to decentralize authority and resources to the district level. The reforms centre on key issues that affect health service delivery: equity, efficiency, cost-effectiveness and

quality of care. The 2003-2006 Health Sector Strategic Plan (HSSP) is the most recent elaboration of Ministry of Health objectives to implement services in the country. It states a particular commitment to reaching vulnerable populations--to increase access and utilization of health services, improve the quality of services, and to ensure equity in allocation of resources.

In the same context, provisions for exemptions and waivers within the cost recovery programme were introduced with a view to protect vulnerable social groups and the very poor. An exemption is an automatic entitlement to free public health care services and is extended to children aged five years and under, for Maternal and Child Health (MCH) services, to those with specific diseases, and for people with long term mental disorders. Exemptions, as such, are not necessarily confined to the poor. They are designed to protect vulnerable social groups. A waiver on the other hand is a conditional temporary entitlement that is provided after evaluations by the relevant authorities (URT, 1997). It is to be granted to patients who do not automatically qualify for exemptions but are considered to be in need of such services and are "unable to pay".

Despite the concrete objective behind cost sharing, there have been counter arguments on the way it enhances quality health care services as intended. Results of a baseline nationwide Service Delivery Survey (SDS) carried out by Tanzania Development Research Group (TADREG) for example indicates that even though three-quarters (75%) of the villagers were concerned about the costs of health care, a majority (71%) still expressed a readiness to pay more for health services, provided the quality of services improved. While people are willing to pay for care if quality is good, this pre-condition does not in general appear to exist. Public perceptions on accessibility to health care reveal that, overall; health services continue to fail the very poor. Deteriorating roads coupled with inadequate and unaffordable transport make it impossible for the poor to reach facilities. Poor women face particular obstacles as they have neither the time, money, nor necessarily the incentive to access distant and low quality care (Maggie and Masuma, 2004). This is contrary to MDGs and guidelines from MKUKUTA for health development.

More specifically, other literature denotes that pregnant women and rural poor are unable to access crucial medical services, although these groups are supposedly exempted. These, especially the women, are the same groups that are doubly taxed, in that they are contributing to the future workforce of the country and then are required to pay for doing so. Women give involuntary subsidies to the health sector in various ways, including caring for the infirm at home, and they should get some benefit. The government has yet to make this connection between the health of the people and the unpaid labour of some groups such as women. Apart from contributing to foreign exchange revenues through production and paying their taxes, they feed most of the patients in hospitals (TGNP, 2003). On top of all that and cost sharing, they have to bring all important items during delivery when it is hypocritically claimed that mothers and children under five receive free treatment.

As already indicated, although the government's overall objective of providing health status for all Tanzanians remains the same, observations show that there is an increased move towards privatisation and the public health sector is increasingly deprived of vital funds. In this process marginalized groups are increasingly impacted.

This is not to argue that the government needs to get rid of cost sharing in the health sector, rather this system should be re- examined as the health of Tanzanians is crucial to development of the country. The Public Health System is the right of all Tanzanians, who contribute to government revenue. If the government can shirk some of its responsibilities, it cannot do so for health. The private sector has an important role to play but the Public Health System should be the backbone of health services the country (Msambichaka and Mjema, 2003)). Otherwise the lives of the citizens would be at risk, as so many examples have begun to emerge showing this.

3. METHODOLOGY OF THE STUDY

According to TOR, the approach to this study aimed to capture qualitative and quantitative data. This section therefore presents the methodology used to undertake the study in order to address the study objectives.

3.1 Study Area

The study was conducted in Temeke, Ilala, and Kinondoni in Dar es Salaam region and Kibaha district in Coast region. This was informed by the rationale of YAV strategic plan of 2006-2009 which covers health facilities within three municipals in Dar es Salaam region namely Temeke, Ilala and Kinondoni and one district in Coast region namely Kibaha. The former was chosen to represent urban and semi urban areas whereas Kibaha represents semi-urban and rural areas.

Within each municipality in Dar es Salaam, the study covered each municipal hospital (Temeke, Mwananyamala and Amana) and two health centers (Mbagala Rangi Tatu and Tabata). Intentionally it was also to cover Magomeni Health Center, however the permit was not granted by responsible official on grounds not well understood by the consultants. For Kibaha District, the study covered Mkoani and Mlandizi Health Centers.

3.2 Study Design

Interventive-descriptive study was conducted with health Service Providers (SPs) and Service Users (SUs) who were randomly selected from public health facilities and sampled from four districts namely; Kinondoni, Ilala, and Temeke in Dar es Salaam region and Kibaha in Coast region. As already noted, the study targeted Service Users (the community members) and Service Providers including the government health boards and committees. Triangulation method was used to reduce biases inherent in one data source and with the aim of complementing data source. Triangulation involves drawing on qualitative and quantitative data collection procedures (Creswell 1998:202)[9]. The qualitative data collection method

[9] The use of multiple and different sources, methods, investigators and theories to provide corroborating evidence is well emphasized by many social science researchers. See for example; Creswell, J. W (1998), *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*, London, Sage Publications

(in-depth interviews) and quantitative data collection method (survey/ questionnaires) were designed to provide insights on the relationship between cost sharing, user fees, waiver and exemption as alternative service provision approaches towards improved quality health services among the poor people in urban and rural areas.

Survey Method was used and administered by the consultants in order to draw out both demographic and descriptive information from the respondents, while in-depth interviews were used so as to examine different levels of understanding the relationship between cost sharing, user fees, waiver and exemption to not only accessibility, affordability and provision of quality health care but also to issues related to ownership, management, accountability and transparency by both Service Users and Service Providers.

3.3 Study Population

The study involved selected/sampled population from health service users and providers (SPs and SUs). The rationale behind the involvement of SPs and SUs as stated was informed by YAV's current Programme Strategy (2006- 2009) targeting realization of outcomes such as; youth awareness, knowledge and active participation in health sector and tracking of health resources; and accountability and transparency of local government authorities and health service providers to the public in matters pertaining an access to information on health sector planning and implementation.

In this setting therefore, experience from SPs and SUs were seen as significant from the fact that they are involved not only in day to day health service operation, but also they are key actors in issues related to cost sharing, user fees, waiver and exemptions as alternative service provision approaches towards improved quality health services among the poor people in urban and rural areas. Qualitative and Quantitative data drawn from SPs and SUs were supplemented with information from related literature and sources such as Ministry of Health and Social Welfare and other deemed necessary institutions.

3.4 Sampling Technique

The study involved triangulation sampling techniques namely accidental sampling and purposive sampling. Accidental sampling was employed in sampling of out-patients and relatives of both in-patients and out-patients while purposive sampling was employed to sample in-patients and service providers.

Accidental sampling involves the inclusion of anyone who is handy at the time of the study due to unavailability of sampling frame (Powell, 2005: 68 and Boxill, 1997: 36). Therefore out-patients were interviewed at the exit of health facilities. In purposive sampling which is popular in qualitative research, subjects are selected because of some characteristic on the basis of knowledge of a population, its elements and the purpose of the study (Patton, 1990 and Babbie, 2004: 183). This sampling

method was used to identify pregnant women, relatives of under- five children, patients with exemption diseases, under waivers and elders above 60 years.

3.5 Data Collection Techniques

As noted in section 3.2, data collection was effected through triangulation method, which is the combined methods of study in which multiple methods of data collection are used with the aim of minimizing bias inherent in particular data sources and complementation of data sources (Creswell 1998:202). This study involved the use of survey questionnaires and in-depth interview methods of data collection. All in-depth interviews were tape-recorded and later transcribed in order to be analyzed.

In-depth interviews were geared towards realizing the objective of describing, analyzing and illuminating issues related to respondents' awareness on cost sharing, user fees, waivers and exemption in health sector systems. In-depth interviews were purposely designed to meet the objective of describing, analyzing and providing a clear picture of how individuals live and experience cost sharing, user fees, waivers and exemptions. In-depth interviews involved health workers/ providers (Service Providers) and in-patients (Service Users) who are parties in these forms of service provision approaches. All potential issues in questionnaires were included in the in-depth interviews guides.

Semi-structured questionnaires were administered to both Service Users (in-patients and out-patients) identified through accidental sampling procedure regardless of whether they have been involved in alternative service provision approaches (cost sharing, waivers, user fees and exemption). This method was used to validate factual data on categories of health care providers involved in these approaches and their levels of involvement, operations, roles and management of health resources in provision of quality health services in their areas.

3.6 Data Analysis Techniques

Both qualitative and quantitative techniques of data analysis were used. After fieldwork, the tape-recorded qualitative data were transcribed. For the purpose of qualitative data analysis software package called N6 was used. Quantitative data were be coded, entered and analyzed by using Statistical Package for Social Science (SPSS version 11.0) to provide Chi-square tests and tabulations.

4. RESEARCH FINDINGS ON COST SHARING

4.1 Demographic Information

Table 1 shows some of the demographic information of the people who were involved in the study. Most of respondents were drawn from Dar es Salaam region and this has to with the fact that the study visited most of health facilities/hospitals of the region. Also most respondents interviewed were drawn from hospitals than health centres given the fact the number of patients who visit hospitals are bigger than that of health centres. The study managed to interview more patients than their relatives as it is indicated in the table. Always the number of out-patients is bigger than the number of in-patients and this is reflected in the findings. As the table indicates, more females tend to visit health facilities than males.

Table 1: Demographic Characteristics

Variable	Frequency	Percentage
Region:		
Dar es Salaam	238	79.6
Coast	61	20.4
Facility Status:		
Hospital	179	59.9
Health Centre	120	40.1
Name of Facility:		
Mwananyamala	65	21.7
Amana	53	17.7
Temeke	21	7.0
Tabata	40	13.4
Mbagala R/Tatu	31	10.4
Mlandizi	30	10.0
Mkoani	59	19.7
Status of Respondent :		
Patient	184	61.7
Patient's Relative	114	38.3
Type of Patient :		
In- patient	144	48.6
Out- patient	152	51.4
Sex:		
Male	44	14.9
Female	252	85.1
Age:		
Below 16	1	0.3
16- 25	102	34.3
26- 35	124	41.8
36- 45	34	11.4
46- 55	19	6.4
56- 65	10	3.4
More than 65	7	2.4
Education:		
Illiterate	31	10.7
Primary	208	72.0
Secondary	44	15.2
University/ College	6	2.1
Occupation:		
Formal Employment	27	9.7
Self Employment	21	7.6
Small Scale Businesses	105	37.9
Street Vendor/ Hawker	3	1.1
Student	12	4.3
Others	109	39.4

N=299

4.2 Understanding/ Knowledge on Cost Sharing, User Fees, Waiver and Exemption

The study tried to measure general knowledge of health care service users on existence and provision of the service through user fees, waiver and exemption systems. The service users seem to have a generalized knowledge on the systems and knowledge scores on each category is not significant enough as indicated in Table 2. Although it was found that the number of service users who were aware of cost sharing in each category outweighed the number of those who were not aware, still it comes from the fact that a significant number lack a mere knowledge of the existence of the system and this casts doubts on the acceptability of the system itself. As indicated in the table below exemption system is well known among service users than user fee and waiver system and this observation is in line with the observation made by Euro Health Group (2006:9).

Table 2: Knowledge on Cost Sharing

Category	Yes	No
User fees	59.6%	40.4%
Waiver	55.5%	44.5%
Exemption	71.0%	29.0%

N=299

As indicated in the table below the knowledge on cost sharing varied across education levels whereby those with high education having high knowledge than service users with low education with regard to user fees (P=0.127), waiver (P=0.000) and exemption (P= 0.005) and the variation of knowledge across education levels is statistically significant, except for user fees category.

Table 3: Knowledge on Cost Sharing across Education Levels

Category		Yes	No
User Fees	Illiterate	66.7%	33.3%
	Primary	57.5%	42.5%
	Secondary	69.2%	30.8%
	University/ College	100%	0%
Waiver	Illiterate	30%	70%
	Primary	53.7%	46.3%
	Secondary	85.4%	14.6%
	University	100%	0%
Exemption	Illiterate	70%	30%
	Primary	66.8%	33.2%
	Secondary	92.7%	7.3%
	University/College	100%	0%

N=299

Further weakness on the knowledge ability of service users on cost sharing were very much reflected through various interviews and the following are typical responses:

> Nimeshawahi kusikia nikiwa kwetu Mahenge, tunachangia hela kwa ajili ya kupata matibabu. Ila sielewi ni kwa nini, labda kwa kuwa huduma za hospitali ni ndogo. Msamaha ni kwa ajili ya wazee wa miaka sitini na watoto wa miaka chini ya mitano. Mimi kwa kweli sijawahi kuchangia, ingawa nikienda hospitali huwa naambiwa ninunue dawa ninapokuwa na homa ndogo ndogo ninapotaka kupiga sindano naambiwa nkanunue bomba, au vidonge (Service User, In-patient, Mlandizi Health Center, 11th September 2007)

Literal meaning:
I heard about it when I was in Mahenge, we contribute for health care but I don't know why, waiver is for the elderly who are in the sixties and under five children. Personally I have never contributed although I am told to buy medicine when I have mild fiver, when I go for injection I am told to buy syringe or drug.

> Nimeshawahi kusikia, inatakiwa utoe kiasi kidogo cha pesa kwa mfano wakati wa kwenda kuandikisha kadi lazima ulipie kadi, kwa mtu mzima lakini si kwa mtoto, kwa mtoto hulipii lakini, ingawa mambomba ya sindano tunaambiwa tulipie, na hizi sirapu nyingi lazima ununue. (Service User, In-patient, Amana Hospital, 7 September, 2007)

Literal meaning:

I have heard about it, you need to provide a small amount of money to get a card if you are an adult but for children it is free although to get syringe and syrup you have to pay.

4.3 Affordability, Accessibility and Resource Allocation to Quality Health Care

4.3.1 Accessibility to health services

With regard to accessibility to health care services, service users were asked to assess the level of accessibility based on the systems of accessing the service. Most of out-patients (78.8%) reported that cost sharing policy is making them access quality health care services[10] than in-patients who reported the accessibility by 61.5% and the difference in accessibility is statistically significant (P=0.044). Also the accessibility to the services varied across categories of patients whereby 63.2% of pregnant mothers, 50% of relatives of under five children, 0% of elders aged for exemption, 62.5% of patients with exemption diseases, 100% of patients under waiver and 84.6% of user fee patients reported that cost sharing policy makes them access quality health care services and the difference across these groups of service users is statistically insignificant (P= 0.208).

Issues related to the location of health facility and transport costs to the facility were also mentioned as important factors in the access to health care as similarly observed

[10] Quality health care can be measured from service providers' and users' point of view. From service users' point of view quality health care is based on courtesy(8.4%), good diagnosis (36.4%), availability of drugs (7.7%), availability of qualified practitioners(6.1%), and 41.1% mentioned all aforementioned dimensions

by Euro Health Group (2006:27). Most service users (67.4%) were more likely to go to the nearest health facility as compared to 1.7% who reported going to the particular facility because of lack of any health facility near their home, 4.1% chose a particular facility because the services provided in the facility near their home are not adequate, 17.4% were for better services and 9.3% mentioned other factors. These reasons were similarly reflected in interviews held with some service users and the following are typical responses:

> Mimi nimezaliwa mwaka 1939 mwezi wa pili, mpaka leo ninaona nina miaka...hebu piga hesabu...mimi bado sijasamehewa, bado nalipa hospitali, nalipa kivuko, nalipa usafiri wa aina yeyote, na hapa nalipa madawa, madawa ya kutibiwa haya nalipa mwenyewe, na wala sisamehewi. Kila ninapoandikiwa dawa inaabidi ninunue zote, si unaona hii dawa hapa, imeandikwa *Fuxamox*, hii ni shilingi elfu sita, kuna *Insulin* nimenunua mwenyewe vile vile, zote hizi na nyingine nimenunua mwenyewe. Mimi naona si sawa, ila tu sina mahali pa kusema hivyo (Service User, In-patient, Temeke, 5th September 2007).

Literal meaning:
I was born February 1939, today am ….try to calculate…. I am not yet exempted, am still paying for treatment, for ferry, I pay for any transport facility, and here I pay for medicine, these medicines for my treatment are self paid and I am not exempted. I have to buy any medicine prescribed, do you see this medicine, it written *Fuxamox* it costs six thousand shillings and I have bought *Insulin* myself, all these medicine together with others I bought myself, this is not fair but I have no where to complain .

The above expression gives an impression that access to health care services was not found to be habitual even if the service user is under exemption or waiver scheme of accessing health care.

4.3.2 Resource Allocation and Affordability to health care services

The affordability of health care is most of the contested issues of cost sharing. All groups of service users reported different burning issues which makes the services out of their reach. The poor, women and children under five and the elderly are to be waived and exempted from paying for health care (URT 1997). While service users accept the rationale of cost sharing, as indicated in Table 4, users who access the service through user fee system complained much about the high costs of care amidst poverty and low income levels. Because the service users are economically incapacitated they are unable to pay full costs of care such as paying for patient card, diagnosis and medicine. Buying half dose is a common scenario among many service users and this is said to result into chronicity of afflictions as confirmed by medical professionals during the interviews.

Table 4: Affordability to Health Care

User category	Yes	No	No response
Pregnant mothers	40.4%	18.1%	41.5%
Under five children	36.9%	45.2%	17.9%
Aged for exemption	100%		
Patients with exemption disease	60.5%	15.8%	23.7%
Waiver	75.0%		25.0%
User fee patients	81.5%	11.1%	7.4%

N= 299 P= 0.000

The idea of exemption and waiver in provision of health services was found to be partially practiced and in some health facilities exemption is a myth. While service providers recognize the right of the waived and the exempted groups of people to get free health care they are at the same time in dilemma to provide the same because they are constrained by the lack of resources that are to be provided by the central government. While the government is spreading the information of improving affordability and access to health care through exemption of pregnant mothers, children under five, patients with outbreak and chronic diseases, waiver for the poor and the elderly, it is not providing enough resources, both human and financial, to cater and provide services for these groups of service users. This discrepancy between theory and practice by the central government seems to be the source of allegations made by some of service users that some service providers use resources provided by the government for personal gains.

According to the observations and comments made by service users during the study, what is waived or exempted in accessing health care is that service users are not asked to pay for the bed whenever they are hospitalized but they find themselves in a situation where they are forced to buy other services like diagnosis and medicine from private facilities. These medicine and diagnosis are normally prescribed to the patients but are not provided in the hospital. Some expectant mothers are forced to buy some items of delivery kit such as cotton, gloves and gauze as it is reflected in Table 4 with only 40.4% of interviewed expectant mother reporting to afford health care services. Despite rhetorical claims on free maternal health services the reality is that many poor expectant mothers can not access quality health care if they can not afford to buy appropriate equipment for delivery as similarly observed by Moulid (2007).

The lack of enough diagnostic and therapeutic and medicinal services in the health facilities explains well the parallel existence of a multitude of private pharmacies and laboratories in places with government owned health facilities because if services are available in the government owned facilities then private facilities can not get customers however the situation is vice versa. This observation in supplemented by observation made by Kachelewa (2007). Again some service providers have started to develop a negative attitude towards exemption and waiver because the government does not provide enough support and hence they are blamed by their customers for

substandard care provision. The following are typical responses from in-depth interviews:

> Katika masuala ya cost sharing kuna matatizo maana kuna watu ambao hawawezi kulipia na matokeo yake unakuta ana nunua nusu dozi matokeo yake mtu haponi inavyotegemewa na akisha chukua nusu dozi hamalizii dozi na matokeo yake magonjwa yanakuwa *resistant*. Hapa haturuhusiwi kutoa nusu dozi lakini unakuta mtu analalamika kuwa hana hela ya kutosha na huwezi kumuacha hivi hivi unamuuzia hivyo hivyo (Service Provider, Tabata 6th September, 2007).

Meaning:
There are problems in cost sharing because there are some people who are unable to pay for health care service and because of that they buy half dose and this makes diseases to become resistant. Ethically we are not supposed to prescribe half dose to patients but you find some patients complain that they don't have enough money for the whole dose, we have to assist them, and therefore we assist by providing them with half dose.

> Kuna mambo mengine ya kuji*risk* ambayo tulikuwa hatujui, tulikuwa tunazalisha tu bila kutumia…kujikinga na kitu chochote, lakini sasa hivi ni nafuu kwa sababu inabidi mama achangie anakuja kama hivi anakuja…kwanza kuanzia yuko ana mimba, akiwa kliniki hapa tunamuelimisha kuhusu kutayarisha vifaa vyake…eeh anapokuja wodini anakuwa angalau na kitu cha kuanzia kama ni mipira ya kuanzia kupima anakuwa nayo, sasa kuna ugumu napo wapo wengine ambao wanakuwa hawana kitu chochote hapo ndio hao tunapata nao shida. Kwa hiyo kama mipira inakuwepo, huwa inakuwepo kidogo, siku nyingine ipo wakati mwingine hamna, kama hamna ndio mnapata nao shida sana lakini kama ipo amekuja mama huyu ambaye hana kitu chochote unachukua mipira ambao uko pale unampima hata kumhudumia na kumzalisha unamfanyia kwa kila kitu kilichopo pale, sasa kama hamna unafanya kazi katika mazingira magumu sana eee…sio watu wote wanaoweza kununua vifaa, hivyo wale ambao hawawezi tunatumia vile ambavyo serikali inatoa, huwa vinakuwepo kidogo, mnaweka emergence kwa mtu ambaye hana. Mnaweka dharura, sasa kama siku hiyo vinakuwa hamna, mtaanza kushikana ndiyo hapo mnapeana lawama, unamwambia yule *relative* akanunue, sasa kama amekuja second stage hivi unachukua kama mwenzie ana mpira unamzalishia ili wakinunua unamrudishia (Service Provider, Mbagala Rangi Tatu)

Meaning:
We used to risk our lives by assisting delivery without any protection, but these days we educate pregnant mothers to prepare themselves for delivery to have necessary delivery items with them and this done when they attend clinic services during their pregnancy and when a woman is hospitalized for delivery she has something at least to start with such as gloves. But also there are some problems because there are some women who come with nothing and we are getting problems with such women. Whenever we have gloves it is always in small amount, sometimes we have gloves and sometimes we don't have, not all people can afford to buy all needed items, so for those who can not afford to buy items we use items provided by the government which we normally have in small amount, we keep some for emergence in case we receive a pregnant mother who can not afford these items, and if you also don't have emergence items that is when you start blaming each other(that is service providers and service users), or you tell the relative of a pregnant mother to buy those missing items, and if she is in the second stage to delivery you borrow gloves from another pregnant woman who has come with gloves and she has to pay back afterwards.

> Kwenye *quarter* ya kwanza ya mwaka huu nilipata only 30% of the *budget, quarter* ya pili nilipata *only* 40% kutoka wizara na pesa nyingine nategemea kutoka *cost sharing*, quarter ya nne sijapata hela, quarter hii sijapata chochote mpaka sasa, *cost sharing* napata milioni20 kwa mwezi lakini nasamehe 80 million kwa watu wa *exemption*, natumia milioni 18 kwa mwezi kuwahudumia akina mama wajawazito tu, hivyo nabaki na million 2 tu kununua dawa pamoja na mambo mengine, hivyo unakuta *budget* ni ndogo sana na kama *cost sharing* ingeendeshwa vizuri pesa hizo zingepatikana. Hivyo hata tatizo la vifaa kukosa kwa akina mama ni kutokana na ufinyu wa *budget* mpaka wengine wanalazimika kuja navyo, mama mjamzito akija hapa kujifungua anatumia minimum ya mipira pair 6 anatumia pamba nusu ya *roll* na *anticeptic*, ukipiga gharama ni kubwa. Bora wangekuwa wanaambiwa waje navyo wale wenye uwezo lakini kwa sababu wameambiwa ni bure wanakuja hapa wanakuta havipo hivyo wanalazimika kununua. Kuna wengine wenye upeo wanakuja navyo angalau *gloves* na pamba *roll, anticeptic*. Bora akina mama wangeambiwa walete vifaa mbona wengine wanapokuja kujifungua wanakuja na khanga mpya? (Service Provider, Amana, 7th September 2007).

Meaning:

In the first quarter of this year I received only 30% of the budget, I received only 40% from the ministry in the second quarter, I also depend on the money collected through cost sharing, I have not received any money in this fourth quarter up to now. I normally get 20 million monthly from user fees but i exempt 80 million for patient eligible to exemption, I spend 18 million monthly to provide services to pregnant mothers, I therefore remain with only 2 million for purchasing medicine and other items. Therefore you find that we have a very small budget and if cost sharing is conducted in a good manner this money can be available. Therefore even the problem of lack enough equipment for pregnant mothers is caused by this constraining budget to the extent that some pregnant women are forced to come with delivery equipment. An expectant mother use an average of 6 pairs of gloves, half roll of cotton and antiseptic and the cost is too high. It would have been better to tell them to come with these equipment for those who can afford them but because they have bee told that the service is free and when they find that there are no these equipment in the hospital they are forced to buy them. There some women who are bit enlightened who come with some gloves, gloves and antiseptic. It is better to tell pregnant women to come with delivery equipments because they normally afford to buy a new pair of *khanga* when they come for delivery.

4.4 Cost Sharing and Provision of Health Care Services

This study was also set to examine the relationship between cost sharing, user fees, waiver and exemption to provision of quality health services at health facility level. With that regard, the study classified issues pertaining to provision of quality health care services and its relationship to cost sharing into two areas; fairness in provision of these services (matters related to rights and whether the service users are equally treated) and freedom and handling of complaints from service users by service providers.

4.4.1 Fairness in Provision of Health Care (Equal treatment)

Albeit the fact that significant percent of the service users noted to be fairly treated by service providers in health care service delivery, still a relatively considerable percentage confirmed to be unfairly treated. These are 52.6% of pregnant mothers, 21.8% of relatives of under five, 34.3% of patients with exemption disease, and 11.5% of patients under the category of user fees. Elders aged for exemption and patients under waiver, did not report to be unfairly treated according to surveys conducted. However, the difference across these categories of service users is highly statistically significant (P= 0.000) something which denotes that together with an emphasis by cost sharing policy to enhance equity in provision of health care services, still this has not been fully achieved due to such findings. The following response from a pregnant woman can also help to demonstrate this situation;

> Kwa huduma hapo naona ziongezwe, mfano kama vile mtu anakuja anakucheki hivi, sasa kwa sababu wao ndio watoa huduma na wanajua huyu mtu mpaka ikifika muda fulani atakuwa hivi, basi ndio wangekuwa wanawajali wagonjwa unapofika huo muda, wawe wanakuja na kukuuliza unaendeleaje, sio mpaka uanze kupiga makelelee...na ukipiga makelele sana anakwambia ukiwa unaniita sana ndo siji na kweli wengine wanasimama tu na kukuangalia (Service User, Temeke Hospital, 5th, September 2007)

Meaning:

There is a need to improve services, service providers have knowledge on issues related to pregnancy and therefore they are supposed to take care of patients when the time comes by asking the progress, they should not wait until you start screaming and when you start screaming you are told screaming cant help, and this happens, they just stare at you.

Cases of misuse of waiver were also reported whereby the rich do benefit from waiver system at the expense of the poor just because of their political influence. Local government authorities and other organs responsible for authorization of waiver are said to operate subjectively under political influence. Being poor is not an automatic qualification for waiver, one need to have a political harmony with the person authorizing waivers as similarly observed by Euro Health Group (2006:10). More specifically, the following service provider confirmed what is really happening in service provision during an interview:

> Kuna misuse ya *exemption and wavers*, kuna *political influence* kwenye *exemption*, mtu kwa sababu ni mtu wa kampeini yake au kwa sababu ni rafiki yake au jamaa anampa kinote cha *waiver* na huyo mtu ukiangalia ni mtu mwenye uwezo hivyo ile *procedure* ya waiver ina *bureaucracy* ina matatizo wale wanao*deserve* waver hawapati na wale ambao hawadeserve ndo wanapata *so long as* wana*influency* na mtendaji. Hivyo nimewaambia madaktari kuwa wadini wakiona kuna mtu hana uwezo wa kulipa basi wampe huduma hata kama hana kibali cha *waiver* kutoka kwa mtendaji (Service Provider, Amana Hospital, 7th, September 2007)

Meaning:
There is a misuse of exemption and waivers, there is a political influence in exemption, some people are given waiver note just because they have political

affiliation with the person authorized to give waiver, or because of friendship, or being a relative, but if you look at the exempted or waived person he/she look an economically able person, therefore procedures for issuing waiver and exemption are bureaucratic and problematic, those who deserve waiver do not have access and those who do not deserve are the exempted and waived just because they have influence with the responsible executive . Therefore I have instructed doctors to provide free services to any hospitalized person who is not able to pay for the service even if that person has no waiver note from the responsible executive.

4.4.2 Complaints and Response

With the recognition that dissatisfaction of service users, several mechanisms have been put in place by health facilities to enable service users to air their complaints whenever they are maltreated or whenever they receive substandard care service. Along with complaints these mechanisms enable service users to give their suggestions on provision of health care or to express their satisfaction with the service they receive. For these mechanisms to be utilized or not utilized there are certain issues that are to be assessed. These issues involved whether services users recognize their right to complain, freedom to complain, knowledge on the procedures to file complaint and the availability of mechanism to enable the airing of complaints.

The likelihood of service users to complain whenever maltreated depends very much on their perception on health care services they utilize. It should be assessed as whether they consider health care as a human right, privilege or commodity that they are supposed to buy. This study found that 74% of service users consider health care as a human right, 11.1% consider it as a privilege and 14.9% consider health care as a commodity that they have to buy. From this finding therefore it is expected that more service users are likely to complain whenever maltreated because the majority consider health care as a human right.

Table 5 below indicates a lot as far as issues of right to complain, freedom to complain and awareness on the procedures to complain are concerned. As indicated in the table below a relative majority of service users are aware of their right to complain whenever they are maltreated although there are variations on awareness across groups of service users and the variation is statistically insignificant (P=0.172). More pregnant mothers(62.9%) and patients with exemption diseases(65.8%) reported to have high freedom to complain than other groups of users of elders aged for exemption(40%), relatives of under five (49.4%), patient under waiver(50%) and user fee patients (51.9%) and the difference among these groups is statistically insignificant (P=0.381).

However the awareness of service users on the right to complain and relative freedom they have to advance their complaints seem to be hampered by low level of awareness they have on the necessary procedures that need to be taken. In all service user categories very few users reported to be aware of the procedures needed to advance their complaints as indicated in Table 5. The difference on levels of awareness on the procedure of filing complaints is highly statistically significant (P=0.000). According to these findings it might be in a safe position to conclude that service users do not

complain whenever they are maltreated because they don't know the procedures to complain.

Table 5: Rights, Freedom and Procedures for Complaints by Service Users

Category of users	Response	Right to complain	Freedom to complain	Awareness on procedure to complain
Pregnant women	Yes	61.9%	62.5%	40.2%
	No	38.1%	37.5%	59.8%
Relatives of under-five	Yes	73.5%	49.4%	8.5%
	No	26.5%	50.6%	91.5%
Elders aged for exemption	Yes	100%	40.0%	0%
	No	0 %	60.0%	100%
Patients with exemption disease	Yes	73.7%	65.8%	23.7%
	No	26.3%	34.2%	76.3%
Patients under waiver	Yes	75.0%	50.0%	0%
	No	25.0%	50.0%	100%
User fee patients	Yes	81.5%	51.9%	11.5%
	No	18.5%	48.1%	88.5%

N=299

Further reflections on complaints and subsequent responses can be observed from narrations given by service users and providers. The following are typical responses:

> Nimeshawahi kukutana nayo, unaweza kwenda hospitali na kukuta foleni kubwa, wahudumu wanazorota katika kutoa huduma kuna hospitali nyingine tangu wawekewe TV tabu, unahitaji huduma lakini wenzako ndo kwanza wanashangaa kioo. Si sawa kulalamikia chini chini, tuendelee kuandika katika sanduku la maoni, au tutumie ofisi za malalamiko,watu waelimishwe na kupeleka malalamiko yao. (Service User, In-patient, Amana Hospital, 7th September 2007).

Meaning;

I personally noticed the complaints; it might happen that when you go to hospital you find long queue and health care providers are indolent in provision of services, for some hospitals since they have been provided with TV it has become a problem, you need service but providers are just watching TV. It is not right to keep murmuring; we are supposed to post our complaints into suggestion box or to use offices responsible for complaints, people should be educated on how to advance their complaints

On whether complaints reach respective departments or organs, the following respondent had this to say;

> Malalamiko mimi nafikiri yanaweza kuwa yanafika sehemu husika au hayafiki. Hayafiki kwa sababu watu kwanza hawajui ni wapi waende kutoa malalamiko yao. Mfano mimi nimefika hapa Mwananyamala toka jana lakini sijui kama kuna hicho kitengo cha malalamiko(Relative of in-patient, Mwananyamala Hospital).

Meaning;
I think either complaints reach respective departments or not. They simply don't reach because service users do not know where to file their complaints. For instance I came here at Mwananyamala since yesterday but I don't know whether there is that department for complaints

On the same issue, the following service provider commented as follows;

> Ni mara chache sana wagonjwa kuja hapa kulalamika sana sana wanapeleka malalamiko yao kwa viongozi wanaogopa kulalamika kwetu wanaona kama watakuwa wanajichongea kwamba wakija mara nyingine wanaweza kunyimwa huduma. Hivyo viongozi wa mtaa wanakuja kulalamika (Service Provider, Tabata Health Centre).

Meaning;

It is very rare for patients to come here complaining in most cases they advance their complaints to their leaders, they are afraid to complain to us as they think that we can not give them service when they need it again. Therefore their local government leaders come to us for complaints

Moreover, this respondent had the following to note;

> Watu wanalalamika tu lakini hawajui utaratibu, inabidi waelimishwe (Service User, In-patient, Mlandizi Health Centre).

Meaning;

People keep complaining without knowing procedures to advance or file their complaints, they need to be educated for that.

The use of suggestion boxes was found to be the common mechanism for receiving suggestions and complaints from services users. Suggestion boxes were found to be in place in all seven health facilities which were involved in this study. The only difference across the facilities is the number and location of suggestion boxes. In five health facilities suggestion boxes are located in Out Patient Department (OPD) only and in only two health facilities suggestion boxes are located in both in OPD and In Patient Department. What is observed here is that, lack of suggestion boxes in the In-Patient Department can be interpreted as a way to deny the right for in- patients to give their suggestions and complaints through suggestion boxes.

Suggestions and complaints are also made through Customer Care Management Office put in place in a health facility. This office is normally occupied by a special person employed by a facility to deal with day to day grievances of service users where customers can walk in at time for the purpose of giving suggestions, complaints, or compliment on the service he/she received. The office operating on this manner was found only in one health facility out of seven that were involved in the study.

4.5 Cost Sharing and Improvement of Health Care Services

One of the underlying assumptions of cost sharing is to improve health care service provision. According to study findings very few (35%) are convinced that cost sharing lead to improvement of health care. Again most of service providers agree with the ideas of cost sharing as way of improving service provision but according them the reality is different. While some financial resources have to be accrued through user fees a big lump some has to be provided or supplemented by the government. According to health providers and as explained earlier the exempted and waived groups comprise the biggest proportion of patients who attend health facilities such as pregnant mothers and children under five. These exempted groups spend a large proportion of health facility budget. It is also common for the government to provide less than half of the budget demanded by a facility and thus facilities become incapable to provide quality health care services. This means that cost sharing does not contribute to the improvement of health care service given the current practice of the government to provide less than half of the financial resources needed by health facilities (*also refer to affordability of services in 4.3.2 on comments made by Amana service provider).* The following comment made by service provider says it all:

> Ilivyopangwa ni kweli nikusaidia watu wapate huduma bora za afya, lakini nimeona kuna mapungufu fulani serikali ina nia nzuri kumchangia mtu mwenye ulemavu au wa umri wa chini ya miaka mitano kama mama mjamzito, kama mzee wa miaka sabini mm...lakini serikali hiyo hiyo, wizara itapeleka bajeti kwamba tunaomba milioni fulani au bilioni fulani, lakini serikali itatoa *three quarters* au *half* ya ile iliyotakiwa sasa kama serikali inatoa nusu na waliobudget wanakuwa wamejumlisha hela za mjamzito, za mtoto, za mzee, za majeruhi na kadhalika, sasa bajeti ile inapokuja bila ya kukamilika ina maana kuna mapungufu ambayo yanatokea wakati wa utekelezaji. ..... Pia hasa kwa watoto, mtoto chini ya miaka mitano anaugua *pneumonia*, utakuta *ampicillin syrup* ya mtoto ni ghatrama zaidi ya ile capsule ya watu wazima lakini kwenye cost sharing hamna, kwa hiyo utakuta mama anaambiwa kuwa mtoto ana *pneumonia* na anatakiwa atumie dawa hii ambayo dukani bei yake ni hii, na pale ile ambayo alitegemea cost sharing haikufikiwa kununuliwa kwa ajili ya kundi lile kutokana na ufinyu wa bajeti ya wizara (Service Provider, Mbagala Rangi Tatu)

Meaning:

It was really planned to help people access quality health care but I have seen some deficit, although the government has clear motive to contribute for disabled, under-five children, pregnant women and elders aged for exemption… but the same government provides three quarters or half of proposed budget by the ministry, inclusive of money for pregnant women, under- five children, elders, for survivors and so forth, when that budget comes while insufficient there must be shortfalls in implementation… Likewise for under- five children, when one suffers from *pneumonia* you can find out that *ampicillin syrup* for children is more expensive compared to *ampicillin capsules* for elders and this is not addressed in cost sharing, therefore it happens that a child's mother is instructed to buy medicine from pharmacy following unavailability of what she expected through cost sharing due to paucity of the ministry budget

4.6 Ownership, Decision Making and Management of Health Care Services

Cost sharing also has the aim of improving the sense of community ownership and involvement in the provision of health care services. The feeling that provision of health care service is the responsibility of the government is still strong among may service users. They always blame the government for whatever short fall in provision of health care. They don't have a strong feeling that they are equally responsible for provision of quality care by committing both human and financial resources. The following expression adds more emphasis:

> *Community* kama *community* naweza kusema kuwa tumegawanyika katika hili, wapo ambao kweli wanafahamu vizuri sana lakini kuna *group* ambalo hii dhana bado, ambao unaweza kukuta kwamba anakuja, sijui katika kampeni hizi za kisiasa yeye mawazo yake ni kwamba akifika pale kila kitu anaweza kupata bila gharama yoyote, yaani tena unakuta anakuja na nauli yake ya kujia na kurudia, ee...kwa hiyo anajua kuwa kila kitu anakipata, lakini wapo ambao wanafahamu kuwa kuna suala la uchangiaji, kwa hiyo bado mimi nafikiri katika elimu bado, mimi nafikiri kuwa elimu inatakiwa sana ili jamii iweze kufahamu kwamba hii dhana ya uchangiaji ikoje, ili akija anajua kabisa kule hospitali anatakiwa kufanya nini (Service Povider, Tabata Health Center)

Meaning;

As community, I can just state we are divided on this matter, there are some who satisfactorily understand this idea but still there is a group which do not, whereas they always come I don't know because of these political campaigns with assumptions that everything is provided free of charge, just he or she comes with his or her go and return fare, eer… therefore the person expects to get everything, however there are those who know that we contribute, for this case I think education is still needed in order for the community to understand this idea of cost sharing, so that when members of the community come here they know for sure what they are supposed to do.

This service provider was of the following view;

> Wananchi wana mwamko katika uchangiaji kwa sababu baada ya kupata ile elimu na kujua kwamba wanachangia kwa sababu gani na kujua kuwa ina faida gani kwao kuwasaidia , kwa hiyo kwa kweli tunaona, mwanzoni ilikuwa ni ngumu, lakini jinsi tulivyoendelea kuwaelimisha kwenye mikutano ya jamii huko vijijini, kwenye misikiti, makanisa tunawatangazia na wakija hapa elimu ile ya afya tunayotoa tunaunganisha na uchangiaji kwa hiyo kwa mwanzoni kwa kweli ilikuwa ni ngumu mwingine anakuja na kukwambia mimi sina hili, lakini baada ya kuingia undani na kuwaambia *private* unakwenda kutoa kule shilingi elfu ishirini labda kwa ugonjwa mmoja, lakini ukilipia hapa ile shilingi elfu tano yako unatibiwa wewe na wale wa chini yako watu kumi kwa muda wa mwaka mzima, kwa hiyo naona kwa kweli ile mgogoro hakuna na watu wameitikia tu. (Service Provider, Mkoani Health Center)

Meaning;

After awareness campaigns on why are they contributing and what are the associated benefits people are now mobilized, therefore what we see was difficulties in the beginning but as we keep on educating them through village meetings, in churches and mosques and even when they come here through health education that we are

providing, we always link it with issues pertaining to cost sharing. We always mobilize those seem reluctant by telling them advantages of contributing five thousand shillings so that you together with ten dependants can access treatment for an entire year instead of paying twenty thousand shillings in private hospitals just for a disease, therefore those problems we experiences in the beginning have ceased and people are now responding.

For effective articulation of cost sharing objectives health boards and committees have been instructed to ensure full community involvement in their operations. For example, it is stipulated that the Council Health Service Board should ensure full involvement of the local community in priority identification, planning, financial contribution, monitoring and evaluation of health service delivery (URT, 2001). However, the reality is different. Very few service users feel that they are involved in decision making on matters related to provision of health care. Only 10% of users reported to be involved ever in decision and 90% reported that they have never been involved in decision making. Again only 26.6% of service users reported that they have the power to influence decision making process even if they are not involved while 73.4% feel that they are powerless to influence any decision as far as health care provision is concerned. Ironically, only 43.9% reported that they would like to be involved in decision making.

The perception of non-involvement in health care provision and decision making by majority of service users comes with the fact that majority of them do not know the modality of representation they have in health facility committees/boards and sometimes they do not know their representatives in those committees because representatives do not make their applications to users themselves or community but to executive authorities. For example, the Council Health Board which has to comprise four community service users, among others, community representatives to the board make their application to the Council Director and not to the people or community they represent in the Council Health Board (URT, 2001). According to the District Council (Council Health Service Board Establishment) Instrument 2001, 6(6) any member community member selected to be a member of Council Health Board has to be recommended by the Council Management Team which is fact composed of government employees as stipulated in the same instrument subsection 14. This act can be translated as involvement by elimination and substitution of the community by the government.

4.7 Sharing of Information on health service provision.

Most of service users interviewed during the study recognized their right to have information related to management, meetings, planning, revenue and expenditure in the whole process of health care provision. Generally access to information, including information related to health care provision, by average people has been a problem in Tanzania. The government has put it squarely that transparency and accountability must now ceases to be a condition to be tolerated, but be perceived as a government's core function to be cherished as party to a deepening culture of service to the people (HakiElimu et al, 2005) through communicating information. However, as indicated in Table 6 most of user categories reported to have the right to information on health care but a small number of pregnant women(47.4%) and patients with waiver(33.3%)

reported to have the same right. But at the same time 53.6% of pregnant mothers and 100% of patients under waiver considered health care services as human right. This finding gives the picture that there is no correlation between consideration of health care and perceived right to information, that is, while pregnant women and patients under waiver consider health care as human right they don't think they have the right to information on health care provided to the same degree. As indicated in Table 6, the differences on the perception on the right to information on health care is highly statistically significant (P=0.000)

Again as indicated in the same table, service users know their right to information in the provision of health care but they think that they don't have the ability to demand the same information. Differences in ability to demand information varied across groups of service users with the patients under waiver reporting the lowest ability to demand information on health care. The differences in the ability of various groups of service users to demand information is however statistically insignificant (P=0.000)

Table 6: Right and Ability to Demand Information on Health Care

User category	Response	Right to information	Ability to demand information
Pregnant women	Yes	47.4%	32.3%
	No	52.6%	67.7%
Relatives of under-five children	Yes	78.6%	7.2%
	No	20.2%	92.8%
Elders aged for exemption	Yes	60.0%	20.0%
	No	40.0%	80.0%
Patients with exemption disease	Yes	78.4%	47.7%
	No	16.2%	52.6%
Patients under waiver	Yes	33.3%	0%
	No	66.7%	100%
User fee patients	Yes	70.4%	25.9%
	No	29.6%	74.1%

N=299

This study found that important information and decisions made by Council Health Board, Hospital Governing Committee and Dispensary Committee are communicated to service users through representatives of the community and it is said that these teams and committees receive suggestions on provision of health care through the same channel. Important decisions that are made about revenue, planning and expenditure of Council Health Board, dispensaries and hospitals are communicated to communities through representatives. However there are wide claims that such information does not reach the service users in their communities. This might lead to the danger of continuation of perceiving community members as consumers of services thus leading to eventual decrease in sense of community ownership and participation in health care provision process (Africa Health Strategy 2007-2015:15).

The reasons for lack of good linkage in information delivery between health boards/committees and communities are not well established so far. But one of the reasons is the modality in which representatives of the community are selected. For example, the District Council (Council Health Service Board Establishment) Instrument 2001, section 17(1)a stipulates that the Hospital Governing Committee should compose three persons of 'reputable character' appointed from amongst the members of the community receiving health services or registered to receive services from the hospital and as stipulated in section 19(3) of the same instrument the selection of these reputable persons must be recommended by Council Management Team (URT, 2001). Although it is not clearly stated what kind of reputation is needed for a community member to be selected a member of the board, it is clear that whoever is selected to be the member of the board feel more accountable to the council authorities that selected him/her to the board than the community that he/she represents and therefore representatives lack moral obligation to their communities.

Another way of communicating information to service users is through the use of notice boards located in the health facility premises. This study found that notice boards are used to communicate information to service users in one hospital of Kinondoni district, one hospital of Ilala district and one dispensary of Kibaha district. It was also found that in one dispensary of Ilala district, one dispensary of Temeke district and one dispensary of Kibaha district there was no notice board at all. In these facilities without notice boards no any information on revenue, planning and expenditure was found displayed anywhere for access of the service users only few announcements were found hanging on walls here and there.

Even in health facilities with notice boards there were variations in terms of the location and contents displayed on the notice boards. All notice boards are located mainly in the administration blocks of the facilities and can not be easily located and accessed by service users, no notice board was found located in OPD for easy accessibility of service users to information.

The research team had a fiery exchange of words with the doctor in-charge of Temeke hospital after the team was found reading notice on the only notice board located in the administration block. The team was told it had no permission to do so because the notice was for 'internal consumption'. All this happened when we were yet to introduce ourselves to the hospital authorities and it was lucky that relations changed to be harmonious after recognizing each other.

The aforementioned scenario says much about the attitude of service providers as far as sharing information is concerned, information is for internal consumption(for service providers) and for public consumption(for service users). In all notice boards observed in this study there were no minutes of any recent meeting. This observation is surprising because it is clearly stipulated in section 21(1) and 30(1) of the District Council (Council Health Service Board Establishment) Instrument 2001 that Hospital Governing Committee and Health Centre Committee will hold ordinary meetings once in every month and once in every three month respectively. What transpires in these meetings is expected to be made public through notice boards and community representatives.

The District Council (Council Health Service Board Establishment) Instrument 2001 section 25(1) and 32(1) states the sources and management funds by hospital governing committees and health centre committee. For the sake of transparency in provision of health care the sources and the manner in which the funds have been managed are to be made public. With the philosophy that health is a human right; the government has the responsibility of guaranteeing health care for all citizens in an equitable manner and with clean and efficient governance, while using the resources accountably under transparent leadership (Africa Health Strategy 2007-2015). However, as far as information on revenue and expenditure is concerned, only one hospital of Kinondoni district and one hospital of Ilala district displayed expenditure of the third quarter of year 2007 on notice board and none of the facilities displayed anything on revenue. This is contrary to what is stated in government instruments that patients should be told about revenue and expenditure of finances they contribute for provision of health care (URT 1997).

4.8 Accountability and Transparency in Provision of Health Services

To attain the objective of providing quality health care there should be a degree of accountability of service providers to service users and the services should be provided in a transparent way. However as it has been already noted in the preceding section with regard to sharing of information on health service provision, there still major questions to be addressed on issues related to accountability and transparency. This study found out during interviews with service users that the same have dissatisfaction with the current system and they urge for changes in order to enhance accountability and transparency in provision of health services. The following comment from the service user helps to exemplify this situation;

> Mimi naona hakuna uwazi na utaratibu wa sanduku haitusadii kwa sababu kama ingekuwa inatusaidia watu walishadumbukiza maoni yao mengi wala hakuna taarifa kuwa maoni yenu yanshughulikiwaje au yanchukuliwaje. Hivyo tunaweka maoni tu lakini kujua kuwa maoni yameshughulikwaje hiyo hatupati (Relative of In- patient, Temeke Hospital)

Meaning:

For my opinion there is no transparency and the system of suggestion box does not help us because people have given lot suggestions and there is no feedback on whether such suggestions have been worked up on or the consideration of such suggestions. So we are just putting in our suggestions but don't the action afterwards.

This concern did not emanate from the service users only, but it also emerged from service providers to an extent that some of their expressions during interviews can be portrayed as the need for them to be more accountable and transparent so as to ensure quality health care services. The phrase below suits as an example;

> Mimi nafikiri wagonjwa hawapewi taarifa zinazoweza kuwasaidia katika maamuzi, nafikiri ni vizuri kwa wao kupewa taarifa, wanapaswa wajue, taarifa wanatakiwa wapewe, na hiyo taarifa mimi ninavyoona labda kwa hospitali wangekuwa wanatoa

> katika mbao za matangazo katika uchangiaji tumekusanya shilingi hizi na matumizi… hapa huwa inafanyika hivyo…inafanyika lakini sasa kwa sisi wafanyakazi ndo tunaelewa ilikusanywa kiasi gani na ilitumika vipi na imetosheleza…haikutosheleza kwa asilimia ngapi hiyo tunaelewa, ila wale wanaotoa hizo hela hawajui. (Service Provider, Temeke Hospital)

Meaning;

I think patients are not given information that can help them to make decision, I think it important for them to be given information, they are supposed to know, they are supposed to be informed on cost sharing especially about expenditure through notice boards, this is done in this facility, but in most cases service providers are the one who knows how much has been collected and how much has been spent and how and whether that much is enough or not, but those who contribute the money do not get information.

4.9 Redefining or abolishing cost sharing?

Respondents had different views on whether cost sharing should be re-defined, abolished or not. On the question of the need to abolish cost sharing in the survey conducted, 22.2% agreed with the abolition and 11.6% did not agree while 66.2% responded they don't know. Concurrently, on the question whether there is a need to redefine cost sharing, 12.6% agreed and 14.3% did not agree while 73.2% replied that they don't know. These findings give the generalized interpretation that significant percent of service users are not certain on whether cost sharing should be abolished, redefined or not given the highest response for those who do not know what is supposed to be done. This is to say that most of service users are not against the idea of cost sharing in provision of health care services however some still think that something is be done to make cost sharing efficient way of enhancing quality health care. This means that there is a fear that the elimination of cost sharing at local level could reduce community ownership (DANIDA et al 2005) although service users still feel that they are not well involved in the whole process of health care provision. The following expression reflects the general perception of service users:

> Binafsi sielewi kama utaondolewa utasaidia au la. Sioni wapi itatusaidia. Labda ikiondolewa ni afadhali. Afadhali yake ni kwamba sasa hivi tunalipa hakuna tunachokipata, tunachangioa kinashughulikiwa nini hasa. Tujulishwe mchango wetu unakusudia kuleta kitu gain hasa. Wananchi tujulishwe kama unahusika na majengo tu na hauhusiki na madawa na vifaa bora tuambiwe (Relative of in- patient, Temeke Hospital).

Meaning:
I don't know whether the elimination of cost sharing will help us or not. May be when it is eliminated things will be better this is because we are yet to know the role of our contribution. We need to know our contribution is for doing what is it for building only and it has nothing to do with medicine and equipment? We should be informed.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusions:

Several major conclusions can be drawn by this study based on major findings;

- Knowledge on exemption is higher than on other systems of cost sharing because majority of service users are in the exemption group, that is women and children
- Exempted and waived service users have mere access to health facilities but not to services which they are indirectly forced to pay for due to unwillingness of the government to supplement the necessary financial resources
- Misuse of waivers is the manifestation of lack of transparency and unstipulated procedures of identifying the poor.
- Procedures to file complaints are not clear to service users
- Cost sharing can lead to improvement of health care provision only if there is political will by the government to sufficiently supplement health care provision
- Low level of sense of ownership and management of care is the result of feeling of powerlessness, lack of accountability and transparency in health care provision
- Sharing of information between providers and users in health care provision is poor thus leading to mistrust between the two parties.
- Transparency in health care provision is minimal due to lack of appropriate flow of information on management, revenue, expenditure and planning between service providers and users
- There is a need to redefine cost sharing by removing major operational weakness.

5.2 Recommendations

- Education about cost sharing need to be provided to service users not only through media but also at health facilities by special earmarked service providers and at the same time every service provider should have the responsibility of providing such education
- The government should give priority to health care provision by providing necessary financial resources especially for expectant mothers and children under-five years.
- The current system of identifying the poor need to be re-examined. A special and new system should be designed to identify the poor eligible for waiver and exemption in the local community through public meetings where the list of the poor in a particular community will be made available
- Health providers and community representatives need to conduct their activities in transparent and accountable way by supplying necessary information to service users through notice boards and other channels.

This is an important step to enhance sense of ownership, management and involvement in health care provision under cost sharing.

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7. ANNEX 1

7.1 Questionnaires

OUT- PATIENTS & IN-PATIENTS QUESTIONNAIRES

Region …… **District ……**
Ward……. **Name of facility……**
Facility status (*Hospital, Dispensary, Health Center*)…….
Interviewer……. Interviewee (*patient, relative*)……

SECTION 1: SOCIO-DEMOGRAPHIC INFORMATION.

q1. Type of patient
ii) In-patient ii) Out-patient

q2. Health facility
i.) Public hospital ii.) Health centre

q3. Sex
i.) Male ii.) Female

q4. Age
i.) 16-25 ii.) 26-35 iii.) 36-45 iv.) 46-55
v.) 56-65 vi.) More than 65 years

q5. Education
i.) Illiterate ii.) Primary iii.) Secondary iv.) University/ college
vi.) Other (specify)

q6. Occupation
i.) Formal employment ii) Self employment (specify)…… iii.) Large scale trade
iv.) Small-scale business v) Street vendor/hawker vi.) Student vii.) Others (specify)

q7. Why have you chosen to come and receive health care at this facility?

q8. Patients' status
i) Pregnant ii) Under five child iii) Aged for exemption iv) Patient with exemption disease v) Patient under waiver

SECTION 2: COST SHARING, USER FEES, WAIVER AND EXEMPTION

q9. How do you consider health care?
i.) Human right ii.) Priviledge iii.) Commodity that you can buy
iv. Others (Please specify)

q10. What do you consider to be quality health care services? (Multiple responses)
i.) Courtesy ii.) Good Diagnosis iii) Availability of drugs
iv.) Availability of qualified practitioners v) others (specify)

q 11. Who pays for your health care service? ……

q12. Do you understand the following scenarios in healthcare provision at individual, group or household level?

a.) User fees

i.) Yes ii.) No

b.) Waiver

i.) Yes ii.) No

c.) Exemption

i.) Yes ii.) No

q13. a.) Are you accessing health care under which scheme in this hospital/facility?

i) Waiver ii.) Exemption iii) Pre-paid government scheme iv) Pre-paid private scheme v) User fee

b.) For how long have you been accessing health care under this scheme? (Month)

i.) Below 1 month ii.) 1 to 4 month iii.) 5 to 11 month iv.) One year+

q14. a.) Does your scheme enable you to access quality health care?

i.) Yes ii.) No

b.) If not, what problems do you experience/ face in relation to your scheme?

……

q15. a.) Are health care services affordable under your scheme of accessing health care?

i.) Yes ii.) No iii.) No response

b.) If not, what kind of costs have you incurred, and on what component of health care?

Note: *For pregnant mother probe about delivery kit (gloves, gauze, spirit, rubber, surgical knife, 2 foseps and marking tosh)*

……

q16. Has user fees reduced your financial burden?

i.) Yes ii.) No

q17. a.) Is user fees policy making you access quality health services?

i.) Yes ii.) No

b.) If not, what are the burning issues related to user fee?

……

q18. Does health care improve as a result of user fees?

i.) Yes ii.) No iii.) I don't know

q19. Does cost sharing prevent people from going to health facilities?
i.) Yes ii.) No iii.) I don't know

q20. a) Variants of schemes under non-emption category.

Scheme	**Type of scheme (*private/Govt.*)**	**Affordability to service**	**Accessibility to service**	**Period under the scheme**
e.g. *TIKA*	*Private*	*1*	*2*	*2*

Key: 1. Yes 2. No 3. Don't know

Period under the scheme: 1). Below 1 month 2). 1 to 4 month 3) 5 to 10 month
4) One year+

b) What are the problems of the scheme you mentioned in the chart above?
…….

c) Have you ever changed from one scheme to the other?
i) Yes ii) No

If Yes, why…….

q21. a.) Is cost sharing better than Nyerere's health system of free health care service?
i.) Yes ii.) No iii.) I don't know

b.) If yes, please explain why do you think so?
…….

q22. Do you think that if cost sharing will be abolished, out – of – pocket will be reduced?
i.) Yes ii.) No iii.) I don't know

q23. a.) Do you think that if the fees will be removed equitably, health care delivery will not be attained by the government?
i.) Yes ii.) No iii.) I don't know

b.) If not, can you briefly explain why?
……

q24. a.) Do you think that if the fees are eliminated at lower facilities will reduce household poverty and susceptibility to illness to a large extent?
i.) Yes ii.) No iii.) I don't know

b.) Why do you think so?
…….

q25. a.) Do you think that EAC/F will solve the problems associated with cost sharing/user fee, waiver and exemption?
i.) Yes ii.) No iii.) I don't know

b.) If yes, or no, please give reasons
……..

c.) Do you think that in EAC/F cost sharing/user fee, waiver and exemption services need to be reviewed to favour the poor at all facility levels and for all health services?
i.) Yes ii.) No

q26.a.) Is there a need to redefine cost sharing/user fee?
i.) Yes ii.) No iii.) I don't know

b.) If yes, please explain why
…….

q27. a.) Is there a need to abolish cost sharing?
i.) Yes ii.) No

b.) If yes briefly explain why
…….

q28. Are you fairly treated as compared to other groups of service users? (*Exempted/ Waiver/Non- Exempted*)
i.) Yes ii.) No

q29.a). Do you think you the right to complain in case of mistreatment from service providers as compared to other groups of service users? (*Exempted/Waiver/ Non-exempted*)
i.) Yes ii.) No

b.) Do you feel free to complain in case of unfair treatment from service providers as compared to other groups of service users? (*Exempted/Waiver/ Non-exempted*)
i.) Yes ii.) No

c.) Do you know the procedures for advancing your complaints to responsible authorities?
ii) Yes ii) No

If yes, what are the procedures? .....

q30. a.) Are you involved in health service delivery decision making processes as compared to other groups of service users? (*Exempted/Waiver/ Non-exempted*)
i.) Yes ii.) No

b.) If not, would you like to participate in decision making processes?
i.) Yes ii.) No

c.) If yes, please explain why and on what issues would you like to participate?
.....

q31. Do you think your scheme gives you the power to influence change in health decision making processes? (*Exempted/Waiver/Non-exempted*)
i.) Yes ii.) No

q32. Do you feel that Exempted/Non-exempted/Waiver service users deserve equal rights in accessing health care?
i.) Yes ii.) No

q33. Do you think you have the right to information on health care delivery?
i) Yes ii) No

q34. a.) Are you able to demand information related to health services as compared to other groups of service users? (*Exempted/Waiver/ Non-exempted users*)
i.) Yes ii.) No

b.) If yes, through which channels do you access such information?
……..

c.) What kind of health information that you normally demand/access?
……

THANK YOU FOR YOUR COOPERATION

7.2 In-depth Interview Guide

IN-DEPTH INTERVIEW GUIDE

For In-Patients and Health Care Providers

1. What is your understanding on cost sharing, waiver and exemption?
2. Does cost sharing reduce financial burden and consequently increase access to quality heath care to patients?
3. Is cost sharing policy making you access quality health services *(probe for burning issues of the policy*)
4. Under which scheme are you accessing health care? (e.g. TIKA, NHIF etc) (*Probe for problems, level of accessibility and affordability among these categories*)
5. Can the delivery of quality health care be attained without the existence of cost sharing? (*Probe on issues related to health care and poverty reduction*)
6. Is there a need to redefine and cost sharing? Why?
7. Is there a need to abolish cost sharing? Why
8. Who assess the patient for waiver? To what extent is the community involved in identifying patients of this category?
9. What has been the participation of waiver/exempted service users compared to non exempted users? (*Probe on participation in decision making, airing complains etc*)
10. Do you think that the abolition of cost sharing program can reduce community ownership, transparency and accountability, responsiveness in health care delivery? (*Probe on how/ to what extent*)
11. Do you share information (namely meetings, planning, revenue, expenditure) in health service delivery systems? (*Probe*)
12. What are your (*service users/service providers*) views or recommendations on measures to enhance quality health service provision, transparency and accountability at health facility level?
13. Do you tell your clients under exemption scheme (e.g. pregnant women) on the services they are entitled to?

7.3 Terms of Reference

4.0 Objectives of the Study

4.1 General Objective

The study aims at examine the relationship between cost sharing, user fees and waiver and exemption as alternative service provision approaches towards improved quality health services among the poor people in urban and rural areas and to contribute to the new approaches towards realization of National Vision 2025 and Millennium Development Goals 2015.

4.1.2 Specific Objectives

v. **To examine the relationship between cost sharing, and waiver and exemption to accessibility, affordability and provision of quality heath services at health facility level.**
   - Ask SUs whether they understand cost sharing, waiver and exemption services as individual and/or as a group-household, peer group.
   - Ask SUs whether cost sharing has reduced financial burden at individual level and/or household, community level to access quality health services over time. Simple terms is the cost sharing policy making them access quality health services or not and what are the issues.
   - Ask SUs whether cost sharing improves health care
   - Ask SUs if cost sharing bares people from going to facilities
   - Ask SUs on their perception on cost paying to the services-fees
   - Ask SPs if cost sharing has enabled government to increase resource allocation that reduce the previous and current SUs needs and priorities -for those who are entitled to exemption and waivers and others? And hat type o resources?
   - Ask and compare views from various SUs e.g. TIKA, ID card, NHIF, etc if there are any difference and/or similarly in terms of access and affordable quality health or not and associated issues.
   - Ask SU if they have been accessing exemption and waivers services freely or not? And if no for any percentage ask them to give nature of services and cost they encored.
   - Trace from SUs if cost sharing today is better than Nyerere's health systems and that are their issues.
   - Ask SUs if cost sharing will be abolished out -of-pocket will be reduced
   - Ask SUs if fees will be removed equitably will not be attained by the government.
   - Ask SUs if elimination of fees at lower facilities will to a large extent reduce household poverty and illness. Ask reasons for their views.

- Ask SUs if think EAC/F will solve cost sharing, waiver and exemption or not?[11]
- Ask SUs if towards EAC/F cost sharing, waiver and exemption services need to be eliminated/abolished, reviewed to favour poor at all facility levels and for all health services[12].
- Ask SUs if cost sharing, need to be re-defined, abolished, or not and how (ask them to give clear reasons and –trace group reasons.

Draw specific and general conclusion

vi. To examine the relationship between cost sharing and waiver and exemption on ownership and management of health service provision by users

- ask exempted service users whether they are treated equally as compared to none exempted users
- Ask them-exempted if they feel free to complain in case of unfair treatment from service providers as compared to none-exempted
- Ask exempted users if they are involved in health decision making processes as compared with none exempted
- Ask if and compare views between exempted and none exempted have power to influence change in health decision making processes
- Trace and make comparison if exempted and none exempted users feel if they have equal rights.
- Ask SUs if cost sharing will be eliminated it will reduce community ownership, transparency and accountability, responsiveness 100% or large, or some extent.

Draw specific and general conclusion

vii. To examine the relationship between cost sharing and waiver and exemption on service providers accountability and transparency in healthy service provision to users

- Ask both service PS and Su if they share information namely meetings, planning, revenue, expenditure as health service delivery systems (observe first at notice board and relate with their statements and files-if managed to get documents.

- Ask if exempted are able to demand that information compared to non exempted

Trace if there could be differences between SUs-exempted and non exempted

viii. To critically discuss recommendations (based on respondents and key informants) on measures to enhance quality health service

[11]We didn't collect information on issues related to cost sharing and EAC/F although questions on such issues were included in the questionnaire. After pre-testing the questionnaire we noticed that questions on EAC tended to disorient the respondents and thus obstructing smooth acquisition on central information of the study.

[12] Ibid.

provision and transparency and accountability at health facility level.

- get views of Service users
- get views of Service providers

Draw specific and general conclusion

However the consultant may add or reduce (combine) objective (s) but this will be agreed at the round table with YAV.

5.0 YAV Work Coverage

YAV strategic plan of 2006-2009 covers health facilities within three municipals in Dar es Salaam region namely Temeke, Ilala and Kinondoni and one district in Coast region namely Kibaha. The former have been chosen to represent urban and semi urban areas whereas Kibaha represent semi-urban and rural areas. Each of the three Municipalities in Dar es Salaam, ten wards and five wards in Kibaha district. The consultant needs to understand these health facilities in this area. Thus, a study sample needs to be drawn from this coverage area.

6. Methodology.

The consultant should state methodically the methodology of this study that aim to capture qualitative and quantitative data. A purpose methodology is also need so as to capture the target people.

7. Sample size

This study will be guided by a clear sample size as per application. Purposive sample will have to be included so as to have a representative sample of the target people.

8. Source of Primary and Secondary Data

YAV expects that other sources of data collection will be the Ministry of Health and Social Welfare, National Institute of Medical Research (NIMR), Prime Minister Office RALG, PCB, TACAIDS, etc.

9. Deliverables

The following deliverables are finally required from the consultant:

1. All questionnaires used in the survey.
2. All tapes used interviews (in in-depth and Focus groups) if will be applied
3. Photocopy or original statistical and literature with clear indication of sources of the data collection in the course of this study.
4. Normal presentation papers and /or power point presentation paper (number of papers to be submitted at the workshop(s) will be identified later and agreed with the consultant) made to the stakeholders group.
5. Three (3) copies of draft final report of the survey report that includes executive summary and abstract.

10. Scope of the Work

The consultant is expected to relate literature review by drawing useful issues from various levels i.e. global, regional and national as well as regions within Tanzania so as to reflect the study area (four districts). The scope is as follow:

- The whole analysis of the work need to be centred on the important landmarks of the heath sector in Tanzania with a historical perspective so as to capture important health issues.
- The consultant will need to available CHF/cost sharing documents, guidelines, some studies, undertaken by ministry of health, individuals, organizations and institutions including universities.
- Some of the interviewees will be central, regional, and district level (health workers, board members) and some user of public health services at various levels in each district including dispensaries, health centres and district hospitals to get their views on how cost sharing, exemption and waivers works and how they can be improved.
- Ad hoc visits of some health facilities that provide 24 health services need to be taking place so as to get some issues that could inform issues of this study.
- To examine broadly the position of the poor people from a gender perspective on change of patterns of health service delivery systems.
- Focus on governance in relation to health governance issues within the study area.
- Write a comprehensive background, statement of the problem and literature review with concrete theoretical framework guiding the whole study.
- Understanding of local government and central government powers and functions and the position of local people in influencing local government in the quest of health sector is vital for this study.
- The there is need to analyze the current Community Health Fund (CHF) frameworks/health frameworks in relation to CHF and others that might come out in the course of undertaking this study and more especially before submission of the final report and/or dissemination of the findings.
- A link to URT National Vision 2025 and the MGDs 2015 is highly needed in this work
- The consultant should note that the guiding principles of this study are gender equity, central and local government relationships.

11. Use of Information

The consultant should note that information obtained out of the survey will be shared with the wider stakeholders including the Prevention of Corruption Bureau, the Ministry of Health and Social Welfare, Ministry of Planning, Economic and Empowerment (MKUKUTA Monitoring), Civil Society Organizations, development partners and the general public. The information will also be disseminated to NGOs through the Policy Forum and FemAct. The media will further be used to disseminate the information widely to the general public. The findings aims at enriching effective interventions in all health facilities within Dar es Salaam and Coast region and institutions namely the Ministry of Health and Social Welfare, Prime Minister Office RALG, PCB and TACAIDS. The findings will further enrich and stimulate academic debates, raise public awareness, influence higher learning institutions' curriculums.

12. Competencies required of the Consultants

The consultants have been hired on the following competences:

- They masters degree in Social Sciences or similar qualifications from a recognized University of Institution as minimum academic qualifications.

- They have minimum researches/surveys on health in relation to other socio-economic aspects that reflect the health sector service and HIV services/resources
- The consultant have independent academic perspective and will stand on the study results
- The consultants have ability to prepare questionnaires and carry out the surveys in any one of the official languages English and Kiswahili.
- Consultants have wide knowledge and experience on the working of the local government reform programmes.
- They are aware of the institutional setup as well operational framework in health sector and HIV/AIDS multi sectoral frameworks and MKUKUTA policy and its implementation levels.
- They are well knowledgeable with the political economy issues of public resources in Tanzania.
- They are well knowledgeable with health reforms within regions (EAF, ECOWAS, SSA, SADC), etc.
- They have capacity of carrying out the study within a bureaucratic system.
- They very familiar with Tanzanian social, cultural, economic, and political multi-sectoral reforms from a historical perspective.
- They have team up and agreed to share the grant as per No.14 below.