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DISSERTATION

ON

UNDERSTANDING THE IMPACT OF
USER FEES

ON GENDER IN TANZANIA

University of Cape Town

Assumpta D Rwechungura
Masters in Public Health (Specialising in Health Economics)
University of Cape-Town
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Understanding the impact of user fees on gender in Tanzania

DISSERTATION

**Submitted to the University of Cape-Town in partial fulfilment of the
requirements for the award of a Master of Public Health (Health Economic)**

by

Assumpta D. Rwechungura (M.D)

CAPE-TOWN, South Africa

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Declaration.

This thesis is entirely mine and has not been submitted to this University or any other institution of higher learning for any award. It is a product of my own original work and study done in Tanzania between January 2003 and February 2003. Other sources are fully acknowledged.

ASSUMPTA DEVOTA RWECHUNGURA

Date.....14/10/2003.....

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-Natal Clinic
ATP	Ability to Pay
CCM	Chama Cha Mapinduzi
CHF	Community Health Fund
CG	Consultative Group
CSO	Civil Society Organisation
DANIDA	Danish Agency for Development Assistance
DMO	District Medical Officer
FGD	Focus Group Discussion
FP	Family Planning
GDI	Gender Development Index
HBS	Household Budget Survey
HIPC	Highly Indebted Poor Countries
HSR	Health Sector Reform
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
IMR	Infant Mortality Rate
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MoF	Ministry of Finance
MoH	Ministry of Health
NGO	Non- Governmental Organisation
PAHO	Pan American Health Organisation
PID	Pelvic Inflammatory Disease

PHC	Primary Health Care
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
SAP	Structural Adjustment Programme
SAPRIN	Structural Adjustment Participatory Review International Network
SAHRINGON	Southern African Human Rights Non-Governmental Organisations Network
STI	Sexual Transmitted Infection
TGNP	Tanzania Gender Networking Programme
Tsh.	Tanzania Shilling
URT	United Republic of Tanzania
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WHO	World Health Organisation

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Abstract

In 1993 the government of Tanzania introduced user fees in health care services. The poor, children under five, Maternal and Child Health /Family Planning and maternity services are among the groups exempted from fees. However, it is observed that the fee exemption system in public health facilities is not functioning. According to the media and gender activists, the introduction of user fees in primary health care services was reported to have impacted negatively on vulnerable groups, particularly poor women.

This study aims at exploring how user fees for health care impacted on poor Tanzanian women. In order to have a clear understanding of the issues, the study establishes the impact of user fees on poor women as perceived by poor women in urban and rural areas, and by key stakeholders involved in user fee policy development. Further, the study looks at efforts made by different stakeholders to take into account a gender perspective in the design and implementation of the policy. Finally, the study examines whether the policy process took into consideration the potential negative effects on poor women after its implementation.

The techniques used to collect data are review of available documents, in-depth interviews with key informants from the government, World Bank and Non-governmental (gender) organisations as well as focus group discussions with poor women from Kinondoni district in Dar-es-Salaam region and Kisarawe district in the Coast region.

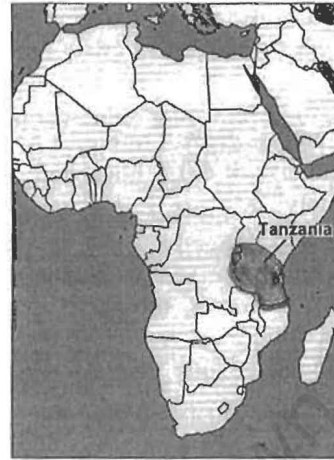
The major findings from this study are: -

- ◆ Poor women in Tanzania are negatively affected from user fee policy in health care. This is illustrated by the costs incurred in utilising health services in relation to their reproductive role and care for others.

- ◆ Women incur a significant and additional cost from unofficial fee payments.
- ◆ User fees in health care were not, in practice gender sensitive despite provision for exemptions for some groups of women.
- ◆ Poverty is a major obstacle for the successful implementation of user fees for health care in Tanzania.

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Figure 1.1 A Map of Tanzania



Key :

DSM – Dar-es-Salaam region

Pwani – Coast region

Source: URT, 2002a

CHAPTER ONE

INTRODUCTION

Many countries are debating the potential effects of reform on equity and the poorest (PAHO, 2000). Good health is observed to be a major determinant of economic productivity and consequently a country's development (Oxaal & Cook, 1998). Further, health is seen to be inversely related to poverty (Oxaal & Cook, 1998). However, up to now, there has been little focus on the differential impacts of health reforms on men and women. Lack of concern, and evidence, on this issue has made governments blind to gender inequities associated with reform (PAHO, 2000; Nanda, 2002). The measures used for reducing the gap between poor and rich people cannot be relied on to correct gender imbalances.

User fees for health care are one of the financing mechanisms promoted by the World Bank and International Monetary Fund (IMF) in the 1980s and adopted by most developing countries (WHO, 1995). Generally its objectives are to raise additional funds, improve efficiency and improve equitable access to health services for the poor (WHO, 1995). It can be argued that the implementation of user fees has taken an utilitarian approach in order to maximize the welfare of the society (Oxaal & Cook, 1998). That is, user fees emphasise achieving maximum benefit at a minimal cost rather ensuring fairness in meeting people's health needs in a society. Further, user fee policy typically fails to distinguish between need and demand for health care between men and women (Oxaal & Cook, 1998).

Gender inequities interact with other types of social inequalities that affect the access to health care. The linkage between user fees policy and its impacts in relation to poverty and gender can be well illustrated in terms of women being overworked and eating inadequately in order to get money to pay for services for themselves and other members of the family (SAHRINGTON, 2002). As well women are

subjected to specific risk factors associated with their reproductive role (SAHRINGTON, 2002). Therefore, it can be argued that women should be more frequent users than men of health facilities (ibid). Yet, the cost of access to health services for women is higher than that for men. Therefore, it is important to recognise that demand for and utilisation of health care are not only determined by poverty, but also by gender inequities (Oxaal & Cook, 1998).

In this study, such issues are explored in Tanzania where user fees were first introduced in 1993. The emphasis on the impact of user fees on gender in Tanzania reflects the need to shed light on an important dimension of inequity that is frequently ignored. User fees policy in health care should not only target the poor, but also women and particularly poor women as an important vulnerable group when assessing the costs and benefits to society of the policy.

1.1 The Tanzania's socio-economic background information

According to the latest census report (URT, 2002a), Tanzania has a total of 34.6 million people, of whom 51.1% are women. More than 70% are reported to live in rural areas (UNDP, 2002). The average annual population growth rate is 3.1% (UNDP, 2002). According to the Household Budget Survey (HBS) report for 2000/01 (URT, 2002c), the employment rate in government and parastatal organisations in Tanzania dropped from 5.2 % (1991/92) to 2.5% (2000/01), while employment in the private sector and in self-employment has increased dramatically. The main source of income for the majority of Tanzanians (70%) nevertheless remains agricultural activities (URT, 2002c). The proportion of women who depend on agricultural activity as the source of their income for the year 2000/01 (62.5%) has dropped by almost 15% from 1991/92. For men, there is a smaller drop from 68.3% (1991/92) to 63.7% (2000/01). According to the HBS report, this suggests that women are now as likely as men to work in the agricultural sector. This could be explained by the fact that men are moving into the agricultural sector because of unemployment in government and parastatal organisations.

The poverty rate is high in Tanzania. There is more poverty in rural than urban areas, and the level of poverty varies from one region to another. According to HBS report (URT, 2002c), 36% of Tanzanians fall below the basic needs poverty line. The poverty rate is reported to be highest in rural areas. It is estimated that 87% of the poor are living in rural areas.

The HBS (URT, 2002c) reported that the income earned by men is twice that of women. In addition, women are also reported to be half as likely to be employed or self-employed compared to men. The above figures reflect that women in Tanzania earn less than men, and the chances of women being hired in formal sectors, or getting well paid jobs, will be minimal because of their generally low level of education. For example, from the analytical report on the Integrated Labour Force Survey for 2000/01 the parastatal organisation with the highest financial salaries, less than 20% of its workforce are women (URT, 2002b).

Generally, the Gender related Development Index (GDI) for Tanzania based on rank and value for the year 2000 was reported to be 126 out of 149 countries and 0.436 respectively (UNDP, 2002). The GDI ranking is to a large extent determined by the overall level of development of the country, rather than the extent of gender inequalities. Nevertheless, these figures show how far Tanzania is in achieving overall well-being and gender equality in social, political and economic aspects in relation to other countries. Therefore, there is a need to recognise that action needs to be taken in order to improve Tanzania's Human Development Index and GDI positions.

1.2 Historical background of health services

In common with other developing countries, the policy approaches in the provision of health services in Tanzania have been shaped by the changes in the global economic trends.

1.2.1 Health care provision before independence

Western medicine in Tanzania was introduced in the 19th century during the colonial era. At that time, health services were directed to serving the urban population rather than the rural population (MoH, 1997), and in particular the rulers and civil servants who stayed in urban areas. Thus, the health care services in that period covered only a small fraction of Tanzanians and the majority of the population who were living in rural areas, and who were poor, were unable to access health services. Also at this time people were expected to pay for health services. During the colonial time, vulnerable groups particularly the poor, women and children were not taken into consideration in the provision of health services. In other words, during the colonial period, the question of equity in health care provision in terms of social stratifications particularly in terms of social class, age and gender was not considered.

1.2.2 Health care provision after independence

Health Sector Reform (HSR) initiatives in Tanzania started immediately after its independence in 1961. The government of Tanzania emphasised the provision of health care services to its people, particularly in rural areas, the poor, women and children. This was intended to achieve the goal of equity in terms of accessibility to health care services in order to improve the population's health status. The mechanism used by the government of Tanzania to achieve this goal was by the introduction of free health services, which focused more on prevention than curative measures (Chiduo, undated). In areas where government health facilities did not exist, the government entered into agreement with mission health facilities. The government agreed to provide financial grants to these facilities, so that services were provided freely or at a subsidised fee (MoH, 1999). Looking at for-profit private health facilities in Tanzania, it is observed that the health facilities are largely concentrated in urban areas (Tibandabage, 1999). However, these health facilities are observed to be not sustainable (Tibandabage et al., forthcoming). Thus, the Primary Health Care services in Tanzania were and still are mainly provided by government, profit and non-profit private organisations.

Under the leadership of the late Mwl. J.K. Nyerere, the Arusha Declaration was born in 1967 and there was the establishment of a decentralisation policy in 1971. Both these policies aimed to expand health care services to the rural areas for the majority of the population (MoH, 1999). Thus, the government aimed to increase the number of dispensaries, health centres and district hospitals. By 1984, about 72% and 93% of the population were living within 5 km and 10 km of health facilities respectively (MoH, 1999).

The Arusha Declaration was developed in the context of socialism. However, it did not provide an avenue for democratic participation. Although, in theory the policy pronounced very loudly the importance of popular participation for community development, it did not provide sufficient structures to enhance mass popular participation. Instead, it facilitated bringing the state organs close to the grassroots level (Mukandala, 1992), and implemented top down decision-making and planning. Interestingly only a few bureaucrats and politicians who held senior position were involved. Historical disadvantages faced by most women in Tanzania (TGNP, 1993; Rwebangira, 1996; Rugumamu, 1998; Kelly et al., 1999) in relation to social, economy and political spheres meant that Tanzanian women had limited chances to contribute to policy even where it directly affected their welfare. The Arusha Declaration faced a lot of criticism from western countries and international organisations such as the World Bank and the IMF in regard to its lack of democracy committed to socialism.

On the other hand, it has been argued that the expressed commitment of western countries and international organisations to democratic participation is not in practice. Most often the direction of the policy is influenced by national or international interests rather than by local needs (Hobel et al, 1996). For instance, Hobel et al. (1996) documented that most donors such as World Bank have been seen to be prescriptive on what has to be implemented in giving financial assistance. Most often when it comes

to crucial decisions there is a limited opportunities for stakeholders involvement. If it happens, stakeholders will be involved at a late stage and the one who makes final decision on how and what to be implemented are the donor and less often the government.

However, the Alma Ata Declaration of 1978 strengthened the objectives set by Arusha Declaration and the decentralisation of health policy to the local level. The Alma Ata Declaration emphasises that Primary Health Care (PHC) services should be closest to the communities and account for those activities performed at the first point of contact between health providers and individuals (MoH, 1999). PHC emphasised eight elements which include; universal Maternal and Child Health/Family Planning (MCH /FP) services, universal child immunisation, supply of essential drugs to dispensaries and health centres and specific disease control programmes e.g. diarrhoea and malaria (Tarimo & Webster, 1994).

From 1967 to the late 1970s, the majority of Tanzanians were getting free health services of good quality (Chiduo, undated). In particular drugs were available and there were adequate numbers of health staff in health facilities. From the late 1970s to 1980s, the quality of health care in health facilities started to deteriorate. This was attributed to the significant increase in number of health facilities and the number of services provided at the health facilities. These increased the financial burden for the government and ultimately resulted in the failure of the government to meet people's health needs (MoH, 1999). Additionally, during the same period (late 1970s-1980s), Tanzania, like most of other developing countries, was faced with economic recession due to the first oil crisis (Nanda, 2002). This was characterised by a large black-market economy, inflation and unavailability of basic consumer goods. Items such as sugar, flour and cooking oil were rationed by government according to the size of the household and on special days rather than on demand and ability to pay. In 1980s, the World Bank and IMF introduced Structural Adjustment Programme (SAP) with attached conditions for loans and debt relief in developing countries. One of the conditions attached to the SAP was that the government

should cut its budget to the social services (including health) and introduce cost-recovery strategies such as user fees (Nanda, 2002). Therefore, because of economic recession and the enormous expansion of health services, the Tanzanian government approached the World Bank and the IMF for loans and other form of financial assistance (such as donations) in order to deal with the crisis. The government finally moved implicitly away from the Alma Ata Declarations of 1978 to move towards selective intervention approach (e.g. basic health care package) and towards cost-recovery (e.g. user fees).

1.3 Problem Statement

One of the reasons, why the Tanzanian government claimed it instituted user fee for primary health care, was to provide health services which were equitable to its people, particularly the vulnerable groups. Equity according to the World Bank (1995b) was expected to be achieved by an increase in accessibility to health care. This would work through revenue collected from the user fees being directed to under-funded health programmes, which would provide benefits to the public. By so doing, the government argued that accessibility to health services for the vulnerable groups, particularly poor women, would be increased. According to claims from the public, especially the media and gender groups such as Tanzania Gender Networking Programme (TGNP), it was reported that the introduction of user fees for PHC has impacted negatively on vulnerable groups particularly women. The negative effects are in terms of accessibility, utilisation and quality of care. Now, the key questions are what are the negative effects experienced by poor Tanzanian women in relation to user fees in PHC, and to what factors can they be attributed?

1.4 Objectives

The main objective of the study is to explore the impact of user fees for PHC on poor women in Tanzania. And to examine how the policy process, implementation and policy evaluation took into consideration such issues.

The specific objectives are: -

1. To establish the impact of user fees in health care as perceived by rural and urban women.
2. To identify the positive and negative effects of user fees in health care on women as perceived by key stakeholders involved in developing user fee policy.
3. To identify efforts made by the different stakeholders to take into account a gender perspective in the design and implementation of user fee policy in health care.
4. To determine whether the user fee policy process took into consideration the potential negative effects which could be experienced by poor women after its implementation.

1.5 Justification and significance of the study

The introduction of user fees for health care in Tanzania and in most of other developing African countries, is generally seen to result in more negative effects for poor women than poor men (Standing 1997;Nanda, 2002). Examining the impact of user fees for PHC on both rural and urban women of Tanzania and the evolution of policy, I will be able to understand whether any measures have been taken to address the issue.

An analysis of existing policy documents will be helpful in considering strategies for improving user fee policy to make it gender sensitive. An exploration of policy implementation will establish whether the changes envisaged in the policy documents are mere rhetoric or whether they reflect what is happening and can happen in practice. By so doing, I will be able to obtain relevant baseline information through exploring in depth and breadth the problem of implementation of user fees in PHC and its impact on women. This baseline can then be used as a basis for monitoring and evaluating progress toward improvements.

Lastly, this study hopes to add to the voices of poor Tanzanian women by capturing their concerns and addressing the negative effects they are experiencing in relation to user fees in PHC. It is hoped it will provide a contribution to what is known on the impact of user fees from a gender perspective.

1.6 Organisation of the remaining chapters

This study report is organised in 8 chapters. Chapter 2 presents a literature review which gives an overview of the reasons for introducing user fee policy for health care and its impacts on vulnerable groups particularly poor women in developing countries. Further, it gives the information on various costs an individual incurs in accessing health care, and a theoretical foundation for understanding the impact of any health reform. Chapter 3 describes the conceptual framework used in this study. Chapter 4 provides the study's methodology, and Chapter 5 presents the results from the policy analysis looking at context, content and policy process. Chapter 6 presents the impact of user fees on poor women as obtained from interviews with key stakeholders and Focus Group Discussions (FGDs) with poor women who participated in the study. Chapter 7 presents discussion of results based on the findings in Chapter 5 and 6. Finally, based on the findings and discussions in previous chapters, Chapter 8 draws conclusions and recommendations on how user fee policy design and implementation can be more gender sensitive and beneficial to poor women.

CHAPTER TWO

LITERATURE REVIEW

This chapter is divided into six sections. Section 2.1, outlines the aims of introducing user fee policy in developing countries and experiences from the policy. Section 2.2, describes the impact of user fees on poor women together with other out-of-pocket costs they incur in order to receive good services. Section 2.3, discusses factors which may affect the success of user fees implementation. Section 2.4, highlights costs other than user fees for access to health services and their implications for receiving health services. Section 2.5 emphasizes the use of the policy analysis triangle in understanding the impact of health policy reform. Lastly, section 2.6 gives a summary of literature review.

2.1 Introduction of user fees in developing countries

A user fees is a type of health care financing reform where, individuals pay for health care at the time of utilisation.

2.1.1 Reasons for introducing user fees in health care

User fees are introduced in most developing countries allegedly in order to improve health care coverage, quality of care, efficiency and sustainability of health care services (World Bank, 1995; Breman & Shelton, 2001; Nanda, 2002). The World Bank promoted user fee policy in health care as a mechanism to ensure services are provided in a cost-effective way while maintaining the quality of care. According to Akin et al (1987), there are two ways by which World Bank thought that user fees in health care services would bring efficiency. These are: -

1). Introduction of user fees would change patient health-seeking behaviour, and as a result people will only seek health care when it is necessary and hence utilisation of health services will be reduced. The overall cost of services will be lower.

2). If user charges differed between different levels of care, it would encourage appropriate use of health facilities and also improve the referral system (e.g. uncomplicated malaria will be treated at a primary level and not at the tertiary level, and hence would reduce the overall cost of services).

According to Gilson et al. (1995) equity is expected to be achieved by exemption mechanisms and by using fee revenue to improve the coverage and quality of health services needed and used predominantly by the poor. The exemption mechanisms aim to protect the low-income groups from the full cost of care and to ensure that fees are levied only on those who are able to pay. By so doing, the accessibility to health services to the poor would be improved and it would protect the poor who could not afford to pay for health services.

2.1.2 Experiences from developing countries

Although user fees aimed at improving the quality of care in an efficient way, it has been observed that the introduction of user fees in developing countries has resulted in a deterioration of quality of health care in most health facilities (SAPRIN, 2002). This is attributed to the reduction of public expenditures which led to the budget for health being insufficient to meet people's health needs (SAPRIN, 2002). In a study conducted in Zimbabwe (ibid) on the assessment of the structural adjustment programme, it was found that there was a significant drop in the quality of health care services in 1993 compared to the post-independence period.

On the other hand, the quality of health services goes hand in hand with income earned by the health worker in a given country. According to SAPRIN (2002), despite an increased budget to the health sector in Uganda in 1990s, the quality of health services was reported to be unsatisfactory. This was attributed to health staff receiving salaries which fell short of a living wage. As result staff morale dropped and they engaged in other activities to supplement their low income. The low income among

health workers was reported to contribute to the presence of poor quality of services among health facilities in Uganda (SAPRIN, 2002). Additionally, McPake et al. (1999) pointed out that there are factors other than salary which may affect staff morale and consequently the quality of health service. In addition to salary, good human resource management was also identified as an important factor for good quality of health care. According to McPake et al., good human resource management includes awards for promotion based on good performance and not on personal interest, and the system used to allocate training opportunity needs to be transparent. Further, clearly defined and workable penalties for health workers who perform poorly need to be in place. Thus, in order for user fees to result in the desired effects, other factors which might have impact on its implementation, need to be carefully examined.

According to studies conducted in a number of developing countries (Getler et al., 1987; Getler & Vander Gaag 1990; Creese 1991; Barnum & Kutzin, 1993; Gilson & Mills, 1995), it has been shown that user fees in health care have exacerbated inequity among the people. It can thus be argued that in reality user fees have a negative impact on vulnerable groups within and between households, locations and economic activity.

For instance, within households women are more affected by the user fees than men because of the power imbalance between them. In a study conducted in Uganda (Lucas & Nuwagaba, 1999) on coping strategies to pay for health care, it was found that despite women having responsibilities for taking care of themselves and children, still they do not have control over cash. Even if women also participated in cash crop production, men were mostly found to keep and have control over cash particularly from the sale of cash crops. Further, it has been observed that poor people will be less able to seek treatment than the rich because poor people already have financial constraints. Therefore, poor people would tend to change their perception of being ill, or report to the hospital when the illness is already in

advanced stage and most often the disease might be at an irreversible stage (SAPRIN, 2002). This has resulted in an increased number of avoidable deaths and created public health hazards such as spreading of communicable diseases e.g. pneumonia, tuberculosis and sexually transmitted infections (SAPRIN, 2002).

In studies conducted in Ghana, Lesotho and Zaire (Creese 1991; Gertler & Van der Gaag, 1990), it was found that the introduction of user fees tend to dissuade poor people from using health services more than the rich, because the exemption procedure was not functioning. In an international survey on cost recovery practice among 26 countries (Gilson et al., 1995), it was found that 69% of countries exempted the poor and other vulnerable groups from payment. However, only 11% of the countries which provided exemptions had used income criteria and in the remainder the eligibility criteria for the poor or indigent was found to be vague. Furthermore, among the studied countries, 96% of countries exempted patients with chronic diseases, 50% exempted health workers and their families, 38% civil servants and their families and 31% the military. These groups are usually not among the most vulnerable in the country. Therefore, lack of control practices on how to determine who is eligible for exemption might have led to the inequities in the access to health care services among vulnerable groups.

According to Bitran and Giedion (2002), several studies which were conducted in Kenya, Uganda and Ghana found that exemption systems were generally not implemented. There were lack of incentives to exercise exemption; the exemption was given to non-poor and there was also a lack of records and monitoring. Bitran and Giedion (2002) add that low salaries of health workers contributed to the lack of implementation of exemption system.

In most African countries, it is observed that most women rely more on informal ways of getting information, such as from health care staff, friends or relatives (ibid). This might be attributed to the

nature of their daily job in that; they do not have time to listen to the radio and to read newspapers, as men do. Further, most women are semi-illiterate (Bitran & Giedion, 2002). In Ghana (SAPRIN, 2002), despite the existence of exemptions for MCH services and children under five, most people particularly in rural areas were still paying for such services because of their ignorance about the policy.

Further, it has been observed that despite exemptions from official fees, poor people may still pay unofficial costs in order to get better services (Killingsworth et al, 1999; McPake et al., 1999). Equally important, people who can pay for official fees for health services may not be able pay additional costs incurred in the form of unofficial payments. In a study conducted in South Asia (Killingsworth et al, 1999) on unofficial payments in health care, it was found that unofficial payments accounted for 30% of patient's health care spending. This is attributed to staff salaries being insufficient to provide a subsistence income; as a result staff use their position and control over services to extract fees from patients.

It is important to note that willingness to pay is not necessarily evidence of ability to pay (Abel Smith, 1993; Russels, 1996). People may find other means of paying for health services rather than face the humiliation associated with exemption (Abel-Smith, 1993). This has an effect on household coping strategies and ability to demand health care (Sauerborn et al., 1996; Russels, 1996). For instance, Russels (1996) reported that in order for household to be able to pay for health costs, some of households have to sacrifice on other basic needs such as education and food. Additionally, he found that households often sell assets such as land, exchange labour or food for cash or borrow money in order to cover health care costs. Russels concluded that willingness to pay is not synonymous with ability to pay. Therefore, the effect resulting from the trade-off made by households in order to pay health care costs need to be carefully examined.

2.2 User fees in primary health care and women's health

In relation to user fees for health care, studies have shown that poor women are more affected than poor men in terms of their accessibility to health care. According to SAPRIN (2002), a lack of clear understanding of gender issues in the area of public expenditure management in Uganda has made women carry unassisted the double burden of production and reproduction. At the household level women are seen to be the ones who compensate for the reduction of provision of public services. Thus drastic cut of budget in a health care services have been seen to affect maternity services (SAPRIN, 2002).

In Zimbabwe SAPRIN (2002), studies show that there were twice as many women found to die in childbirth in Harare hospital in 1993 than before the introduction of user fees in 1990. This had resulted in an increase of Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). Additionally, it is reported that the user fees policy in Zimbabwe has resulted in the reduction of women attending prenatal services and an increase in the rate of under-five malnourished children particularly in rural areas (SAPRIN, 2002). The study speculates that increased MMR and IMR may not only be due to the Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic but also to increased barriers to access through user fees.

In most developing countries where user fees were introduced for PHC, fees for maternity services were reported to have been free or at nominal cost. But, it has been observed that women incur other out of pocket costs for maternity care such as gloves, syringes, drugs and costs for bribing health providers in order to be attended to appropriately. In a study conducted in Bangladesh (Nahar & Costello, 1998) on the hidden cost of free maternity care and affordability of maternity services among low-income population in Dhaka, it was found that about 29% of families spent 51% -100% of their

monthly income and 27% of families spent about 2-8 times their monthly income on maternity services. Among studied families, 51% had no money to pay for maternity fees, of these 51%, 79% borrowed money from moneylenders or relatives. The hidden cost for maternity services included cost for unofficial medical charges, porters and female helpers, travel and food expenses. Thus, it was argued that these hidden costs have made maternity services expensive and unaffordable for poor women (Nahar & Costello, 1998).

In a similar vein, in a study which was conducted in Uganda on the implementation, impact and scope of user fees in government health units (Konde-Lule & Okello, 1998), it was found that a pregnant woman who comes to deliver typically incurs costs much higher than the official amount (3,000 Ugandan shillings) she is supposed to pay for delivery services. In reality, the pregnant woman pays about 15,000 Ugandan shillings for items such as gloves, injections, paraffin and polythene bags for an attended delivery. Payments were said to be given to the midwives who attended the patient and no receipt was given to them. Failure to pay unofficial fees resulted in women receiving poor attention during service delivery (Konde-Lule & Okello, 1998).

2.3 Factors which may affect the success of user fees implementation

Looking at an assessment of the impact of user fees in PHC services on poor women, there is a need to consider other factors which may cause the negative effects which are seen today among poor women in relation to user fee policy in health care. Introduction of user fees in poor developing countries such as Tanzania may be seen inappropriate because of other underlying factors such as poverty.

In Tanzania, the prevalence of HIV/AIDS infection is high. It is estimated that by the end of the year 2001, about 7.8 % of adults (15 –49 years) were living with HIV/AIDS. Of this 7.8 %, 58.5% were women (UNAIDS, 2002). This age group which is most affected by HIV/AIDS epidemic is the same age

group which is economically active. These are groups of people which the nation, community and households depend on for income generation. Furthermore, the money which will be available in a household will mostly be used to provide services to HIV/AIDS patients and hence the household will not be able to pay for health services for other household members. In other words, the extent of HIV/AIDS epidemic has a negative effect on the economic production from national to the household level, and consequently poverty and ill health. Thus, inability of women to utilise health services may not necessarily only be attributed to the costs of seeking health care, but may also result from poverty and HIV/AIDS.

Social norms in our society may also result in poor women being unable to utilise health services whenever needed. For instance, in some societies women are not allowed to go to the health facility without the matters being discussed by the family members (e.g. parents, husband or in laws) (Oberlanänder & Eleverdán, 2000). In this case, the family members are the one who decide whether a woman should seek treatment at the health facility or the traditional healer or stay at home.

Therefore, user fees for PHC services might be unsuccessful where there is poverty, social norms that oppress women and / or a high prevalence of HIV infection. Thus, one should take into consideration the above-mentioned factors when assessing the applicability of user fees for PHC services.

On basis of the impact of user fees for PHC and the possible underlying factors which were discussed in relation to other developing countries, there is a need to understand in depth the impact of user fees from a gender perspective in Tanzania. As well as, at what extent those effects were considered during policy development.

2.4 Cost of access to health care services

Although this study focuses on the impact of user fees among the poor women in Tanzania, it is also necessary to have a clear understanding on other costs which may affect on the accessibility to health services among the poor women in developing countries. There are different costs (i.e. monetary and time) incurred by vulnerable groups particularly poor women in order to receive health services. These are kind of costs that are present before and after the introduction of user fees in health care. For this reason, these kinds of costs might be barriers for poor women to access and utilise health services. According to Sauerborn et al., (1996), and Hjortsberg and Mwikisa (2002), monetary costs include fees for services and travelling costs. Time cost include time for reaching the facility, waiting time, time for consultation and time off duty.

2.4.1 Cost from fee for service

Fees for service include out-of-pocket payments for both official and unofficial charges at the time of utilisation (Killingsworth et al, 1999). Unofficial charges most often are paid concurrently with official charges (Killingsworth et al, 1999). As official charges have been discussed in previous sections, this section focuses on describing different forms of unofficial fees in health care services.

According to Killingsworth et al. (1999), unofficial fees can be defined as a form of unauthorized fee charges that co-exist with free service or approved official service charges collected at a public health facilities. Unofficial fees are divided in three categories (Killingsworth et al., 1999): -

1. Fee for commodity payments; in this case individual pays as a contribution to the cost of care. It includes payments of drugs and other medical supplies such as gloves, needle and syringe.
2. Fee for service payments; in relation to health worker position in health care market, health worker demand payments from patients without giving them extra services. This is

attributed to the information asymmetry that made patient unable to seek treatment at a cheaper price.

3. Fee for access payment; a patient pays health provider in order to get better services, such as reduce waiting time and better food.

Based on the findings from different studies (Killingsworth et al., 1999; McPake et al., 1999), it can be argued that most often individuals incur all together three types of unofficial charges at the time of receiving health services. It has been observed that extent of unofficial fees is inversely related to the accessibility to health care. (McPake et al., 1999). These have made the poor less access to health service and vice versa to the rich (Nahar & Costello, 1998; Konde-Lule & Okello, 1998; SAPRIN, 2002). This could be explained by the poor being unable to pay the fees and consequently they change their seeking behaviour pattern (McPake et al., 1999).

2.4.2 Cost from physical accessibility to health facility

Cost of receiving health services and its impact on access to health services are seen to differ between and within geographical location. In a study conducted in Zambia on the cost of access to health services (Hjortsberg & Mwikisa, 2002), it is reported that, the distance to health facility was perceived as a major obstacle for seeking health care among 56% of interviewed households in rural areas. While, in urban areas only 7-16% of interviewed households perceived that distance to health facility is a major problem. This difference in perception was said to be explained by presence of poor infrastructure and lack of transport in rural areas. This meant that, people in rural areas use longer time to reach health facilities compared to urban areas even if the distance from households to health facilities could be equal.

It has been observed that, within rural areas there is also seasonal variation in terms of costs of access to health care. Different studies (Hjortsberg & Mwikisa, 2002; Sauerborn et al, 1996) shows that people incur higher cost during dry and harvest seasons. During harvesting season, the cost of a visit to a health facility is said to be high in terms of loss of income. For example, in a study conducted on poor women in rural areas of Northern province in Zambia (Evans & Young, 1988) found that women could not afford to be ill during the harvesting period. This is because of an increased treatment cost and high opportunity cost of staying away from productive activities.

Similarly, according to Hjortsberg and Mwikisa (2002), the cost of access to a nearest health facility as a percentage of monthly income varied in different areas. It was found that the cost of access to the nearest health facility per one visit was highest (17% of monthly income) in rural areas during the high season of farming. These rural areas are the ones earn the lowest average monthly income per adult household member (18,557 Kwachas) among the studied areas. Whereas, the same cost was found to

be lower (9% of monthly income) in townships and urban areas of which people earn the average monthly income per adult household member of 39,431 Kwachas and 36,471 Kwachas respectively. In urban areas where people earn 75,925 Kwachas as the average monthly income per adult household member the cost was reported to be lowest (4% of monthly income) among all four studied areas. This difference in cost of access to health services was also to be attributed to the distance of households from health facility.

2.4.3 Cost implications on access to maternity services

Looking specifically to maternity services and financial costs for access to health care, it was found that travel cost consumes a large proportion of total financial cost in health care services. In a study conducted on user costs of maternity services in rural Southern Tanzania (Kowalewski et al., 2002), it is reported that, travel costs consume about 50% of average financial costs for antenatal visits (US\$ 11.60) and that for caesarean section (US\$ 135.40). The rest of financial costs were for admission, drugs, and other medical supplies. Due to irregularity and variation in the extent of unofficial payments, unofficial payment was not included in the calculation of financial cost. From this study (Kowalewski et al., 2002), direct payment and fear of unofficial costs were reported to be barriers for pregnant women to use maternity services.

In a similar vein, unaffordability of charges from unofficial payment in Uganda (McPake et al., 1999) was seen to reduce accessibility and utilisation of maternity services in the public health facilities. The study found that women opted for alternative services such as unsupervised deliveries or being assisted by traditional birth attendants during delivery. Moreover, unaffordable charges were not only found to be barrier for utilisation of health services. Other factors such as poor quality of health services was mentioned as a reason of not using health facilities.

Time cost is also seen to have effect on access to health care services among poor women. According to Kowalewski et al. (2002), time cost among studied women in rural Southern Tanzania, was reported to be constantly higher than financial cost. Similarly, in a households study survey in rural areas of Kenya (Hodgkins, 1996) on factors that affect mothers to deliver at the health facility, it was found that travel time was an important barrier for pregnant women to deliver at health facility.

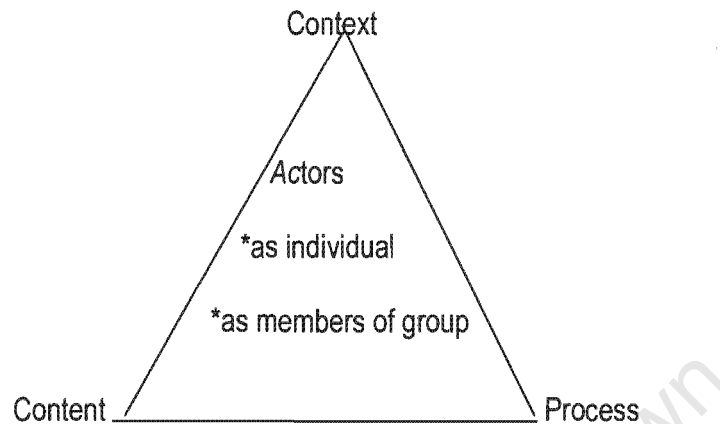
Having discussed different costs of access to health care, it can be argued that there is a necessity to take into consideration other costs other than costs from user fees which might also be barriers for poor women to access health care services. This will help to understand their effects in women utilisation of health services. By so doing, it will be possible to address the effects of user fees in health care together with other costs in order to develop policies which will be beneficial to vulnerable groups particularly poor women.

2.5 Understanding the impact of health reform

Having discussed the reasons for introducing user fees in health care and its impacts on the poor, particularly poor women in Tanzania and other developing countries, it is also necessary to highlight how policy design and its implementation may have an impact on the outcome of any reform (in this case user fee policy). Walt and Gilson (1994) say, policy is not simply about prescription or description, it is the result of complex interaction between social, political and economic factors. Therefore, looking at the impact of the policy in relation to its content and ignoring other factors, one will not able to explore fully the underlying factors which lead to those effects. For this reason, Walt and Gilson (1994) developed a model of health policy analysis (Policy analysis triangle, fig.2.1). This comprises of four groups of factors which influences the development of any policy reform. These are: the contextual factors, which include international, national and local level environments where the policy is developed

and implemented; actors involved in policy change; the process whereby the policy was formulated and implemented; and the content of the policy.

Figure 2.1 The policy analysis triangle



Source: Walt and Gilson, 1994

The SAZA study which explored the process-making process on implementing health financing reform in South Africa and Zambia (Gilson et al., 2003) uses the above mentioned four factors to analyse reform. The SAZA study, explains how the policy design shaped some of policy impacts. For instance, the retention of user fees at local facilities and use of tiering mechanism in setting service charges in Zambia promoted the use of lower level facilities. On the other hand, the use of revenue to fund staff bonuses resulted in negative effects. In some cases it discouraged staff from issuing exemptions, since staff wanted to generate as much revenue as they could in order to ensure a bonus.

Gilson et al. (2003) report that the political context in South Africa and Zambia was a major influence over the reform opportunities and experiences in 1990s. The political transition was seen to speed up the recognition of health problems and the need for health policy change. Additionally, they say that political changes provided the opportunity for radical health policy change. For example, in South Africa, the implementation of free PHC and resource re-allocation after 1994 were widely seen as politically symbolic gestures. In Zambia the national Ministry of Health was the first sector to allow allocation of budgets directly to district health management teams on the basis of health resource allocation formula

(Gilson et al., 2003). However, because of fast changes in the health sector in the presence of new officials and new governments in both countries there was inadequate preparation to support implementation of those changes. This impacted negatively on implementation and eventually the desired policy outcomes. For instance in Zambia, the Minister of Health who was appointed at the time of user fees implementation did not know which strategy he should start with, in order to improve quality of health care services (Gilson et al., 2003).

Equally important Bach (1994) and Cassels (1995) say that significant actors in health reform might be relevant but are overlooked or ignored, since they may slow or de-rail the reform. The ability of actors to block or facilitate the reform is determined by the balance between different groups of actors, whose behaviour is influenced by economic, historical and political contexts. Salter (1994) reports that in the United Kingdom the balance of power between medical professionals and managers was seen as a major determinant of pattern and degree of policy implementation within the United Kingdom reform. Significantly, the lack of power among disadvantaged groups in a country is also seen as an important factor to explain the failure for the policy to implement equity oriented reform (Carr-Hill, 1994).

Additionally, it has been observed that donor's interests have been seen to play a significant role in shaping policy design. In Zambia, donor support played a greater role in facilitating policy change in 1990s together with creating an environment supportive for revenue generation (Gilson et al., 2003). The Minister of Health was also seen as a key player and had a strong influential in health financing reform in Zambia. Often technical staff were not consulted during the reform process (Gilson et al., 2003).

In the SAZA study, it is reported that there was lack of communication and consultations between the central level and local level and also to the users. People were reported to be unknowledgeable about

the policy (Gilson et al., 2003). Therefore, the failure to involve all relevant actors in the policy design and implementation process, which includes the implementers at local level and the community is found to be one of the cause for the implementers (health care providers) and the public to undermine policy implementation and consequently resulted in undesired effects. This finding lines up with findings reported by Konde-Lule and Okello (1998) who found, lack of community mobilisation before the introduction of the user fees, and lack of community involvement in the policy process, to be the source of resistance to the policy implementation. Thus, it can be argued that when analysis is only done on the content of the policy and ignores the context, process and actors in understanding the impact of health reform, it would not be possible to understand the process which explain why the policy has resulted in undesired or desired effects.

2.6 Summary of literature review

The key points drawn from this literature review and which need to be taken forward for the study are:- Poor women are seen to be more negatively affected than poor men in user fees for health care, but little has been done so far to address the issue. Most studies to date focus on the impact of user fees on poor people.

Poor women are said to be more affected than poor men in relation to user fees for health care. This is found to be attributed to fact that the management of government public expenditure are often gender blind, women need health services more than men due to biological differences and their preeminent role in care for others; exemptions often do not function and women are least favoured when it comes to intra-household decisions within limited budgets. On top of that poor women can also be faced with costs resulting from unofficial payments.

Finally, the literature review highlights the need to consider other factors which may affect user fee policy development and its impact on poor women. These factor needs to be examined, to understand the impact of user fees and the form in which they occur. One of the factors is poverty, which may lead to financial constraints within the government budget and low salaries among health workers. All these together have a negative impact on implementation of user fees policy and consequently the quality of health care. In order to understand the impact of any health reform, four factors need to be looked at following Walt and Gilson (1994). These four factors are context, content, process and actors involved during policy process and implementation. Failure to do so will limit understanding of how and why the policy has resulted in desired and /or undesired effects.

University of Cape Town

CHAPTER THREE

CONCEPTUAL FRAMEWORK

This study was based on the conceptual framework outline in fig.3.1. This is derived from a theoretical foundation of understanding the impact of health reform discussed in the literature review, section 2.5. The theoretical foundation explains the relationship between the policy design, implementation and impact.

The first assumption behind the above conceptual framework is that the design of user fee policy is shaped by the process and the environment in which the policy was developed and implemented. Accordingly, the above-mentioned two factors also would shape and set the direction of the impact of the policy on poor women.

In relation to policy process, actors who were or are critically involved (directly or indirectly) during policy development and implementation were interviewed. Actor's interest, influence, supports or opposition in the policy process was analysed. By so doing, the effect of the policy process on user fee policy design and consequently its impact on poor women were demonstrated.

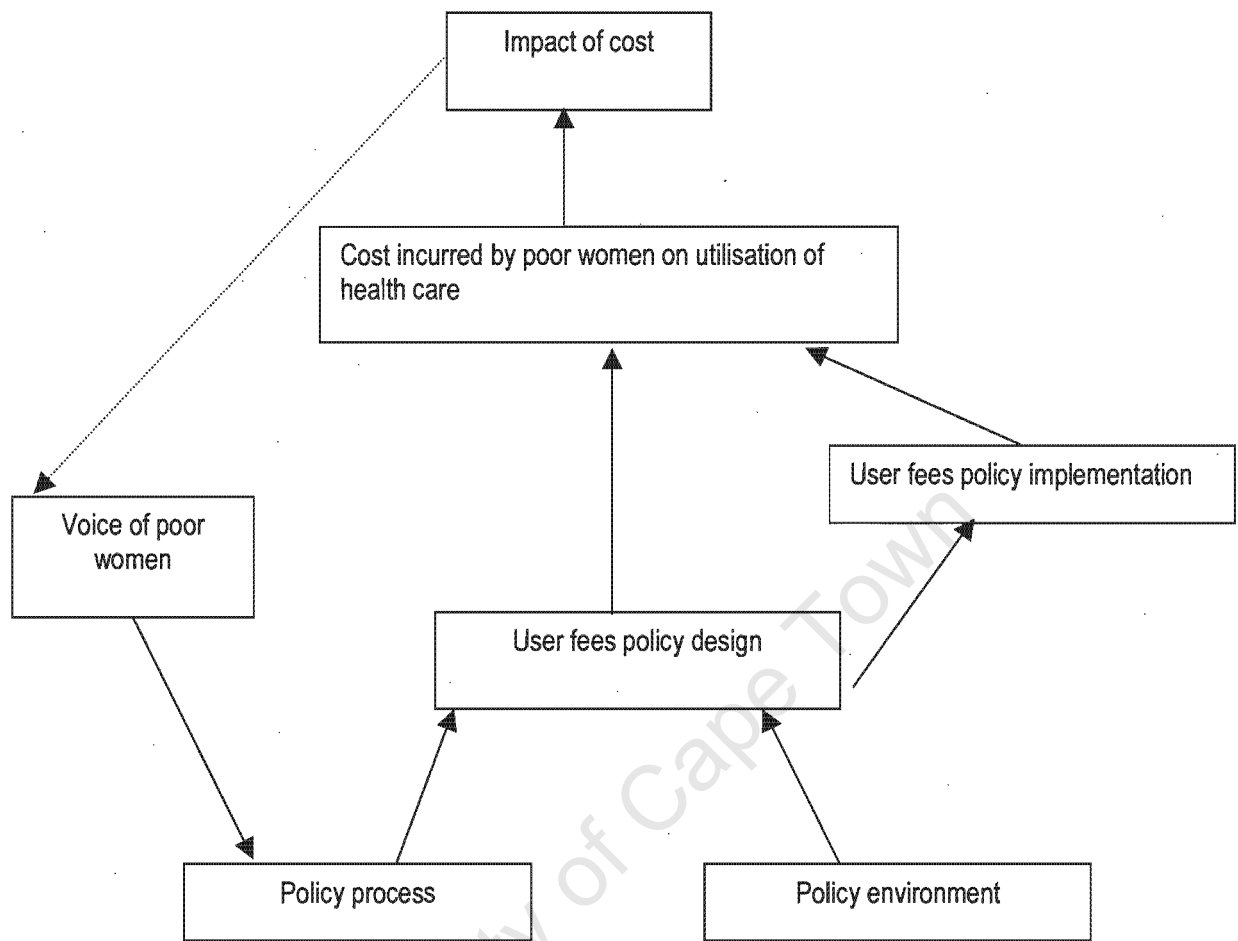
Looking on how contextual factors shape the policy design and consequently the impact on poor women, the national and local environments where the user fee policy is developed and implemented were examined. Further, both the current and past situation of donor relations was assessed. The donor relations were examined because it is true that the Tanzanian government depends heavily on donor support for economic development. And in most of developing countries donors are often seen to play a great role in policy development.

The second assumption behind the conceptual framework (fig.3.1) is that the design of user fee policy may affect poor women both directly and indirectly. In this study the impact of the policy design on poor women was looked in relation to the cost incurred by poor women on utilisation of health care and the effects of these costs on them. The direct effect of user fee policy design on poor women was examined in terms of its contents. This means, the policy objectives, how exemptions criteria were developed, routine monitoring reports and policy evaluation studies were examined. The indirect effect of the policy design on poor women was examined by looking at whether the exemption criteria are implemented as they are provided in the policy.

Lastly, the conceptual framework assumed that when important women concerns regarding their health are incorporated in the policy development process, there may be possibilities that the potential negative effects resulted from policy design and implementation are likely to be reduced. Thus, among other things, this study examined whether the voice of poor women was incorporated during policy process.

Hence, by using the above conceptual framework (fig.3.1), the impact of user fee policy on poor women was explored. Further, the conceptual framework has helped to answer the questions why and how user fee policy has resulted in the effects which are experienced by poor women of Tanzania today.

Figure 3.1 The Conceptual framework



CHAPTER FOUR

METHODOLOGY

This chapter describes the social background of the study area and the methodology used to collect data from various sources in order to explore how poor women in Tanzania are affected by user fee policy in health care. Equally important, the methodology which is used to collect data aimed at establishing how the policy was designed and implemented. Further, the chapter provides a detailed description of how the research was conducted in terms of sampling, data collection and data analysis. In the end, this chapter presents the scope and limitations of the study.

4.1 The social background of the study area

This study was conducted in Kinondoni district in Dar-es-Salaam region and Kisarawe district in the Coast region. These are two out of the twenty-five regions of Tanzania. Tanzania is divided into 129 districts, of which 119 are on the mainland and 10 are in Zanzibar.

Dar-es-Salaam is the main business city of Tanzania with a total population of about 2.5 million and an inter-censal population growth rate of 4.3 % i.e. from 1988 to 2002 (URT, 2002a). It is a relatively well-off part of the country, with consistently low levels of poverty (URT, 2002c). Kinondoni district is one of three districts in Dar-es-Salaam, with a population of about 1.1 million people, with 49.5% women (URT, 2002a). The Focus Group Discussions (FGDs) took place at Msasani ward within Kinondoni district. The ward of Msasani comprises a mixture of better and worse off settlements. Because a key focus of this study is exploring the impact of user fees on poor women, the FGDs were conducted at Mikoroshoni area where the majority of people are poor. The Msasani (Mikoroshoni) is a slum area inhabited by people of different tribes; the majority of citizens are employed in informal sectors, engaged in petty trading and as wage labourers. Most do not have sustainable and reliable sources of

income. The main road from different areas to Mbasani is tarmac, and public transport system is good and reliable.

The Coast region is adjacent to Dar-es-Salaam. It has a total population of about 889,154 with intercensal population growth rate of 2.4% i.e. from 1988 to 2002 (URT, 2002a). The Coast region is consistently reported to be among the poorest in Tanzania, with higher levels of poverty (URT, 2002c). The study took place at Kisarawe district, which is one of six districts in the Coast region. It has a population of 95,614 people, of whom 49.4% are women (URT, 2002a). The study took place in the ward of Sokoni area. The majority of the citizens are Zaramo in tribe. Most of the people are low-income earners, small-holding peasants who depend on seasonal farming. They usually sell their crops within Kisarawe district at low prices producing little revenue that cannot cater for their daily needs. Most houses are built with mud and roofed with aluminium sheets or grasses. The settlements are in scattered villages to allow area for farming. Transport between Dar-es-Salaam and Kisarawe is reliable. Main roads to and from Kisarawe town are gravel and dusty. However, currently there is a road construction going on from Pugu to Kisarawe town.

The basis of selecting these two study areas was the study wanted to gather information from two areas which differ in the level of poverty. By so doing, it was hoped that information obtained from these two areas would highlight any difference(s) on the impact of user fees on poor women in relation to the regional poverty level. Also, the presence of almost equal proportion of women in Dar-es-Salaam (49.5%) and the Coast regions (49.4%).

Figure 4.1 A map of Dar-es-Salaam region

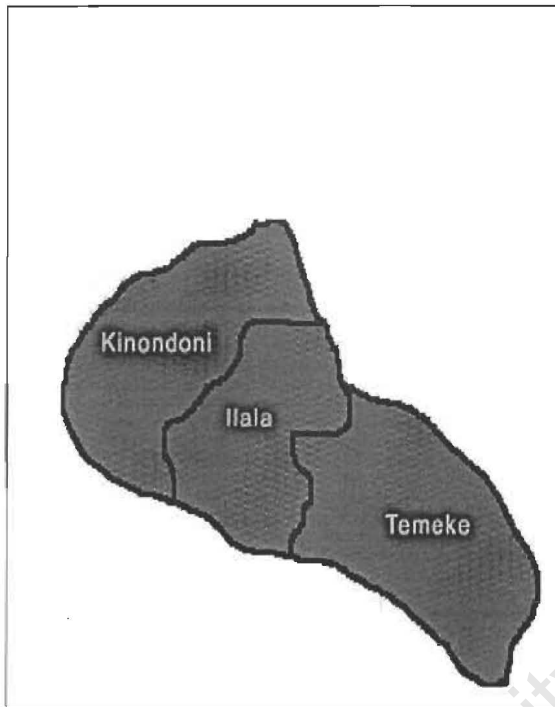
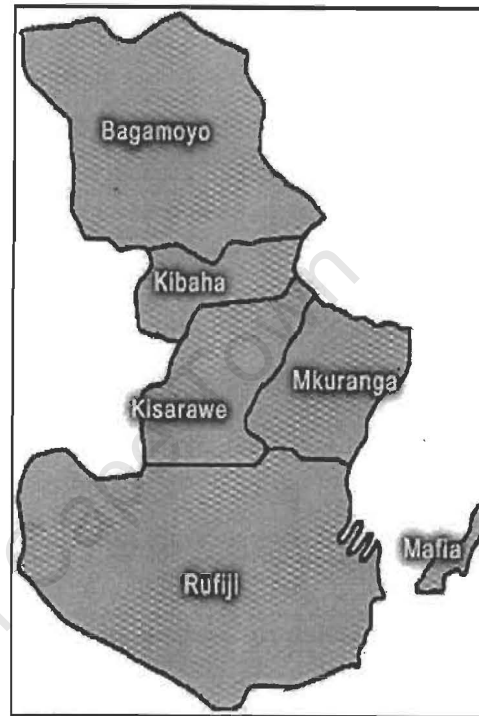


Figure 4.2 A map of Coast region



Source: URT,2002a

4.2 Study design

The study design used was an exploratory qualitative study that covered a period of six months:- from January 2003 to June 2003. The data collected were qualitative because it was thought that this was a better vehicle looking at how different groups perceived the impact of user fees on poor women. It gives the personal voices of people as it brings views in history, which is important to hear.

According to Folch – Lyon and Trost (1981), a study which uses quantitative method can identify how individuals behave in certain circumstances, while the study which uses qualitative method is better

equipped to answer the diagnostic question of "why". Therefore, in order to be able to understand why user fee policy resulted in the positive or negative effects on poor women, there is a need to understand the policy process that is best undertaken with qualitative research methods. As in this study, qualitative case studies have been seen to be most useful when contextual conditions are central to understanding what happens (Yin, 1994).

Generally, material collected in a case study in nature has a wealth and depth that cannot be got from a quantitative study. Qualitative material is also useful for monitoring gender impacts of policies (Korrie et al., 1998; McPake et al., 1999). Although a quantitative study could also be used as a complementary to the qualitative study it could not be done in this study because of limited resources and time. It is thus, beyond the scope of this study.

4.3 Data collection techniques

Because of the nature of data collected and in order to be able to collect relevant information for each objective, the techniques used to collect the data were: -

- Interviews; in each interview, the researcher used in-depth semi- structured approach (face to face) with the key stakeholders. The FGD was not used to gather information from key stakeholders because:- FGD seems to affect the freedom, in giving their views in relation to policy. It was expected that stakeholders would differ in terms of interest, and perception to the policy and power (position) in institution they serve. This may hinder their ability to give information because of fear of losing their working position.
- Reviews of available documents:- Policy documents were consulted. These included the reports from previous studies (published and unpublished) and relevant information for the study was extracted.

- Focus group discussions; FGDs were used as an instrument for data collection to assess the extent to which women are affected or perceive themselves to be affected by the user fee policy. FGDs were conducted both in a rural area of Kisarawe district in the Coast region and the urban area of Kinondoni district in Dar-es-Salaam region.

Instead of face to face interview, the FGD was chosen to gather information because it enables the researcher to understand in depth the perceptions and opinions of women regarding what effects they think were due to the implementation of user fee policy. According to O'Brien (1993), the research which is exploratory in nature, the quality and depth of information from focus group is often better than that from a one to one interview. Furthermore, FGDs encourage and stimulate participants to talk freely about their own experience and to react to each other's opinions and experiences in a way that is not possible in one-on-one interviews.

4.4 Sampling

4.4.1 Study population

The sample population for the interviews included key informants from the government (Ministry of Health, Ministry of Finance, Planning and Privatisation Commission, Local Government Officers and District Medical Officer (DMO) offices of Kisarawe district and Kinondoni municipal), World Bank, TGNP and other members of the Macro-gender groups. At the district level, apart of DMOs, other health workers were also interviewed. This includes Medical Doctors (females and males), nurses and hospital administrators. Poor women from the Kisarawe district (rural) in the Coast region and Kinondoni district (urban) in Dar-es-Salaam region were sampled for the FGDs.

4.4.2 Sampling method

Sampling was in two forms. One form relied on purposive and snowballing techniques (Katzenellenbogen et al., 1997), The form of sampling was done to identify the key informants at the Ministry of Health (MoH), Ministry of Finance(MoF), Planning and Privatisation Commission, World Bank, TGNP, Macro-gender groups, Local Government officers and DMO offices of Kisarawe district and Kinondoni municipal.

In this study, the total number of 23 key informants was interviewed. That is, 2 (MoH), 1(MoF), 2 (Planning and Privitisation Commission), 1(World Bank), 1(TGNP), 2 (Macro-gender group),6 (Local government offices), and 7 (DMOs offices and hospitals). At the local government level, in each district three key informants were interviewed. At DMOs offices and hospitals, the interviewed staffs were four in Kinondoni municipality and three in Kisarawe district.

The second form of sampling was in relation to the FGDs. This form of sampling was purposive in nature helped by ward leaders at the study area to identify and select women who met the study criteria. The study criteria for women to be included in the study were to be poor (this was defined with the help of ward leader), having given birth to a child/children at any time and in the reproductive age group (18 – 45 years). Involving women who have given birth will allow comparison of experiences among poor women who utilise health services before and after the implementation of user fees in health services. Furthermore, the researcher decided to choose women who are in this age group because such women tend to use and need more health services, in relation to their physiology. In this age group, most often women have responsibility in relation to care for the core and extended families. Additionally, if all participants are within a restricted age group, it may help them freely give their experiences, and views and discuss the subject fully.

Furthermore, the study being conducted in rural and urban areas of Tanzania, allowed me to explore the impact of user fees in health care in different geographic areas, since the experience of user fees among poor women was expected to be different in rural and urban areas. The group allocation was done based on age category. Women who were younger than 30 years were allocated into group 1 (urban) and group 3 (rural). Women who were 30 years or older than 30 years were allocated into group 2(urban) and group 4 (rural). In FGDs, two focus groups were conducted in each study area. Each focus group was comprised of eight women. In total 32 women participated in the study. The average age of participants in the rural area was 20 years and 30 years for each group. For the urban area, the average age group was 25 and 38 years for each group.

This study was an exploratory study ,therefore it is expected that information obtained from the sample size in FGDs will give an insight on the impact of user fees on poor women. While the findings may not be generalised, the results will be useful for developing working hypotheses for testing in future and illuminate the experiences of poor women in relation to user fees in health care.

In a similar vein, Varkensser C.M et al. (1991), say that the number of participants and number of FGD sessions to be conducted depend upon research needs, resources and whether new information or contrasting views are still coming from the various groups. Thus, in this study on basis of limited resources, the nature of the study (exploratory) and absence of non-contrasting information between groups within the same area, it may still argued that information from the FGDs is valid.

Table 4.1 Demographics of participants in FGDs: Age, source of income, marital status and number of children

Group 1 (urban)

		Number
Age	Average age 25 years Range: 20 to 28 years	
Marital status	Married Single Divorced/ separated	2 6 0
Number of children	1 to 3 4+	8 0
Source of income	Informal sector (e.g. selling food, domestic worker) Informal sector and from relatives/ spouse	5 3

Group 2 (urban)

Variable		Number
Age	Average age 38years Range: 31 to 45 years	
Marital status	Married Single Divorced/ separated	4 2 2
Number of children	1 to 3 4+	3 5
Source of income	Informal sector (e.g. selling food, domestic worker) Informal sector and from relatives/ spouse	2 6

Group 3 (rural)

Variable		Number
Age	Average age 20years Range: 18 to 25 years	
Marital status	Married Single Divorced/ separated	7 1 0
Number of children	1 to 3 4+	8 0
Source of income	Informal sector (e.g. selling food, domestic worker) Informal sector and from relatives/ spouse	0 8

Group 4 (rural)

Variable		Number
Age	Average age 30 years Range: 26 to 36years	
Marital status	Married Single Divorced/ separated	6 1 1
Number of children	1 to 3 4+	6 2
Source of income	Informal sector (e.g. selling food) Informal sector and from relatives/ spouse	0 8

4.5 Data collection

The data collection process occurred over the course of one and half months; between January 2003 and February 2003. The data collection from primary and secondary sources was carried out concurrently. The documents/ studies reviewed were: -

- Report on the potentiality for cost sharing whereby information that led to be the basis of introducing user fees for health care in Tanzania was extracted.
- Report on Implementation of user fee from 1993 to 1995. This report provides information on the implementation process, the success and difficulties faced during the first two years of user fees implementation. The difficulties and success are in

terms of revenue collection and management capacity of revenues at local health facilities.

- Guideline for Implementation of user fee policy. The guideline gives information on the reasons which led to the introduction of the policy and its implementation in 1993, how user fees should be implemented and what are expectations from the policy.
- Gender Budget Initiatives study report. This report provides information on contextual factors which led to introduction of user fees in health care in Tanzania and how those factors impacted on women's health.
- Report on evaluation of the cost-sharing programme implementation; the report gives the contextual factors that led to the introduction of user fees in health care in Tanzania and the implementation of user fees policy. Further, it provides the objectives and findings of the evaluation study after five years of its implementation in health care.
- Guideline for the preparation of Medium term plan and budget framework for 2002/03 – 2004/05. This guideline provides information on contextual factors that enhance the existence of user fees for health care in Tanzania.

4.6 Ethical considerations

After identification of participants for interview and FGD, participants were told by the researcher the aims of the study, their role and the importance for their participation in the study. Then informed consent was obtained from the participants. The appointment for interview and FGD was arranged according to the participants' convenience time. In order to ensure confidentiality; the interviews were conducted in a private room as chosen by a participant, FGDs were conducted at a place which made participants free from being afraid to be intimidated as a result of what they would say during discussion. Additionally, the name and official positions of respondents are not mentioned in the study report, and results are presented in groups.

4.7 Data analysis

Although, the conceptual for the study was developed based on the policy analysis triangle (Walt & Gilson, 1994), the time - line analysis was used to analysed data for contextual factors as well the policy process in relation to user fees development and implementation. The time-line framework was used during study analysis because, it was thought that this analysis would explain clearly and easily how the context and the process impacted on user fees policy design in different periods of time. The data were analysed into two phases: -

- Phase 1 covers the key contextual factors which led to the introduction of the policy and the process in the formulation of the policy. In other words, phase 1 analyse the policy from late 1970s up to 1993 where the policy started to be implemented.
- Phase 2 covers the key contextual factors and policy process after the introduction of the policy. That is to say, phase 2 analyse the policy after its introduction in 1993 to date.

The analysis was done in two phases because of differences on key contextual factors which led to or enhance the existence of the policy, and actors involved or interested to the policy are not all the same. This might have effect on the policy process as well as policy design.

In analysis of the impact of user fees on poor women, the study explored two key issues in relation to the policy. These are impact in relation to reproductive role and care for others. This means, there are could be other impact in relation to poor women which were not explored in this study.

For in-depth interviews, data were compiled and analysed qualitatively on daily basis. This enabled one to identify the effect of the policy on poor women and what has been done to address the problem. Immediately after every FGD session, the data obtained from the session were written up by the

researcher. Then, data were analysed qualitatively using a thematic approach. On the basis of the similar themes, data among all four groups were compared; areas of differences and similarities were noted. Thereafter the full report was written for the FGDs for urban and rural areas. The FGDs helped to give an insight on experiences poor women have in relation to user fee policy in health care.

4.8 Scope and limitations of the study

4.8.1 Scope of the study

There is socio-economic and cultural diversity between regions in Tanzania. This study is exploratory in nature and aims to give an insight on how user fees policy impacted on poor Tanzanian women. The information obtained from this study may not be generalised, but the findings can be used as working hypotheses and it is sincerely hoped that they can be tested in future.

4.8.2 Limitations of the study

- Because of financial constraints, research assistants, transcribers and tape-recorders were not used when conducting the FGDs and data processing. Instead, the researcher conducted alone the FGDs in rural and urban areas based on the questions designed earlier. In order to overcome the problem of forgetting information, the researcher wrote the notes based on earlier designed topic questions soon after every FGD.
- Data were collected by the researcher alone, therefore biases that could arise from the researcher being the one who conducted all interviews and FGDs can not be ruled out (Denzin & Lincoln, 1998). In order to minimise researcher bias, information obtained from in-depth interviews was cross-checked with the information obtained from secondary sources and interviewees. Also, quotations which express views of the participant were recorded. In FGDs quotations from participants were used to illustrate issues and perceptions. The quotations helped to express the views of poor women.

- Selection biases that may arise during the selection of women for FGDs by ward leaders, can also not be ruled out. In minimising selection biases, the researcher informed the ward leaders fully the reason and the importance of him being used to select women for FGDs. Also, women in each group were selected from different location (streets) in order to have information which may give us different experiences in relation to the effects of user fees on poor women.

- Recall bias

User fee policy were initially introduced and implemented almost ten years ago in Tanzania. Actual remembrance of precisely what happened during policy formulation in detail is highly unlikely. For this reason, the interviewer focused on certain critical issues during the interview rather than the detail of each step during the policy process.

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CHAPTER FIVE

TIME-LINE ANALYSIS OF USER FEE POLICY IN HEALTH CARE

This chapter is divided into five sections; Section 5.1 gives an overview of results of policy analysis. Section 5.2 presents phase 1 of time analysis which outlines key contextual factors that led to the introduction of user fee policy. Key events discussed in this section are; global changes which impacted on resource allocation to health in development countries i.e. the fall of communism and introduction of SAP in 1980s; poor economic performance in Tanzania between late 1970s and 1980s which affected budget allocation in health and quality of health services. Then, this is followed by discussion on policy processes during policy development, where actors involved during policy development and their influence on the policy is analysed.

Section 5.3 presents the content of the policy; in particular the policy objectives. Further, the section describes how the policy was implemented and evaluated. The policy objectives and evaluation of the policy reflect the significance of actors who were involved or not involved during policy process. As well, the above-mentioned issues reflect how the environment in which policy was developed shaped the policy design.

Section 5.4 presents phase 2 of the time – line analysis. In this section the key contextual factors which enhance the existence of the policy are discussed (i.e. Poverty Reduction Strategy (PRS) and objectives of ruling political party). This is followed by discussion of the policy process after its introduction in 1993. The result from the process is examined. Finally, section 5.5 discusses whether there have been any change(s) in the policy design and implementation since its introduction in 1993.

5.1 Overview of results

Looking at time-line analysis of policy process and contextual factors, the following salient features in the two phases are noted: -

Context

The major factors which led to the introduction of user fees in phase 1 were the macroeconomic environment (poor economic performance) and the introduction of SAP. In phase 2 the major contextual factors which enhance the existence of the policy are political factors and PRS.

Table 5.1 Major contextual factors which influence user fee policy in phase 1 and 2 of time-line analysis

Period of time-line analysis	Local contextual factors (Macroeconomic /political)	International contextual factors
Phase 1 late 1970s – 1993	Poor economic performance	SAP (instituted by World Bank and IMF in 1980s)
Phase 2 1994 – to date	Objectives of political ruling party	PRS (instituted by World Bank and IMF in late 1990s).

Policy process

In phase 1 it is found that broad stakeholder involvement was limited:- in that Civil Society Organisations (CSOs) and women representative groups were not involved during policy process. Although opposition political parties raise their concerns on the policy, they focused on the poor in general and not poor women. However, it can be argued that the power of opposition parties was too weak to influence the policy development.

In contrast to phase 1, in phase 2 there is involvement of CSOs and gender activists in the policy process. When looking at the issues on their agenda, the impact of the policy on poor women is prominent. However, their active participation in the policy process such as in the development and drafting of PRS paper was found to be limited. In both phases, it is found that international interests of powerful donors (i.e. World Bank) played a greater role in influencing the health sector system in Tanzania.

Generally, poor women as a vulnerable group in the society were ignored in policy development, which has implications for policy design, implementation and evaluation. For instance, objectives for exemption did not consider women's health and data for monitoring and evaluation of policy were not gender sensitive. This might result in effects which arise from the policy on poor women not to be easily detected. So far, no change has taken place on policy design since its introduction in 1993.

5.2 Phase 1 of time–line analysis

5.2.1 Contextual factors which led to the introduction of user fee policy in health care

The Global Context

The global changes and the fall of communism between 1980s and early 1990s were seen to result in changes in the flow of resources from donor agencies to the developing countries (TGNP, 1998). This resulted in most donor shifting funds from countries in Sub-Saharan African region to fund programmes in countries in Eastern Europe. Owing to this, there was a reduction of financial support for social services to the developing countries including Tanzania. Health as a sector was reported to be much affected by these global changes (World Bank, 1999). SAP policies in 1980s came with conditions; one of which was that governments in developing countries should cut government subsidies to some services. This affected public social services such as health (Cornia et al., 1987; Standing, 1999).

Therefore, another financial mechanism was needed in Tanzania and other developing countries to reduce the financial gap in health services (Standing, 1997).

The macroeconomic context

In 1970's and 1980's Tanzania faced economic crises which played a great role in the deterioration of the quality of social services (such as health services) (Kiwara, 2000). This situation meant that the vulnerable groups, particularly women, carried a large share of the burden of the economic crisis (TGNP, 1998).

The initial mechanism used by the Tanzanian government to overcome the crisis was the introduction of the National Economic Survival Programme (TGNP, 1998). The Programme aimed to promote the export of goods in order to increase substantially foreign exchange earnings, to save on imports, to eliminate food shortages and to control public spending in the government and parastatal organisations. The programme was implemented in 1981 and lasted for only two years. This programme failed because the Tanzanian economy depended almost entirely on donor support (ibid).

In mid 1980s, the Tanzania government opted for SAP as a measure for restructuring the economy (MoH, 1999). The SAP was introduced in two phases. Phase one was the Economic Recovery Programme which operated from 1986 to 1989. The second phase was the Economic and Social Adjustment Programme which operated from 1989 to 1992 (TGNP, 1998). These two restructuring measures changed the nature of the Tanzanian economy through privatisation, improvement on revenue collection and implementation of civil service reforms (e.g. retrenchment) (MoH, 2001). Based on that the Tanzanian economic ideology was changed from one of government control over the major means of production, to an economy that relies more on market forces which are determined by

demand for and supply of goods and services. These reform measures had negative effects on the lives of the majority of Tanzania's citizens (TGNP, 1998).

Tanzania's government in particular depends heavily on donor support for the provision of health services. This has forced the Tanzanian government to agree with conditions set by the World Bank and the IMF in the SAP. It is documented that (MoH, 1999) the foreign financial component of the development budget for health in 1987/88, 1988/89 and 1989/90 was more than that of the local component. This dependence of the government on donor support is reported to be at least partly attributed to the inflation began in the mid 1980's, illustrated by the devaluation of the Tanzania shilling (Tsh.) from 18 Tsh. against the US dollar (1985/86) to 191 Tsh. against the US dollar (1989/90) (MoH, 1999).

Resource constraints

The extent of resources allocated to health by the government was seen not to be proportional to the increasing number of public health facilities in the country. According Ministry of Health (1997), in 1971 the Tanzanian government aimed to expand health services by building 100 dispensaries per year so as to achieve a target of between 6,000 – 10,000 people per dispensary by the year 1980. Further, the government aimed to build 25 health centres per year to meet the target of 50,000 people per health centre by the year 1980 and to build district hospitals in districts that do not have hospitals. Therefore, there was an increase in health facilities which led to increased financial burden to the government. As result the government failed to meet people's health needs (MoH, 1997; MoH, 1999).

Devaluation of the Tanzania shilling against the US dollar has also reduced the effective size of the budget allocated to health (MoH, 1999). It can be argued that, because Tanzania depends largely on imported medicine for local use, devaluation of the Tanzania currency has a strong negative impact on

the quality of health care services. According to the MoH (1999), the budget allocated to health (Tsh) year in a year might seem to be increasing because of inflation, however the budget allocated to health has had little or no effect on health services. The total government expenditure on health for 1977/78 was about 7.5% of total government expenditure for the year 1977/78, while that of 1982/83 was about 5% of total government expenditure for the year 1982/83. If one would take into account the element of inflation, per capital expenditure on health in 1977/78 was four times that of 1982/83.

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Quality of services provided at public health facilities.

Despite the improvement in accessibility of health services to the people, i.e. by 1984 about 72% and 93% of the population were living within 5km and 10km from health facility respectively (MoH, 1999), the quality of health services was seen to deteriorate over time. In the study report on the potential for cost sharing in Tanzania (Abel-Smith & Rawal, 1992), it was found that all levels of health facilities were faced with the problem of financial constraints. This situation was worse at the health centres and dispensaries, as a result patients tended to by pass these health facilities to attended at the district, regional or referral hospitals.

Features reported in the study, indicating financial constraints, were over-dependence on foreign aid for essential drug supplies for the studied dispensaries and health centres, inadequate supplies of drugs and other medical consumables at the hospital level, lack of repair and replacement of medical equipment and of vehicles and inadequate supplies of fuel. Further, lack or inadequate number of staff particularly doctors and nurses, low salaries for health workers and lack of functioning information systems were also identified as features indicating financial constraints in the studied health facilities.

5.2.2 Process in user fee policy development

The process of formulating user fee policy in health care involved the government, World Bank and a team of evaluators. The Ministry of Health (MoH) was involved in the user fee policy design. The MoH had reviewed the existing finance mechanism, conducted health care financing studies in order to assess the ability to pay, willingness to pay and benefits the people particularly the poor could get from the policy. Based on that, guidelines on how user fees should be introduced and implemented were established.

The main health care financing studies were carried out between 1989 and 1991 by the Ministry of Health and the London School of Economics (Abel-Smith & Rawal, 1992). The studies involved a survey of households and health units countrywide in order to assess the ability and willingness to pay of households for health services. The study showed that people are willing to pay for health services provided the quality of services are improved. The findings of these studies provided the rationale for charging user fees in public health facilities.

The policy was supported by the government and backed by the World Bank. The government supports the user fee policy because it sees that user fee is an appropriate additional mechanism to increase financial resources to health. The World Bank supports the idea of user fee because, this idea goes hand in hand with the SAP which was introduced in 1980's.

The Ministry of Health, Planning and Privatisation Commission and the Ministry of Finance represented the Tanzania government in policy development. The Planning and Privatisation Commission (at that time Planning Commission) was involved in user fee design by encouraging cost sharing. The Ministry of Finance (MoF) was involved in the policy design through consultation committees by giving advice on fiscal issues. It gives advice based on country's fiscal condition. Using health care financing studies, MoF advised the government to introduce user fees as a supplemental source in filling a financial gap in the government health budget. The World Bank was also involved in the policy process by providing training of staff in capacity building in workshops and abroad.

The introduction of the user fee policy in Tanzania was said to face opposition from opposition political parties and the public. In 1991 multi-partism was introduced in Tanzania. Opposition parties argued that majority of Tanzanians were poor, therefore they could not afford to pay for health services. In addition, it was reported that the public first argued that people are already paying fees through indirect

and direct taxes, and secondly why should they pay again for services which are already paid for by the government?¹ Furthermore, the public argued that the quality of health services is poor therefore, in order for the people to pay for health services the government has to improve the quality of services first².

As a response to the opponents, the government argued that most people in rural areas are using mission hospitals for health care. These people afford to pay for services at a higher price in mission hospitals than what they would pay at the public health facilities. Together with findings from the health care financing studies, the user fee policy paper was brought forward to the cabinet. In June 1993, the user fees policy paper was proposed to, and passed by cabinet. In August of the same year, the policy paper was approved by the National Assembly of Tanzania and implemented in the same year.

5.3 User fee policy design and implementation

5.3.1 Objectives of user fee policy in health care

The Ministry of Health sees the main objective of introducing the user fee policy in health care as being to improve availability and quality of health services (MoH, 1997). As a mechanism to achieve the objective, the money collected from user fees would be retained at the health facility where it is generated. The retained revenue would be used to buy items such as drugs, medicine supplies, maintenance of equipment and buildings. By so doing, user fees in health care would improve the availability and quality of health services.

In order to achieve the objective, the government decided to introduce user fees in order to generate additional revenue for health services. The government (MoH) established the fee structure in 1993

¹ Information obtained from interview with MoH official

² Information obtained from interview with MoH official.

with details at what level the fees would be charged, how much was to be charged in relation to the type of service provided and who was to be exempted from paying health care services (Appendices 1 & 2).

In order to ensure that the revenue collected from user fees was going to be used to improve the quality of health services, the Ministry of Health provided a guideline for hospitals as to which items should be purchased using the revenue collected from user fees. Additionally, the MoH established an Advisory committee at each hospital, which reviews the proposals on what is to be purchased and to see whether the proposed items would meet the priorities set by hospital management in terms of improving the availability and the quality of health services.

The government also aimed to reduce the tendency of patients to by pass the lower level facilities, to rationalise the utilisation of health services and to strengthen the referral system. The government aimed to do so by using a "tiering" mechanism whereby there will be different charges for health services at different levels, with service charges increasing from primary to tertiary level. By so doing, everybody would have responsibility for taking care of his/her own health together with the health of his, or her, families.

At the same time, the government also wanted to ensure that user fees in health care would not negatively affect the vulnerable groups. Doing so, the government aimed at ensuring equity and access to health services to be achieved during the policy implementation. Equity and access to health services was expected to be achieved by: -

- a. Making better health care services accessible to everybody by improving availability and quality of health care. As a mechanism to improve availability of services, the government decided to retain

all revenues at the local health facility. It was expected that revenue will be used to fund services which are not provided because of inadequate funds.

- b. Setting fees at low levels based on ability to pay and not based on the cost of service provided.
- c. Establishing exemption mechanism for certain types of diseases and social groups and waivers whereby the patient asks for free health services because of inability to pay at the time of illness.

It might be argued that in order to achieve equity in terms of accessibility to health care, an exemption system needs to be functioning. However extra subsidies may compete with the improvement in quality of care, whereby a significant amount of revenue is needed to be raised in order to improve quality. Furthermore, the accessibility of the target groups will only be achieved if the exemption criteria are designed in an equitable way (e.g. to include vulnerable groups such as poor women) and may also depends on the discretion of those who apply the criteria.

According to the MoH (1997), the objectives of exemptions are: -

- 1). To improve access to health care for those with infectious disease or diseases of outbreak/epidemic;
- 2). To reduce the negative impact of high costs which are associated with chronic diseases;
- 3). To facilitate growth in under fives;
- 4). To enable poor people to access health services whenever they need to do so.

Therefore, from exemption objectives, the criteria for exemption from paying health services was developed based on: -

- a) Demographic characteristics

By age: children under five and elderly (age above 60 years). And by sex: MCH/FP services and maternity services for grade III patients.

b) Type of illness

Inpatients and outpatients with referral documents from district and regional hospitals; Patients with chronic diseases such as stroke, typhoid, cancer, HIV/AIDS, diabetes, tuberculosis, disease of epidemic or outbreak (e.g. cholera, meningitis, plaque), and patients with mental illness who will be admitted for a long time.

c) Poor

If a poor patient comes with a document that declares that she/he is not able to pay for health services from the ward and village executive officers of his/her residential area, then the patient will be given free health services. However, the exemption will be given only after the documents have been examined or investigated by a social worker at a given health facility.

The incentives behind the criteria are to ensure that everybody is responsible for taking care of his/her own health together with that of his or her family. It is hoped this will reduce the burden to the government and, therefore, will reduce the negative impact resulting from financial constraints and consequently will improve the quality of health care (MoH, 1997).

The involvement of the public in provision of health services is expected to create a sense of ownership among the people. The extent of revenue generated from user fees as an increased share of health facility to revenue is determined by income, culture and the awareness of communities on valuing good health. Therefore, it can be argued that the revenue generation capacity among regions is expected to be different, since regions in Tanzania are not homogenous, and the retention of all revenue at the local facility would most likely perpetuate geographical inequities. Compared to poor regions, the better off regions most likely will receive services of better quality.

5.3.2 Implementation of user fee policy in health care

Following the approval of the user fees policy in July 1993, the policy was implemented in a phased manner. The entry point as phase I (August 1993), involved the introduction of new and revised charges for grade I and II patients (explained below) at district, regional and referral hospitals. Phase II began to be implemented in January 1994, whereby a user fees were implemented for grade III patients at regional and referral hospitals. Phase III was implemented from July 1994, whereby user fees were introduced for grade III inpatients and outpatients in district hospitals (Ilomo, 1995). Phase IV which involved the introduction of user fees at health centres and dispensaries, started in 1996 in some regions of Tanzania, such as Dar-es-Salaam, Tanga, Mbeya and Kagera.

It should be noted that Grade I and II refers to patients receiving extra attention in getting services e.g. self-contained single rooms, special food services. Grade III refers to patients receiving ordinary services. It should be noted that all grade I, II and III patients receive theoretically the same quality of services in terms of disease management.

During the implementation process, the MoH appointed a Task Force and an Implementation team to be responsible for pre-implementation work and eventual implementation. The advisory committees were introduced at the districts, tertiary and referral hospitals in order to ensure that the policy was implemented appropriately. In all regions, members of advisory committee were given training during the implementation process (MoH, 1999).

At the central level, the National Advisory and Supervision Commission and Implementation Committee were established. The Advisory and Supervision Commission comprised members from MoH, Ministry of Finance, Planning and Privatisation Commission, Dar-es-Salaam City Council, Prime Minister and Vice-President's office, Cabinet ministers and the chairperson of the implementation committee. The

function of the commission was to monitor the implementation national-wide, looking at the development, success and problems arising from user fees as well as to advise the principal secretary of the MoH (MoH, 1997). The Implementation Committee comprises economists, medical doctors, Principal Secretary of MoH and Accountant. Both the National Advisory and Supervision Commission and Implementation Committee have responsibilities to monitor how people pay for health services (ibid).

At the local level, the local government at district level is responsible for implementation of the user fee in health. The local government implement the policy by using guidelines issued by MoH. As a mechanism to educate, to create awareness to the public and to change their thinking on the introduction of user fee in health care, media such as radio, newspaper and pamphlets were used as ways to sensitise the public (Ilomo, 1995).

As routine government monitoring (MoH, 1997) a report on user fees in health care is compiled monthly at health facilities, quarterly and annually at the district and regional levels. The report includes: -

- The amount of revenue collected from user fees. This will enable one to assess the ability of health facilities in generating additional revenue from user fees and their ability to manage the revenue collected from user fees;
- The number of people exempted from paying health services in terms of type of treatments provided;
- The extent of debts and the mode of payments;
- The number of patients utilising health services.

Several evaluation studies were conducted during policy implementation to evaluate the progress of user fees in health care. Ilomo (1995) describes the success of implementation in terms of which phase

user fee policy has reached and the extent of revenue generated from user fee. Further, Ilomo (1995) explained problems encountered during the first two years of the implementation process. In this case the evaluation looked at accounting and management of revenue collected from user fees, availability of drugs and other medical consumables in health facilities and the availability of funds for cost-sharing meetings at all levels.

Two evaluation studies were conducted in order to assess the state of user fee implementation so that the information obtained from the studies could be used in decision-making (MoH, 1999). The evaluation study of 1998 examined the availability of medicine and other medical consumables in health facilities, accountability and management capacity of staff on revenue collection, and the perception of providers and users of health services as to the quality. Further, the study examined level of community awareness of user fee, impact of user fees at household level in terms of health seeking behaviour and utilisation of public versus private health facilities. It examined the implementation of waivers and exemptions and type of MCH services, which are paid in under fives and mother's health care.

One of the findings in the evaluation of 1998 study was that community was aware of cost-sharing (user fee) policy implementation, and the users and providers of health care recommend that MCH/FP services should be provided freely. This includes treatment of mothers and under-fives. Although the MCH/FP services are exempted under the user fee policy, it is reported that a large proportion of users pay for services as cash or purchase items which are said to be out of stock (MoH, 1999). Additionally, the payment for the services was reported to be unofficial (MoH, 1999). Based on the findings, the evaluation report for 1998 recommended that the District health management teams and hospital management teams need to ensure that fee schedules are written in large letters, well displayed and accessible to the patients and clients. This will enable patients and clients to know what services to pay

and at what rate. Furthermore, disciplinary action should be taken against health personnel who practice against the fee schedule.

5.4 Phase 2 of time-line analysis

5.4.1 Contextual factors which enhanced the existence of user fee policy in health care

Macroeconomic environment

The fiscal constraints resulting from poor economic performance had exacerbated poverty in Tanzania. This meant that the Tanzania government carried a heavy burden of debts because of the failure to repay previous debts and interest on the due date to World Bank, IMF and other bilateral agencies.

In 1997, the Tanzanian government adopted strategies for poverty eradication. During the same period (1996), the World Bank and IMF took initiatives to address debt and poverty in the Highly Indebted Poor Countries (HIPC). The World Bank and IMF provide debt relief to HIPC who fulfilled conditions set for debt relief. The debt relief which is given by World Bank and IMF is operating in a such a way that the funds which could be used to pay debts would be deviated to funds priority programmes identified by the PRS. However, it has been observed that our country still faced financial constraints which resulted in the existence of a financial gap to fund the priority programmes and to reduce poverty in Tanzania.

In the Poverty Reduction Strategy Paper (PRSP) strategies which was released by the government in 2000 as part of its application for HIPC assistance, user fees for primary education were abolished while those in health care were retained. According to DANIDA (2001), Civil Society Organisations (CSO's) who were involved during PRS process were able to convince the government to reverse the user fees policy in education and not in health care services. The review report on PRS process in Tanzania (DANIDA, 2001), reported that CSOs argued consistently for abolition of user fees in primary education and in health services. Significantly, the CSOs addressed the negative impacts of user fees

in primary education using their own studies. These studies were demonstrating how the poor and other disadvantaged groups in the society were impacted negatively from the policy. In the health sector, it was reported by some of CSO's that the failure to convince the government to reverse the policy in health care was contributed to the fact that gender issues were not sufficiently mainstreamed.

Political factors

In the general election manifesto for the year 2000, the Tanzania ruling party, Chama Cha Mapinduzi (CCM), aimed to develop policies which would improve and sustain economic growth (Planning and Privatisation Commission & Ministry of finance, 2001). These policies were consistent with objectives stated earlier for PRS. Among the objectives sets by CCM were to achieve macroeconomic stability through fiscal policies and to strengthen the competitive market in order to create a conducive environment for investors. Further, CCM aimed to ensure efficiency in utilisation of available scarce resources and to enhance budgetary support to basic social services including health. Due to the financial constraints, all these objectives could only be achieved by involving households and private sectors in provision of services. For this reason, the user fee policy continued to be implemented in health care services as an additional source of finance to enhance budgetary support to health care and consequently to improve quality of health services.

5.4.2 User fee policy process after its introduction in 1993

In the year 2000 the government of Tanzania instructed the Planning and Privatisation Commission to develop guidelines for MoH by taking into account the government commitments in the PRSP, i.e. to increase resource allocation to health. User fees in health care are one of key cost-sharing mechanisms to be used to increase financial resources to health in addition to that allocated by the government.

The interim PRSP that includes user fees policy in health care has created debate between the government, World Bank and Non-governmental Organisations (NGO's) such as Tanzania Gender Networking Programme (TGNP). TGNP opposed the inclusion of user fees policy in PRSP. TGNP argued that the introduction of user fees in PHC services would have resulted in a negative effect on the rural population particularly the poor, women and children. User fees exacerbate inaccessibility and unaffordability to health services, and would increase morbidity and mortality of the people.

Despite TGNP lobbying against user fees in health care because of their negative impact on marginalized groups such as poor women, the World Bank endorsed the PRSP interim with inclusion of user fees in health care in December 2000. Although it was reported in previous section (5.3.1) that failure to convince the government to abolish user fee policy in health care during PRSP preparation was attributed to gender issues not being sufficiently mainstreamed, TGNP (2000) argued that the CSOs were involved in a superficial and half-handed manner. The CSOs attended a separate process convened by the Tanzania Coalition for Debt and Development, while the government was developing the document internally.

Further, the CSOs were invited at a later stage in the sharing sessions on document prepared by government at zonal workshops. And NGOs were invited to comment on the strategy paper at a national level. However, some of the inputs from the CSOs and the NGOs were reported not have been taken into consideration in developing the PRSP. Generally, it was said that the consultation was conducted in a rushed manner that did not allow time for dialogue, discussion and debate (TGNP, 2000). Despite failure to remove user fees in health care in the PRSP interim, TGNP has been continuing to campaign for government to stop user fees in health care. TGNP has done this through protest and press releases. TGNP advocate for people so that the whole population receive health services which meet their health needs.

The mechanism used by TGNP to oppose user fees in health care is through coalition with other feminists to form the FemAct Coalition in order to increase the power and to be able to achieve its goal. Additionally, TGNP is linked with Fifty Years is Enough (an NGO in USA) on campaigning for World Bank to stop user fees in health care. The success of this campaign is not yet seen. However, through such kind of strategy, TGNP has achieved some of its goals.

Through Fem-Act Coalition, TGNP raised the issue of the necessity of positive HIV pregnant mothers in Tanzania to be also given free anti-retroviral drugs to prolong life as their children who found to be HIV positive. The policy initially was planned to give anti-retroviral drugs to the newborn and left out their mothers. Together with Fem Act Coalition, TGNP argued that leaving mothers out of free anti-retroviral drugs which are too expensive to be afforded by ordinary and poor people will increase the number of orphans as well the deterioration of socio-economic status of the family. Based on that, the MoH has agreed to provide free anti-retroviral drugs to both mothers and newborn that are found to be HIV positive. Therefore, TGNP is continuing to campaign and is trying to build on this success to abolish user fees in health care.

In the macro-policy forum of Consultative Group (CG) meetings, the macro-gender groups (hereby referred as gender activist organisations involved at national and international level to ensure that policies are developed and implemented in a gender perspective) presents gender statements on the effects of user fees at community level particularly among the poor women (without concrete data). The CG meetings involve the government, NGO's, CSO's and views from the field. The issues which have been raised by gender activists are the need for an increase in the health budget and that poor women are still suffering more than poor men in relation to reproductive health and HIV infection. Thus, user fees in health need to be looked at from a gendered perspective. Recently, the macro gender group

became a key partner of the Public Expenditure Review working group and are involved in the annual plan for health so that the allocation in health should be more gender sensitive. However, during the interview, it was felt that its impact on policy direction was too early to tell.

5.5 Changes in the user fee policy since its implementation in Tanzania

Since the policy started to be implemented in 1993, there has been no change observed by both interviewed stakeholders and women participated in the FGDs. Moreover, from the interviewed stakeholders, it is reported that the Community Health Fund (CHF) has also been introduced as another form of health care financing mechanism in some regions of Tanzania. In CHF each household contributes 5,000.00 Tsh. every year and the World Bank provides grants of the same amount to each household which is a member of CHF. Therefore, all members of households who join the CHF receive health services without extra payments for the whole period of one year. For those who do not, each household member pays fees on utilisation of health services. A study on the evaluation of CHF and its impact on vulnerable groups, such as poor women has not yet been conducted.

CHAPTER SIX

IMPACT OF USER FEES IN HEALTH CARE

In understanding the impact of user fee policy, there is a necessity to explore gaps between the policy and its implementation. Therefore, this chapter starts with a discussion on gaps between user fee policy and implementation as observed by interviewed stakeholders, and possible factors to which those gaps are attributed. Equally important, the level of awareness on the policy among studied women is also discussed. The above-mentioned issues might be contributing factors for the impact of policy that are seen today among poor women. This is followed by discussion on the advantages and disadvantage of the policy as perceived by interviewed stakeholders. Lastly, the chapter presents the impact of the policy on different socio-economic groups particularly poor women as obtained from interviewed stakeholders and FGDs with poor women.

6.1 The Gaps observed between user fee policy and its implementation

Before discussing the gaps observed by interviewed stakeholders between user fee policy and its implementation, there are number of factors mentioned by stakeholders which seemed to affect the implementation of the policy. This meant that, there could be other factors which are not discussed here, and have an effect on implementation of user fees for health care, but they are not considered to be the most important.

For the policy to be implemented effectively, adequate funds were seen as an important factor by interviewed stakeholders in order to back up the policy³. Thus, the fiscal constraints which are present in Tanzania were said to have contributed to the gaps which are seen between the policy and its implementation. It is said that fiscal constraints have led to inadequate numbers of staff in health facilities, demoralisation of staff because of poor working conditions and low salaries which do not even

³ Mentioned by officials from MoH, MoF, Kinondoni municipal and NGOs.

meet their daily needs. Additionally, fiscal constraints have led to unavailability of drugs and other medical consumables, lack of equipment, and poor health facility environments. All these together have been observed by stakeholders to have a negative impact on implementers at local level.

Another important factor is the lack of targets on how much revenue should be collected from user fees in a given region⁴. This was seen to result in difficulties in assessing the revenue generation capacity of different regions in the implementation process. Interviewed stakeholders also identify unavailability of drugs in health facilities as another factor which discourages people who are willing and able to pay⁵. This has resulted in people who have the ability to pay to shift to private health facilities, whereby they are assured of good services. Shifting of people from public to private health facilities was seen by interviewed stakeholders to be one of contributing factors for less revenue collection that has a negative impact on the quality of health services.

The kit system for supplying drugs to health centres and dispensaries is uniform for all regions of Tanzania. However, disease patterns differ among and within regions. The kit is opened on the first day of each month regardless of whether drugs are finished before this. Thus, the kit system might have contributed to some extent to the frequent lack of drugs for common diseases in some health facilities in a given geographical area⁶.

The gaps observed by interviewed stakeholders between user fee policy and implementations are on: -

Exemption

Free services are supposed to be given to the poor, MCH/FP services, maternity services and elderly people. But exemption is observed most often to be given according to personal relationship and not

⁴ Mentioned by MoH official

⁵ Mentioned by officials from MoF and Kinondoni municipal

⁶ Mentioned by officials from Kinondoni municipal and Kisarawe district.

based on age/sex or poor criteria⁷. Additionally, in most health facilities no records are available on who were exempted⁸.

In some health facilities, it was found that pregnant women used to pay for antenatal clinic and delivery services. This was done in order to raise revenue collection at the local health facility⁹. Criteria used to charge these pregnant women were subjective, a pregnant woman who was considered better off had to pay for services. This is contrary to the user fee policy. This situation is attributed to the fact that some of staff at the local level tend to implement the policy arbitrarily. Additionally, despite MCH and delivery services being free, it was noted that pregnant women in some areas still pay for a MCH card and for investigations¹⁰.

Additionally, the criteria used to exempt a pregnant mother for health services are not uniform for all regions. In certain areas the criterion is based on gestation age, while in some areas it is based on whether the pregnant woman is already attending Ante-Natal Clinic (ANC). Items for conducting labour are reported by some interviewed stakeholders to be always adequately available in health facilities. Nevertheless, charging of items by a certain number of health care providers is used as a mechanism to increase their income¹¹.

The use of revenue

It was observed by some interviewed stakeholders that there is inappropriate use of revenue collected from user fees at local facility¹². Revenue collected is often used to purchase items which do not benefit the patients. For example, revenue is used to pay staff allowances, and to buy fuel. Contrary to the

⁷ Information obtained from MoH official.

⁸ Information obtained from MoH official.

⁹ Information obtained from Kinondoni municipal official.

¹⁰ Information obtained from Kinondoni municipal and NGOs Officials.

¹¹ Information obtained from Kinondoni municipal official.

¹² Information obtained from MoH official.

policy, in some of health facilities items have been purchased without being approved by advisory committee.

6.2 Level of awareness among poor women on the policy

There is a notable difference in the level of awareness towards user fee policy and free services among urban and rural studied women. In urban areas, women know which services are not charged, such as for pregnant women, children under five and elderly. However, some of the services are said to be charged in daily practice. In rural areas, women reported that people exempted from the fee for health services are pregnant mothers and children under five.

“... Elderly ladies are often forced to pay fees for services. They are told by health workers that their grandchildren have to pay for them (services) because, they are frequent users of health services....” (A woman from group 2)

In urban areas, the main source of user fees information is from the radio, posters at the health facilities, friends/relatives, and at the antenatal clinics. In rural areas, the major source of information is found to be from children and antenatal clinics, other patients and relatives or friends.

In urban area, it is thought that the aim of the government in introducing user fees in health is to help the poor. However, there are no advantages so far to poor women in relation to the policy. They say it is because of fees and cost they do have to pay during antenatal visits and delivery. While among participants in the rural studied area, the study found that participants do not know the government's reason for introducing the policy.

"...I know the government has introduced the policy to help us the poor, but we do not benefit from the policy ..." (A woman from group 1)

"...I just take the child to the hospital and I was told not to pay for services. I do not know why the government has introduced the policy, may be you are the one you should tell us ..." (A woman from group 4)

6.3 Perceptions over advantages of user fees in health care

The majority of stakeholders interviewed from the government and World Bank, perceived that there is an increase of funds in health facilities which has led to the improvement of drug availability in some hospitals, health centres and dispensaries¹³. On the other hand, some of them said that lack of drugs in health facilities is still a problem. Among those that said there is an improvement of drugs in health facilities, some mentioned that drug availability depends much on revenue generation capacity and its management at the local facility. However, they said that generally the quality of services in health facilities is still unsatisfactory.

"...There is improvement in drug availability at health centres and dispensaries..." (World Bank official).

".... There is a problem of drugs adequacy at health centres, the kit only last for two to three days...." (Kisarawe district official).

"... Drug availability is still a problem, additional to consultation fee it cost about 2,000/= Tsh. to buy drugs from private pharmacies...." (Kisarawe district official).

The difference in perception on drug availability at health facilities could be explained by differences in geographic location. In contrast to urban areas, rural areas may be suffering more from the problem

¹³ Information obtained from MoH, MoF, Kinondoni municipal and World Bank officials.

shortage of drugs because of transport problem in bringing drugs on time. Furthermore, there is the probability that the interviewed officials in Kisarawe district are closer to the community than those at the central level who might rely mostly on reports for information.

Other advantages mentioned by interviewed stakeholders are; the retention of revenue at local facility has made unlikely for funds to be deviated for other uses¹⁴ and that funds are available whenever needed as opposed to where the hospital has to wait for the government to provide funds when needed. Additionally, it may take a long time and need long procedures before the hospital can received the funds from the government for its use¹⁵. User fees in health has created a sense of ownership among users of health facilities and hence the rational use of drugs ¹⁶.

6.4 Perceptions over disadvantage of user fees in health care

All interviewed stakeholders from the government and World Bank, said that as the poverty rate is high in Tanzania, most people are unable to pay for health services. This has resulted in the majority of people being unable to utilise health services whenever they need to do so. Unreliable sources of income, low levels of income and lack of infrastructure particularly in rural areas (such as transport increasing the cost for health care among the people) are among of obstacles seen by interviewed stakeholders which make people not to be able to pay for health services.

“... Most of citizens here are peasants not generating enough income for living”

(Kisarawe district official)

“...The exemptions procedures demoralises the poor...” (Kinondoni municipal official)

“... Exemptions forms are inadequate. A poor patient has to look for 30.00 Tsh. in order to photocopy the exemption form at a private shop. Additionally, electricity supply is unreliable;

¹⁴ Mentioned by Planning and Privatisation Commission official

¹⁵ Mentioned by Planning and Privatisation Commission official .

therefore despite difficulties in getting 30.00 Tsh, a patient may be forced to come more than once.

The cost for health services for poor people is still high..." (Kisarawe district official).

".... Not all people are able to utilise health services, especially the poor..." (World Bank official)

6.5 Impact of user fees in health care as perceived by interviewed stakeholders

From the interviews, the majority of stakeholders perceive that user fees have impacted differently according to socio-economic group.

User fees hurt the poor more than the rich people

Poverty is inversely related to health, i.e. user fees in health prohibit poor people from health services.

Rich people access health services easier than the poor¹⁷. Several informants noted that the financial status of rich people allows them to get free services based on their personal relationships with health care providers. In other words, user fees hurt the poor more than the rich people.

"... Most often rich or educated people have a colleague/ friend whom is a doctor, in this case it is most likely for the educated or rich patient to consult a colleague doctor without paying a consultation fee...." (MoH official)

".... User fees hurts the poor, makes them opt for other treatment. Currently about 60% of deliveries in Tanzania are taking place at the household level. However one may not exclude quality of care as a factor for high rate of home deliveries..." (MoF official)

The perception of the interviewed stakeholders over the impact of user fees in poor versus rich people agrees with findings reported by Abel-Smith (1993), Mackintosh and Tibandebage (2000). Abel-Smith

¹⁶ Mentioned by MoH official

¹⁷ Mentioned by officials from MoH, MoF, Kisarawe district, Kinondoni municipal, World Bank and NGOs

(1993), Mackintosh and Tibandebage (2000). These authors say that after the introduction of user fees in health services most of studied population were excluded from treatment because of inability to pay for health care. Some were forced them to borrow money or sell their possessions in order to pay the treatment fees. Failure to pay such fees disqualified them from treatment and hence had increased the rate of diseases transmission and often deaths (Mackintosh and Tibandebage, 2000).

Further, despite the presence of guidelines on who should be exempted from service fees, the exemptions system was found not to be operating in public health facilities (Mackintosh and Tibandebage, 2000; Abel-Smith 1993). It was found that majority of the studied population were not given an exemption, and some of health facilities exempted young children, health facility staff and relatives from paying service fee. Additionally, some of the tuberculosis and HIV positive patients who were included in the exemption criteria were found to be paying for health services. Further, Mackintosh and Tibandebage (2000) reported that exemption based only on being poor was not acceptable to the majority of health managers. Health managers believed that exemption for poor is not practicable under severe financial constraints.

Women are more negatively affected from user fees than men

The majority of interviewed stakeholders said that women are more negatively affected by user fees in health care than men¹⁸. Women use health facilities more than men. Further, women-headed households are said to be increasing¹⁹. On top of that, most women are not educated and so do not get well paid jobs. Therefore, women are seen to receive low income that cannot cater for needs for themselves and their families.

¹⁸ Mentioned by officials from Kinondoni municipal, MoF, Kisarawe district and NGOs

¹⁹ Information obtained from Kinondoni municipal and NGOs officials.

"... Because women's nature, particularly in rural areas, women take care of children, disabled, orphans and elderly. Therefore women incur extra costs..." (MoF official).

"...Women utilise health services more than men, because women care for others. Women's biological nature and women are more affected by HIV/AIDS compared to men ..." (Kinondoni municipal official).

- **User fees and women's reproductive role**

Based on the reproductive role, interviewed stakeholders argued that women undergo extra cost for antenatal clinic, delivery and problems which occur during pregnancy²⁰. A pregnant woman is supposed to pay Tsh. 100.00 for an MCH card on the first day of attendance and for a delivery kit. Even though it was not clearly identified by some of stakeholders as having a negative effect for women, it is agreed that women do incur extra costs in relation to maternity services and the overall cost of seeking health care might be reduced by providing free maternity services.

The following quotes illustrate different perceptions of the impact of user fees on the cost of reproductive health services:

"...Abortion cases pay for health services like other patients, therefore the cost of services on women is still high..." (Kinondoni Municipal official).

"... Pregnant mothers still pay for gloves when they come to deliver. That is to say there is no change for maternity services, although it is said to be free...." (Kinondoni Municipal official).

"... Women are benefited from the policy, since ANC and delivery services are free...." (Kinondoni Municipal official).

"...Women are benefited from the policy, delivery services are given free... " (World Bank official).

²⁰ Mentioned by Official from Kinondoni municipal and NGOs

“... Women do get free delivery services, therefore overall cost might be reduced...” (MoH official).

This difference in views among interviewed stakeholders on impact of user fees on reproductive role can be due to:-

- The differences in perception as well as knowledge on what is meant by reproductive health and women's health needs;
- Lack of information or awareness on hidden costs women incur when receiving maternity services.

This may be an indication of the need for actors who are involved in the policy development to be oriented on the costs that women incur from the policy. And by so doing, it will be possible to review the policy and make it more gender sensitive.

Again, it was argued that during labour, if a pregnant woman comes into the labour ward with no or inadequate number of required gloves, the woman will not be examined ²¹. This has led to the failure of a health worker to detect as early as possible problem(s), which arose during the course of labour, which could save the life of the mother and the unborn child. Additionally, some pregnant women have been seen to deliver at home attended by unskilled personnel, because they do not have money to buy a pair of gloves²². In this situation a woman and an unborn child are said to be at risk of dying from complication(s) which may arise during labour, contracting infections and disability which are preventable.

These findings are consistent with findings found in a gender budget study conducted in Kondoia district (TGNP, 1997). The gender budget study (TGNP, 1997) found that if a maternity patient fails to pay the fee, she would be attended but she would not be discharged until she is able to pay. Thus, it can be argued that even if maternal services are given free of charge or are greatly subsidised, women of

²¹ Mentioned by Kinondoni municipal official

²² Mentioned by NGO official

Tanzania still bear the hidden costs that may result to their inability to utilise health services when needed.

- **Exemption criterion for free maternity services**

The cut-off point for free service for a pregnant woman is reported by interviewed stakeholders to be based on gestation age, while in certain areas it is based on whether a woman is booked at ANC. Thus, exemption is provided for a woman with a pregnancy of seven months and above or one who is attending ANC. For example, in cases whereby exemption criterion is based on gestation age, if a woman of five months pregnancy is admitted for disease related to pregnancy (e.g. abortion), or not related to pregnancy (e.g. malaria), she would pay for services.

..." A pregnant woman admitted in a gynaecological ward for a threatened abortion at five months pregnancy would pay an admission fee, while the same patient admitted at an obstetric ward with premature rupture of membranes at eight months pregnancy would not pay an admission fee. What makes the difference between these two scenarios?" (Kinondoni municipal official)

- **Women's responsibilities on caring others**

As mentioned earlier, women are responsible for taking care of their family. It has been observed that most often women bring sick children to the hospitals and are responsible for paying for drugs, once drugs are found not to be available. Malaria incidence in Tanzania is high. If a child comes with severe malaria and needs to be treated with quinine, which is out of stock, the mother has to buy it from private pharmacies. Additionally, in order to administer quinine, cannula, and infusion set, intravenous fluids are needed. All or one of these items might be out of stock, therefore the mother has to buy the missing item(s) so that the child can get treatment and be cured ²³.

²⁴ Information obtained from Kinondoni municipal official

“... It happens most often mothers do ask financial assistance from us who attended the child so that she can buy the prescribed quinine for her child” (Kinondoni municipal official)

In a similar way, it is observed that although children are often vaccinated and weighed at no cost, once the child comes to the children clinic with common diseases such as upper respiratory tract infection or malaria, the mother is asked to buy drugs from the private pharmacies²⁴. In most cases, mothers cannot afford to buy the prescribed drugs for the child, and as a result they end up staying at home with a sick child. Alternatively, the mother would ask financial assistance from a better off neighbour or from her employer in the case of domestic workers. Then, the mother would buy drugs from the informal shops, where the quality of drugs given to the sick child is questionable. Thus, in spite the fact that health services for children under five are free, there is a significant cost incurred by mothers in order for their children to be treated and cured ²⁵.

“... At least every 1 to 2 weeks, a mother carrying a very sick child comes to my home to ask for money to buy medicine for her child....” (NGO official).

“... Most often mothers are directed by a health provider to buy drugs from a specific private pharmacy, regardless of which private pharmacy is nearby....” (NGO official).

“... Sometimes mothers buy drugs from “cheap shops” in order to remains with some money to buy food for a child and other members of the family...” (NGO official).

Therefore, it can be said that the burden of household coping strategies in order to meet health care cost and at the same time trying to meet other basic needs seems to fall more on women. Yet, because of the nature of health care market women incur extra cost from travelling in order to buy drugs from

²⁴ Information obtained from NGO official

²⁵ Information obtained from NGO official

the pharmacy of which the health worker would benefit from. That is to say, when households faced with limited budget, the burden on how to meet basic needs for household often falls on women.

User fees hurt the rural people more than urban population

Comparing the impact of the policy between the rural and urban areas, it is observed by some stakeholders that it is unclear what the differences are. However, based on the fact that poverty in Tanzania is concentrated in the rural areas, participants perceived that user fees hurt rural people more than the urban population²⁶. This is partly because of the poor infrastructure in most rural areas, which increases the cost of seeking health care. All impacts of the policy which are seen in different social groups are reported to be similar to the impacts observed in other developing countries which have instituted user fees in health care.

The impacts which are seen today after the introduction of user fees are said by the interviewed stakeholders to be exacerbated by the extreme poverty of the majority of Tanzanians and low salaries among civil servants which encourages unofficial charges²⁷. These two factors have led to a large number of exemptions / waivers (eligible and ineligible) resulting in revenue generated from user fees to be minimal. This together with unofficial payments and limited budget allocations to Health Ministry has led to the quality of health care being unsatisfactory.

6.6 Impact of user fees on poor women as identified from focus group discussions

It should be noted that during FGDs, there were no significant differences observed on experience and knowledge between groups from the same area. The differences were observed when one compares the rural FGDs with the urban FGDs. The differences can be explained by differences in level of understanding on the issues and in what they actually experienced. These differences could be

²⁶ Information obtained from MoH, MoF and NGO officials

²⁷ Mentioned by officials from MoH, MoF, World Bank, Kinondoni municipal and Kisarawe district.

determined by source of information and socio-economic development between the two geographical areas.

Maternity services paid by women

All participants from rural and urban areas reported to have been charged for some MCH/FP services. In urban areas, a pregnant woman is supposed to pay 100 Tsh. for an MCH card and 100 Tsh. at every visit for check up investigations. But the majority of participants reported that they paid 500 Tsh. for the MCH card and were charged between 500 to 1,000 Tsh. for investigation at every antenatal visit.

“...I know that I have to pay 100 Tsh for investigation per visit, but to my surprise I was told to pay 500 Tsh when I attended the clinic...” (A woman from group 2)

“...Yesterday I went to the ANC with my sister, she was told to pay 500 Tsh for the MCH card. When she said that she doesn't have the money, the health staff told her that she should tell the man who impregnated her to pay the money...” (A woman from group 1)

Some of the participants in urban areas reported that no drugs were given during ANC visits and that; pregnant mothers have to buy drugs from private pharmacies. In contrast to the urban areas, in the rural areas pregnant women attending ANC received services free of charge (i.e. free MCH card, free investigations and most often they do get drugs from the antenatal visits).

In the urban areas, studied women said that pregnant women are required to come with gloves, cotton wool, disinfectant solution, sterile syringes and needle during delivery. Although initially at the antenatal clinic session they are told not to bring items for delivery, in subsequent visits they are told to bring items for delivery. However, women reported that even if a pregnant woman brings her own delivery items during labour, she still has to pay 3,000-5,000 Tsh to the health care provider, as delivery items are claimed by a nurse not to be enough for the whole process of delivery. If a pregnant mother does not have the money, she will be given poor service.

“...I went to deliver at the hospital with all the required items, but when I reached there I was told the delivery items were not enough I have to pay 3,000 Tsh. for more delivery items....” (A woman from group 2).

In the rural areas, during the FGDs, women said that pregnant women are told to come with gloves, cotton wool, sterile needle and syringes and sometimes with ergometrine. If the woman did not bring the items, she is asked to pay between 500- 1,000 Tsh so that the item can be provided to her. If she does not have money, she will be attended to but the relatives will have to pay the money before she is discharged. No receipt is given to them.

“... If it happens you go to the hospital without delivery items and you do not have the money, the nurse will attend you but your relatives will have to pay 1,000 Tsh. before you are discharged....” (A woman from group 3).

Additionally, most of the women in urban areas reported bribing the health care provider in order to be attended to appropriately during delivery. They often pay about 5,000 Tsh during labour. Women are often told that the drugs prescribed by a doctor are out of stock. However, once a certain amount of money is given to the staff, the drugs prescribed will be provided. Similar to urban areas, participants in rural areas also said that they have to bribe the health care provider in order to get good service during delivery. They often bribe the health provider between 1,000 to 1,500 TSh. Thus, despite announcements of free health services in maternity wards in both rural and urban health facilities, women still endure costs from unofficial payments. These pregnant mothers are forced to do so, because they said do not have any choice. They want to deliver safely, to have a healthy baby and themselves to be healthy. In relation to family planning and vaccination services, some of participants

pay 100 Tsh for syringe for vaccination and 500 Tsh for the injectable (Depo- provera) method of family planning.

“...We know that we are not supposed to pay for deliveries, but we have no choice, we want to deliver an alive healthy baby and to be safe ourselves. That is why we are paying for the delivery services....” (A woman from group 1).

However, it is observed that not all women in rural and urban areas incur costs from unofficial payments during delivery. This is mainly determined by the attitude of health care provider attended the patient during the time of labour or delivery, or whether a pregnant mother or her relatives have a relationship with the health staff. In the case where there is such a relationship, a pregnant mother would not be charged for health service.

“ ...Not all the time when you go to deliver at the hospital you will pay for services, on the same day one may pay for services and another will not pay. It depends on the attitude of staff in that shift or if you know one of staff in the labour ward...” (A woman from group 4).

Table 6.1 Type of services or items charged in MCH/ FP service (Unofficial payments are examples of how much women said they have paid for services during the FGDs)

Service / items	Service / items Cost (Tsh.) Official payments	Services /items cost (Tsh) unofficial payments	Urban/rural
MCH card	100/=,	500/=	Urban
Laboratory test per ANC visit	100/=	500/=, 1,000/=	Urban
Syringe and needle		100/=	Urban
Delivery items		500/=, 1,000/= 3,000/=, 5,000/=	Rural Urban
Delivery services		1,000/=, 1,500/= 5,000/=	Rural Urban
FP injectable method		500/=	Rural

Other paid services

Women incur costs for bribes in order that their children can get the prescribed medicine when admitted in the hospital. When there is a high rate of children admitted in the ward, mothers have reported to pay a certain amount of money to health workers in order for their children to get a prescribed drugs or drips. If the mother will not do so, she will be told there is no medicine or drip is out of stock.

".... It could be better if you could to talk to us in April, most women could tell you a lot on how they bribe health providers in order for their admitted children to get drips or medicine as prescribed by the doctor. April is the time when most children are admitted in the hospital..."

(A woman from group 4).

Other costs for health services

In both rural and urban health facilities, no food is provided for in-patients from the local area. Women bear the burden of preparing food for patients and occasionally their husbands or other male relatives are the ones who take food to the hospitals.

Looking at unofficial charges in maternity and child services, it may be argued that low salaries and inadequate budget allocated to health have contributed to high rate of unofficial fees in health facilities. Health workers use unofficial payments as a coping strategy to cater for their needs. Insufficient budget in health and hence inadequate medical supplies might be used as a loop-hole by health workers to legalise selling of items such as gloves within health facility premises. However, when it is looked at in relation to McPake et al. (1999) on factors attributed to informal activities at working place, poor human resource management could be also one of the reasons. This includes lack of opportunities for training, lack of defined workable sanctions for health staff who performed poorly and lack of opportunities for health workers to raise their problems or concerns at work. And even if they are given such

opportunities, no action is taken to solve the problems at work. Therefore, the high prevalence of unofficial fees in health facilities could be attributed to all of above-mentioned factors.

Coping strategies to meet the demand of health care

Women are forced to find means of taking care of the family members once they get sick. In urban areas, inability to pay for health services has made some delay seeking medical treatment or self-medicating, which may lead to wrong treatment and development of drug resistance. Women also do piece jobs, engage in labourers jobs such as making gravel stones ("kokoto") by breaking big stones etc. Some women even when they are already pregnant continue to do these labourers jobs so that they can get money to buy items required for delivery and thereafter. These types of jobs put a woman's health at risk and then to a vicious cycle of poor health, then poverty and so on.

In rural areas, women cook and sell food and other items such as tomatoes, onions and peppers. The income from this small business is unreliable, therefore, women said they have to depend on their spouses, and contributions from relatives to pay for the service. Often pregnant women use small amounts of money to buy food and keep some of the money to buy items for delivery or to pay for health care providers when they are in labour.

"... Once you know that you have conceived, whenever you get money for food, you use some of the money to buy food and you leave some to buy items for delivery and for bribing the health provider during labour. Otherwise you will not manage at the time of delivery...." (A woman from group 3).

In contrast to urban areas, rural women who participated in the study perceived that getting free services when they are pregnant and for their children when they fall sick is one of the advantages of

the policy. However, sometimes they said that they do not get drugs hence they have to buy from private pharmacies.

During the FGDs with urban women, culture or social norms were seen not to play a part in preventing a woman utilising health services. Most women have sources of income other than from their spouses and also they have control over cash. Therefore, they said when they fell sick they just decided themselves to go to hospital. Some married women reported that they have to discuss the matter first with their spouses before they seek medical attention. They do so in order to show respect and to avoid conflict in case things went wrong during the course of treatment. However, if the spouse does not show any sign of concern, the woman would decide to go herself to the health facility without the consent of the spouse. In rural area, women seem to be free in seeking medical treatment whenever they fall sick. No restriction was observed among women on seeking medical treatment during FGDs.

CHAPTER SEVEN

DISCUSSION OF RESULTS

Discussion of results is presented in four sections. Section 7.1, discusses the impact of user fees on poor women in relation to their reproductive role and care for others. Section 7.2, outlines barriers for user fees implementation as identified in the study. Section 7.3, describes how the design of the user fee policy affects poor women in terms of reproductive role and care for others. Finally, section 7.4 discusses the role of context and policy process in shaping policy design and its impact on poor Tanzanian women.

7.1 Impact of user fees on poor women in relation to reproductive role and care for others

The results obtained from this study have given an insight into the impact of user fees on poor women and possible factors which have contributed to the additional costs incurred by them. It has been observed that both rural and urban poor women experienced extra costs in the utilisation of health care. Two aspects were used to look at the impact of user fees on poor women in health care services, relating to their reproductive role and care for others. Interestingly, many of the negative effects of the policy which were identified by key stakeholders were similar to those identified by the poor women who participated in the study. Nevertheless, no specific studies have been done so far on addressing the effects of user fees on poor women in Tanzania, apart from the gender budget studies of TGNP.

The above-mentioned findings are align to the findings reported by Konde-Lule and Okello (1998), Nahar and Costello (1998) and SAPRIN (2002). For this reason, it can be argued that although fees in health care have been considered as a strategy to improve distribution of benefits and burdens among the people, if not properly designed they may have a negative impact on equity between poor women and rich women (Abel-Smith,1993). The needs and ability to afford health services for poor women differ from that of rich women.

Both poor women in rural and urban areas incur cost for health services in relation to reproductive health. Pregnant women above seven months or who are booked for antenatal care are the only ones exempted from service fee. Thus, one may say that the rationale used to set the criteria was not fair. For instance, if a pregnant woman who is less than seven months pregnant fell sick, she may be in danger of losing her life in case she does not seek medical care promptly. Alternatively, she may end up with disability which may have negative effects on the rest of her life.

Women experience multiple ways of cost sharing in relation to user fees in health care. Women do have responsibilities for caring for others. In hospitals, food is not provided for in-patients except for referrals and grade I patients. Therefore, women have responsibilities to search for food, to prepare it and sometimes to take the food to the hospital. Additionally, if a member of their family falls sick, women have to be involved in extra work in order to increase the income and be able to take the relative to the hospital. Thus, poor women devote extra time and energy to care for others.

Conversely, one may argue that user fees in health care are seen to be better for rural women than urban women. The study indicates that rural women perceive free maternity services and free services for under fives to be advantageous. On the other hand, the same group of women are the ones found to be less knowledgeable about the policy. Thus, perception on benefits from the policy is determined by the level of understanding on women's health and the ability to critically analyse the policy in relation to gender equity. This conflicting idea needs to be verified and addressed among poor women, as a mechanism to create awareness on fairness between men and women in user fee policy and health service provision. Additionally, women needs to be informed that women's health does not only mean maternity services, but also it includes other reproductive health services such as management of infertility and fistula.

On the other hand, one may argue that poor rural women perceived differently compared to poor urban women in relation to free maternity and MCH services because of differences in the way services are provided in these two geographical areas. For example, unlike urban areas, in rural areas women get attention during delivery even if they do not have money to pay on time and they receive free antenatal services. More over, perception of rural poor women over user fees in health care may be explained by lack of availability of alternatives.

7.2 Barriers for user fees implementation

The study found that on top of user fees in health care, poor women also incur significant unofficial payments. Unofficial payments are experienced by both rural and urban poor women. However, the extent of unofficial payments differ between the two groups. This may be explained by differences in income between rural and urban areas. However, the impact of unofficial payments on urban women may not be bigger than that on rural women, because its impact would depend on how difficult it is to get the required amount of money. Thus, the trade-offs that women made in order to pay for health services may lead to poor nutrition and debts which may have adverse effects on their health.

Pregnant women who came to deliver at health facility without delivery items and money are poorly attended. This has made some pregnant women decide to deliver at home without being attended by trained health staff. Thus, the requirement for a pregnant woman to bring delivery items when she is in labour might be a contributing factor to the high MMR which is seen in Tanzania (UNDP,2002). Additionally, this might also be a chief cause of morbidity among women in a reproductive age as well as among neonates.

The study shows that items required to be brought for delivery are usually already available in the health facilities. Payments made by women in order to be given good services during delivery is used as a mechanism by certain health care providers to generate income in order to cater for their own needs. Co-existence of unofficial payments and user fees in health services might be a contributing factor to women's perception of exemptions in maternity services and children under five, as not being beneficial. Further, review of user fee policy would not work properly if unofficial charges will be still practised in health facilities.

Poor policing at local level also has contributed to poor women incurring extra cost while receiving health services. In urban areas, a pregnant woman pays for the MCH card and for investigation during each visit. On average a pregnant woman would attend eight visits before delivery. That is to say, in urban areas a pregnant woman has to incur cost of not less than 900 Tsh. for MCH card and for laboratory tests over the duration of antenatal visits.

Low incomes of health staff, and other members of society, are an obstacle to the success of user fees in health care. Low salaries in health staff encourage unofficial payments which the majority of women faced when seeking health care. Low incomes of the majority of people impacted negatively on household coping strategies. Poor people, particularly women, are forced to engage in extra work which consumes a lot of energy and time in order to be able to pay for health services. This may have impacted negatively on women's health. Thus, poverty is a major obstacle to the successful implementation of user fees for health care in Tanzania.

7.3 How the design of user fee policy affects poor women in reproductive role and care for others

Reviewing the content of policy; the objectives, exemption criteria, monitoring reports at all levels of health care and evaluation, it can be argued that the user fee policy in health care for Tanzania is not gender sensitive in implementation, even though there are some women-specific exemptions. This has masked the problems faced by poor women.

The objective of the policy is to provide health services which are accessible to everybody and are of an acceptable quality. While women are often able to pay for health services for themselves and for their children, women are forced to do extra work beyond their capacity in order to be able to pay for health services. This has forced women to eat inadequately in order to save money and, to engage in heavy work which has a negative impact on their well being. Taking into account that women utilise health services more than men, addressing equity on the basis of the ability to pay without differentiating the ability to pay for health care between men and women may be inappropriate.

Again, the objectives and criteria used to decide the types of diseases to be exempted are not gender sensitive. Diseases to be exempted were looked at in broad terms and not in terms of men and women. Women often suffer from gynaecological conditions which have implications for social, emotional, physical and economic well being of women and their families. Gynaecological conditions are excluded from the exemption criteria. Such gynaecological conditions are abortion, infertility, fistula, irregular vaginal bleeding, sexually transmitted infections (STI) and Pelvic Inflammatory Disease (PID). Yet the MMR in Tanzania is extremely high. Unfortunately, most of the above mentioned conditions are regarded by most societies as a woman's problem rather than the problem of both a woman and her spouse. Thus, such a woman will struggle on her own in order to be treated, cured and to be accepted by her partner and society in general. For instance, infertility, chronic PID and fistula are chronic

diseases which consume a lot of money until the patient is treated and cured. Failure of a woman to seek medical care promptly would not only affect woman's health, being abandoned or abused by their husbands, but it may also have a negative impact on the community e.g. untreated STI would facilitate the transmission of disease to her partners and to the unborn child in cases of pregnancy.

The content of the standard user fee report does not differentiate by gender. Consequently the monitoring system does not differentiate utilisation of health services or exemptions by gender. This means that it is difficult to detect the impact of the policy in relation to biological and social differences as it interacts with geographic location, age and poverty.

An evaluation of user fees in health care has not been conducted with gender perspectives in mind. The report of the implementation of user fees in 1994 only looked at revenue generation capacity and its management. The evaluation studies on the implementation of user fees in 1996 and 1998 did not specifically look at the impact of user fee in relation to gender, though they did examine MCH services paid for by women. Generally, the reports from these studies did not give insights into how women, particularly the poor, were affected by the policy.

7.4 The role of context and policy process in shaping user fee policy design and its impact on poor Tanzanian women

7.4.1 How contextual factors shaped the policy design and impact on poor women

The macro-economic environment in which the policy was developed was not gender friendly. Globalisation, and poor economic performance have influenced the macro-economic policies in Tanzania, based on SAP and PRS. Although the government emphasises improving maternal health, its greater emphasis is the free market economy. This has led the government to cut its budget to social services, including health, and focus more on competitive markets than equity. Furthermore, the

Tanzania government has emphasised households involvement in the provision of health care in order to increase revenue collection and consequently to improve the quality of health care. While it considers in particular impact of user fees on poor, the policy does not consider the effects of user fees on poor women. While, there is an emphasis on reducing MMR in policy documents no measures have been established to ensure that maternity services are free at the point of contact and of good quality. Equally important, reproductive health has not yet been given priority in the provision of health services (MoH, 2000).

Resource constraints are the major factor which contribute to the failure to improve the quality of health care. Yet, user fees for health care contributed less than 1.5% of actual expenditure from 1997/98 to the year 2000/01 (MoH, 2002). This shows that health facilities still depend entirely on government and donor support in order to run services. Features which were identified as symptoms of under financing in the 1992 health sector financing studies are still present to date. Such symptoms are low salaries for health workers, inadequate drugs supply and over reliance on donors for essential drug supplies to health centres and dispensaries. In other words, although user fees were introduced to eliminate the symptoms of under financing in health facilities, they have done little to help, if anything. Therefore, there is a need to assess the value of continuing implementing user fees while there are negative impacts and revenue generated is little.

7.4.2 Effect of policy process on user fee policy design and impact on poor women

The patriarchal relationship (i.e. men are dominant and women are subordinate) in user fee policy development could be one contributing factor to the negative effects of the policy which are seen on poor women. At the central level, women representative groups were not involved during the policy development. Additionally, no women group representatives are included in National Advisory and Supervision Commission and Implementation committee. Consequently, the likely differential effects on

men and women were not detected. In other words, women were not represented during policy development and implementation. In such settings it is unlikely for the gender issues to be considered during policy development and during the evaluation of implementation process. Even if some of the men involved in the policy process were gender sensitive, their thinking and experiences differ from that of women. Further, their actual influence on decision making in relation to gender issues was minimal.

The user fee policy was developed in a top-down fashion. At the local level the policy was implemented as directed from the central government. No initiatives on implementation of the policy so far arose from the local level. This might contribute to health needs of poor women not being met by the policy. Yet this may have been a vital missing input to improve user fee policy. Further, it is observed that most women particularly from the rural areas are not knowledgeable about policy. Most of them get information informally. This might result in women not knowing their rights on when, what, why and how much they should contribute in maternity services.

Based on findings from other studies and observations, gender activists have been campaigning against user fees in health care and they give statements in consultative group meetings on the effects of user fee on poor women. Despite such efforts, there have been no changes to the user fee policy design and its implementation in relation to Tanzanian poor women. However, there has been an introduction of a CHF in some regions of Tanzania, operating in health centres and dispensaries. The government expects that the introduction of CHF at the community level will enable every member in each household to utilise health services whenever they need to do so. However, the feasibility of CHF in urban areas is limited because of high population mobility. That is to say, the CHF idea might be more applicable in rural areas rather than in the urban areas. Additionally, factors such as who has a final say in the allocation of resources within households need to be examined. Power imbalance between men and women in a given household could be one of the determinants of whether a

household becomes a member of CHF. The issue of affordability for households, which are willing to pay for 5,000, Tsh. also needs to be carefully assessed. In other words, the CHF might still not be the appropriate solution for ensuring equity in Tanzania in relation to gender, social class and geographic location.

University of Cape Town

CHAPTER EIGHT

CONCLUSION AND RECOMMENDATIONS

The following conclusions and recommendations can be drawn from the study: -

8.1 Conclusion

User fees for health care were not in practice gender sensitive despite provisions for exemptions for some groups of women. In this study, this is illustrated by the costs pregnant women incur for health services during antenatal visits and delivery. Additionally, the criteria used to determine free maternity services are not fair. Although, some poor women pay for health services, they can often only do so through additional work which consumes extra time or a reduced food intake. This may worsen women's health and reduce their capacity in productive activities.

On basis of the above, it is argued that patriarchal relationship and top-down user fee policy development have made it difficult to predict possible negative effects which might occur in different social groups particularly among poor women. Thus, a lack of women groups' representation in policy development and implementation, including in the National Advisory and Supervision Commission and the Implementation Committee has resulted in the policy not being gender sensitive.

Further, most studies conducted in Tanzania on user fees in health care exclude poor women. In this way user fees may seem to improve the quality of care of services and access in general terms, while hiding the real impact on poor women.

Lastly, the study concluded that poverty is a major obstacle for successful user fees implementation.

For the user fee policy to be effective and efficient, the issues of accountability, transparency, commitment and advocacy need to be addressed at the local level. This is where the policy is implemented and its effect is experienced by the users.

8.2 Recommendations

- 1) The policy process and decision-making need to change from a top-down to a bottom-up approach. This would allow the involvement of vulnerable groups particularly women in the policy process and its implementation. Thus, avoidable negative effects of the policy would be addressed and tackled accordingly.
- 2) Women groups need to be represented in the National and Supervision Commission and the Implementation Committee. Involvement of women groups in the commission and the committee will enable these two organs to monitor and evaluate the success and problems with a gender perspective. Hence the policy would be refined in a way would meet health needs of poor women.
- 3) Strategies to ensure that women particularly in the rural areas are educated on user fee policy in health care are needed. This will enable women to understand the aim and fairness of the policy and women's rights during the policy implementation.
- 4) With the reproductive health of women in mind, there is a need to review the group of people exempted from hospital fees so that the user fee policy is gender sensitive.
- 5) There is a need to re- consider the ability of a patient to pay for health services from a gender perspective.

- 6) Data in routine monthly reports of user fees at all levels of health care and evaluation of its implementation should be disaggregating by gender. This will allow one to identify the effects of the policy in a gendered perspective.
- 7) A specific quantitative study on the impact of user fees on poor women should be conducted. This will be used to document the negative effects poor Tanzanian women have experienced from user fees in health care. The data will be used in decision-making and refining of the user fee policy to make it gender sensitive.
- 8) Mechanisms should be developed to improve staff motivation in order to eliminate unofficial payments e.g. introduction of staff allowances, increasing staff salaries and staff promotion based on good performance. In this way poor pregnant women are more likely to benefit from free maternity services.
- 9) The on going Health Sector Reform (HSR) process which emphasises the involvement of households in the provision of health services should not only focus on the poor, it should also focus on the effects of HSR between men and women. That is, HSR needs to be reviewed and made more pro-poor and gender sensitive.

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Appendix 1. Original Fees Structure in TShs'. as recommended by the MOH by July, 1993

Type of service for user fee	Description/Clarification	Referral Hospital	Regional Hospital	District Hospital
1. Consultation	Grade I & II Grade III	500/= 300/=	300/= 200/=	200/= 150/=
2. Drug for out-patient		50/=	50/=	50/=
3. Medical examination				
[a] Students		500/=	500/=	500/=
[b] Civil servant		1,500/=	1,500/=	1,500/=
[c] Special examination test		3,000/=	3,000/=	3,000/=
[d] Workman's Compensation		3,000/=	3,000/=	3,000/=
[e] Medical board		10,000/=	10,000/=	10,000/=
4. Gate Toll:				
[a] Motor vehicles		100/=	100/=	100/=
[h] Motor hikes		50/=	50/=	50/=
[c] Bicycle		20/=	20/=	20/=
5. Mortuary:				
[a] Post-mortem		1,000/=	1,000/=	1,000/=
[b] Storage		200/=	200/=	200/=
6. Admission (hospitalisation):				
Grade I	Daily fee excluding food, dress,	2,000/=	1,500/=	1,000/=
Grade II	Laboratory services or other tests	1,000/=	750/=	500/=
Grade III	For the whole period of admission including food, drug and laboratory services or other tests	500/=	300/=	150/=
7. Other services for grade I & II				
Laboratory & Eye tests	1,000/= (average)			
Surgery:				
(a) General:				
Major	13,000/=			
Minor	3,000/=			
(b) Ophthalmology:				
Major	13,000/=			
Minor	2,000/=			
(c) ENT				
Major	7,500/=			
Minor	1,500/=			
(d) Orthopaedic/Trauma				
Major	15,000/=			
Minor	3,000/=			
(e) Neurosurgery				
Major	40,000/=			

Minor	10,000/=			
(f) Urosurgery				
Major	8,000/=			

Note: These services are charged only to grade I & II patients, particularly at referral and regional hospitals where the services are available. Source : Cost-sharing programme, 1999

Appendix 2 : FEE SCHEDULE STARTING FROM DECEMBER 1 - 1996

NO	TYPE OF SERVICE	CLARIFICATIONS	REFERRAL HOSPITAL	REGIONAL HOSPITAL	DISTRICT HOSPITAL
1.	REGISTRATION				
	Fee charged for first attendance per year		1,000/=	500/=	300/=
2.	DRUGS AND INFUSIONS				
		Fee charged at 50% of the real cost according to prices of the "Medical store department"			
3.	MEDICAL EXAMINATIONS				
	(a) Students joining school		500/=	500/=	500/=
	(b) Employee first appointment		1,500/=	1,500/=	1,500/=
	(c) Special tests		3,000/=	3,000/=	3,000/=
	(d) Workman's compensation		4,000/=	4,000/=	4,000/=
	(e) Insurance	Filling forms for life insurance	4,000/=	4,000/=	4,000/=
	(f) Medical board	The cost will be covered by the employer	20,000/=	20,000/=	20,000/=
4.	LABORATORY TESTS AND OTHER TESTS				
[a]	BS, Urine, Stool, IIB	Grade I & II	300/=	200/=	200/=
		Grade III	100/=	100/=	100/=
(b)	WBC,ESR, Grouping & Cross Matching	Grade I&. II	500/=	200/=	200/=
		Grade III	200/=	100/=	100/=
(c)	VDRL test, Widal test , Pregnant test, and Other Biochemistry tests	Grade I & II	500/=	400/=	400/=
		Grade III	400/=	300/=	200/=

(d)	X-Ray (per exposure)	Grade I&II Grade III	1,000/= 750/=	700/= 500/=	500/= 400/=
(e)	Special tests (Ultra sound, ECG; ECHO, Barium meal etc.)	Grade I&II	3,000/=	1,500/=	1,000/=
		Grade III	1,000/=	1,000/=	500/=
5.	DENTAL SERVICES				
	[a] Extraction of permanent teeth	Grade I & II: per tooth Grade III: per tooth	1,000/= 500/=	800/= 500/=	500/= 500/=
	[b] Extraction of deciduous teeth	Grade I & II Grade III	500/= 300/=	400/= 300/=	300/= 300/=
	[c] Filling permanent teeth	Grade I & II per surface Grade III per surface	1,000/= 500/=	800/= 500/=	500/= 500/=
	[d] Filling deciduous teeth	Grade I&II: per surface Grade III per surface	500/= 300/=	500/= 300/=	500/= 300/=
	[e] Root canal treatment	Grade I & II Grade III	5,000/= 2,000/=	4,000/= 1,500/=	2,000/= 1,000/=
	[f] Denture full plastic bases each upper & lower	Grade I & II Grade III	15,000/= 12,000/=	13,000/= 10,000/=	10,000/= 8,000/=
	[g] Dentures: partial plastic base	Grade I&II Grade III	5,000/= 3,000/=	4,000/= 3,000/=	3,000/= 3,000/=

NO	TYPE OF SERVICE	CLARIFICATIONS	REFERRAL HOSPITAL	REGIONAL HOSPITAL	DISTRICT HOSPITAL
	(h) Repairs of dentures or orthodontic appliance	Grade & II Grade III	5,000/= 3,000/=	4,000/= 2,000/=	1,000/= 1,000/=
	(i) Orthodontic appliance	Grade I & II Grade III	15,000/= 13,000/=	12,000/= 11,000/=	10,000/= 10,000/=
	(ii) Scaling per visit	Grade I & II Grade III	1,500/= 5,000/=	1,500/= 5,000/=	1,000/= 5,000/=
	[k] Gingivectomy tooth	Grade I&II Grade III	1,500/= 500/=	1,000/= 500/=	500/= 500/=
	[l] Oral surgical operations	Grade I & II Grade III	10,000/= 7,000/=	8,000/= 6,000/=	4,000/= 4,000/=
	[m] Gold inlays excluding the cost of gold	Grade I&II Grade III	5,000/= 4,000/=	5,000/= 4,000/=	4,000/= 4,000/=
	[n] Gold crowns excluding the cost of gold	Grade I & II Grade III	8,000/= 5,000/=	6,000/= 5,000/=	5,000/= 5,000/=
	(o) Jacket crowns & post crowns: porcelain, bonded	Grade I&II Grade III	15,000/= 7,500/=	10,000/= 5,000/=	7,500/= 3,000/=

	or acrylic				
6.	ADMISSION FEE				
	Grade I	Paid daily food, laboratory test and other tests fees	3,000/=	1,500/=	1,200/=
	Grade III		1,500/=	1,000/=	750/=
	Grade III	The fee charged once for the whole period of admission but excluding drug, laboratory test and other test fees.	2,000/=	1,000/=	500/=
7.	SURGERY				
	Major operation :Any surgical procedure under anaesthesia	Grade I & II	15,000/=	10,000/=	5,000/=
		Grade III	3,000/=	2,000/=	1,000/=
	Minor operation: Any surgical procedure under anaesthesia	Grade I & II	3,000/=	2,000/=	1,000/=
		Grade III	1,000/=	500/=	300/=
8.	NORMAL DELIVERY				
		Grade I & II per day	1,000/=	500/=	300/=
9.	PHYSIOTHERAPY				
		Grade I & II only per day	500/=	300/=	
10.	MORTUARY FEE				
	(a) Post mortem		1,000/=	1,000/=	1,000/=
	(b) Storage		500/=	200/=	200/=
11.	FEES FOR FOREIGNERS		US\$	US\$	US\$
	(a) Consultation fee	Payments shall be by US dollar or Equivalent Tanzanian shillings	20	20	20
	(b) Appointment consultation		20	20	20
	(c) Admission fee: daily fee		30	30	30
	(d) Investigation		10	10	10
	(e) Special tests		50 – 200	50 – 200	50 – 200
	(f) Major Operation		200 – 2,000	200 – 2,000	200 – 2,000
	(g) Minor Operation		50	50	50
	(h) Postmortem		100	100	100
	(i) Mortuary (Storage) fee		30	30	30

NOTE/CLARIFICATIONS

1. Please read carefully, note the fee schedule indicated in the table and apply them accordingly.

2. Poor people and other vulnerable groups should be exempted/waived user fees.

3. Special hospitals should follow the fee schedule for district hospitals

4. Caesarian section for grade III shall be free.

5. Mortuary fee:

There shall be a grace period of three days for deaths occurred in the respective hospital. For deaths that occurred some where else shall pay from the first day.

There shall be a grace period of one day for a dead body brought for postmortem

6. Patients referred to government hospital from private hospitals shall follow the fee schedule for grade I.

7. The actual cost (prices) of drugs from the Medical Store Department that shall be used for calculating the 50% of drug fees.' Revenue collections from drug fee shall be used to purchase drugs on basis of "drug revolving fund.

Source: Cost sharing programme, 1999

Appendix 3: Questionnaire for Ministry of Health, Ministry of Finance, Planning and Privatisation Commission, and World Bank

1. What have been your personal involvement, and the involvement of your organisation/institution in policy-making on user fees in health? (Prompt for how far back this goes in history, and how long they have been in position).
2. What are the (a) advantages and (b) disadvantages of user fees in health? Are there any aspects that are specific to Tanzania, i.e. different from in other countries?
3. Is the impact of user fees different for different social groups e.g. women vs men, urban vs rural, poor vs rich? Please describe how? Is there anything that makes Tanzania different from other countries in this respect.
4. Have there been any 'gaps' between policy on user fees in health in Tanzania and how it has been implemented? Have there been any differences between the expected and actual impact/result of implementation of user fees?
5. Have there been any changes in the policy on user fees in health in Tanzania since it was first implemented? If YES, what were the Reasons for these? Would there have been different impacts on different social groups (see above) because of these changes?
6. Which other groups, institutions, stakeholders have been involved in policy-making or advocacy around user fees in health? What have been their different positions? Have any of them raised gender issues?
7. Where do you get your information on user fees in health in Tanzania?
8. Do you know of any data sources or studies on this topic?

Appendix 4: Questionnaire for TGNP and Macro gender group

1. What is your view about user fees for PHC services?
2. Have you engaged in any advocacy or research? If YES, what you were advocating for? And did the advocacy have any impact?

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Appendix 5 : Questionnaire for DMOs

1. Have there been policy changes since the actual implementation of user fee policy.
2. What is the policy initiatives in local government context regarding the improvement of implementation of user fees apart from those directed by central government?
3. What are your views about user fees for PHC services?

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Appendix 6: Questionnaire for local government office

1. Do you think that use fees have impacted more on poor women and children than on poor men? How?
2. What could be contributory factors for the mentioned effects? Are any of these specific to women?
3. Is there exemption from fees to health care services for all services including maternity services?
4. Who are the parties involved in developing exemption criteria?
5. What are the criteria for exemption from fees to health care? How are implemented?
6. Are the exemption criteria functional? If yes/no why
7. What are problems caused by exemption?
8. Do you think there are other factors, which have contributed to these negative effects which are seen today among poor women in relation to health care?
9. Have you received any complaints from women and other people in relation to user fee in maternity services, and other services?
10. If yes, what did you do? What was the outcome of the action taken?
11. What is the policy initiatives in local government context regarding the improvement of implementation of user fees apart from those directed by central government?
12. What are your views about user fees for health care?

Appendix 7: Topic questions for FGD

1. When do you last visit a health clinic or other services, whether for yourself or accompanying someone else (family member)?
2. Did you have to pay, take anything along?
3. If there are differences in number (2), why do you think there are these differences?
4. Are you are aware of any 'rules' about what you should be paying? If yes, how did you become aware of these rules?
5. Is there are any changes on the system of payments over time? If yes, when? And why do you think these changes occurred?
6. Why do you think the government is charging user fees?
7. What are the advantages and disadvantages of user fees for ordinary people like you?

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Appendix 8 The Summary of study findings

