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UNIVERSITY OF CAPETOWN

Assessment of User Fee System:

**Implementation of Exemption and Waiver Mechanisms in
Tanzania.**

Successes and Challenges

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February, 2010

Prepared as a thesis for Masters in Public Health in Health Economics at the University of Cape
Town

DECLARATION

This research is my original work, produced with normal supervisory assistance from my supervisor. All the relevant sources of knowledge that I have used during the course of writing this dissertation have been fully credited and acknowledged. Also, this dissertation has not been submitted for any academic or examination purpose at any other university.

28/02/2011

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ACKNOWLEDGEMENTS

I would like to convey my sincere gratitude to my supervisors Veloshnee Govender and Di McIntyre for their constructive ideas, critique and guidance in the development of the proposal, and writing of this report. I also acknowledge the financial support given by SIDA through the University of Cape Town; without this support the study would not have been possible.

I am deeply indebted my family (my husband and five children), for their patience and encouragement they provided to me for the whole period of my studies.

My thanks also go to the Ministry of Health, Tanzania; Coast and Mtwara Regions; Bagamoyo and Mtwara Districts for their support and guidance in reaching the participants. Also, I am grateful to all interviewees for their valuable responses that enriched the data and report.

Last but not least, my sincere gratitude goes to those who in one way or another provided input and moral support to make this work possible. My friends Michael Sam and Dereck Chitama whose input made it possible to finalize this work. My current employer German Technical Cooperation (GTZ) Tanzania, who partly financed my study.

ABBREVIATIONS AND ACRONYMS

CCHP	Council Comprehensive Health Plan
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Services Boards
CBIS	Community Based Initiative Schemes
DED	District Executive Officer
DMO	District Medical Officer
ESAP	Economic Structural Adjustment Programme
FGC	Facility Governing Committees
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GNP	Gross National Product
HIMS	Health Information and Management System
IMF	International Monetary Fund
ISSA	International Social Security Association
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Work
NHIF	National Health Insurance Fund
NGO	Non Governmental Organization
NIMR	National Institute for Medical Research
PHI	Private Health Insurance
NSSF	National Social Security Fund
RMO	Regional Medical officer
STD	Sexually Transmitted Diseases
SHI	Social Health Insurance
TB	Tuberculosis
WB	World Bank

ABSTRACT

A user fee policy was introduced in the health sector in Tanzania in 1993 with the purpose of generating additional revenue for primary health care programmes, which were previously under-funded.. To protect the poor and vulnerable groups from user fees, the policy also included exemptions and waivers. The aim of this study was to evaluate the implementation of exemptions and waivers and to support efforts to address current challenges and promote use of public sector health services. The study was conducted in Bagamoyo and Mtwara rural districts. A qualitative approach (in-depth interviews and focus group discussions) was used since it was considered appropriate for a study focusing on the perceptions, views, and experiences of users and providers.

The study noted that communities lack knowledge about the exemption and waiver systems which could have enabled them to access health care services as well as to demand their entitlements. Major problems identified in this analysis include: poor policy, design of the systems, lack of information, lack of monitoring and evaluation, difficulties in identifying of the poor and poor quality of services. There was also a lack of monitoring and evaluation at all implementation levels, particularly in the districts. The most likely factors contributing to these problems include lack of commitment by the central ministry in supporting the implementations of the policy at facility levels, poor communication between levels of implementation and lack of policy guidelines in facilities.

Results from the study revealed that there is a great need to work on the exemption and waiver challenges in order to protect the poor and to enable them to access quality health care services. Therefore, in order to strengthen the exemption and waiver systems, recommendations are made with respect to the policy level, implementation level, users of public health facilities and interactions with the private sector.

CHAPTER ONE

This dissertation is composed of five chapters. Chapter one describes the aim and objectives of the study as well as the socio-economic context and health system of Tanzania under which user fees and exemptions and waivers were introduced. Chapter Two presents the literature review and includes a discussion on the conceptual framework. Chapter Three explains the methodology used in this study. Chapter Four presents the results and discussions of the study and chapter five presents' conclusions and recommendations.

1.1 Background

Tanzania is a country with a remarkably good health infrastructure. Seventy two percent of the Tanzanian population is within 5 kilometres of a health facility and ninety percent are within a 10 km radius (MOH, 2002). This is a tremendous improvement in the health sector since independence in 1961. After independence in 1961, health care facilities were re-directed towards rural areas and free medical health services were introduced. For the past thirty years, health services delivery has been largely a prerogative of the state during which time only a limited number of "private for profit" health services were permitted to function in the major towns of the country.

In the 1990's, following a series of major economic and social changes, making it difficult for the government to maintain its commitment to providing free medical care, the Ministry of Health initiated discussions and put forward a Proposal for Health Sector Reform (MOH, 1994). At the same time MOH reaffirmed its commitment to improving the quality of health services and increasing equity in service accessibility and utilization. The aim of the reform was to re-define health priorities and improve the institutions in which these policies were implemented (Semal, 2003). In 1993 the MOH adopted a "user fee" policy, the aim of which was to address the financing gap and increase the resources available for the health sector (Mbuji et al, 1996). However, it was noted that with time user fees alone could not address the funding gap and several alternative funding options were explored such as the National Health Insurance Fund (NHIF) and the Community Health Fund (CHF) (MOH, 2002).

Protecting the poor and improving access to health care is a national priority and is stated in the National Health Policy (MOH, 2003). Exemptions and waivers were introduced and established by a Parliamentary Act in 1994 as a mechanism for ensuring access to health care services for poor and vulnerable groups (Mtei et al, 2007; MOHSW, 2008). However, the effectiveness of exemptions and waivers as a mechanism for protecting the poor and vulnerable groups remains under debate. There are problems of under coverage that occur when the poor are not receiving the benefit intended and leakages when the non- poor receive the benefits intended for the poor. This study critically analyses the problems of equity in the implementation of exemptions and waivers and the extent to which the poor and vulnerable are protected.

1.2 Rationale for the study

The implementation of exemptions and waivers involve many stakeholders with different interests. In that kind of environment, clear set of harmonized guidelines are needed ensure effective implementation. Several studies which have appraised the system of exemptions and waivers in Tanzania have found a lack of clear guidelines for implementing these systems in public health facilities. In addition, despite the introduction of exemptions and waivers, access to health care services remains a challenge particularly for the poor and vulnerable groups (Save the Children, 2005; McIntyre & Gilson, 2002; Hutton et al, 2005; Mamdani & Bangser, 2004; Newbrander et al, 2000).

Although most of these studies (Laterveer et al, 2003; Buns & Mantel 2006; Save the Children, 2005; Hutton et al, 2005; Newbrander et al, 2000) have provided empirical evidence on the need to address equity under user fees in Tanzania, none of them have critically appraised perceptions, experiences and views of policy makers, implementers and the users of health services using a qualitative approach.

In addition, many of these studies were conducted in well resourced regions such as Dar-es-salaam, Kilimanjaro Iringa, Mbeya Tanga and Kagera (Burns & Mantel 2006; Hutton et al 2005; Newbrander et al 2000; Laterveer et al, 2003). This study attempts to fill that gap by assessing the challenges around implementing exemptions and waivers that adversely affect equity, in both town council and rural districts using a qualitative study design approach. The

findings from this research will be useful for policy makers, health planners and health care providers in addressing challenges under an exemption and waiver system.

1.3 Aim of the study

The aim of this study was to evaluate the implementation of exemption and waiver mechanisms under the user fee system in Tanzania, to support efforts to address current challenges and promote use of public sector health services.

1.4 Objectives of the study

The objectives of the study were to:

1. Assess awareness of the exemption and waiver policy and processes among health service providers;
2. Assess the awareness about exemptions and waivers among beneficiaries and non-beneficiaries in public health facilities;
3. Assess the experience of health care providers in the implementation of exemptions and waivers in public health facilities;
4. Assess the experience of beneficiaries with regard to exemptions and waivers in public health facilities; and
5. Make recommendations for addressing challenges with the exemptions and waivers system in Tanzania, particularly in relation to promoting use of public sector services vulnerable groups.

1.5 Tanzania: A situation Analysis

1.5.1 Geographical and Population characteristics

Tanzania is located in East Africa and consists of Tanzania Mainland and Zanzibar, comprising 21 and 5 regions respectively. Each region is divided into districts. There are 129 district council authorities in Tanzania Mainland (MOHSW, 2006). The total population of the country is 38,329,000 and the growth rate is 3.8 percent. The fertility rate was 42 per 1,000 in 2007. About 80 percent of the population lives in rural areas. Approximately 40% of the population is under the age of 25 years (URT, 2007a; URT, 2005a).

1.5.2 Macro-economic Context

Tanzania remains one of the poorest countries in the world with a per capita income of 660 USD per person (WHO, 2006). Although, the GDP and per capita income show steady growth, poverty remains a major challenge. About twenty percent of the population spend less than 1US\$ per day and sixty percent spend less than 2 US\$ per day (MOHSW, 2008). In addition, income inequalities have increased over time. For example, the Gini coefficient¹ increased from 0.34 in 1992 to 0.38 in 2006 (WHO, 2006). The high levels of poverty and income inequalities are barriers for the poor and vulnerable in accessing health care.

Key economic activities in Tanzania include industry, forestry, animal husbandry, game hunting and agriculture (URT, 2007b). Agriculture plays a dominant role and contributes almost 50% towards GDP and accounts for 80 percent of employment in the country. However, increasing GDP has not brought about an improvement in poverty and income inequalities. As was observed in the MOHSW Strategic Plan III, ‘despite efforts by the government of Tanzania since independence to create an equitable society, more and more evidence is generated that inequity in increasing’ (MOHSW, 2008p.13)

1.5.3 Health status

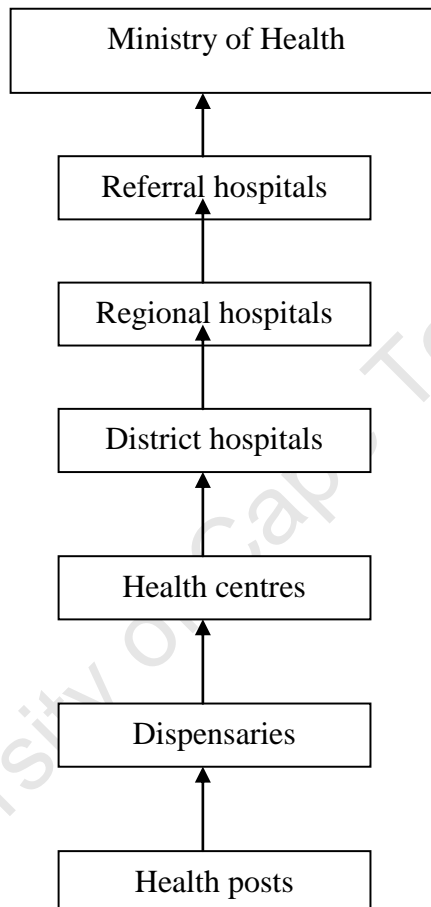
Overall, the health status of Tanzanians is poor when reviewed across a range of health indicators. Infectious diseases such as malaria, HIV/AIDS and tuberculosis, are counted as major health burdens of which malaria accounts for 17.7 percent of deaths. This remains a key public health challenge (MOHSW, 2008). There is also an increase in non-communicable diseases particularly diabetes, anaemia, cancer and cardiovascular diseases. The mortality rate of children under the age of five is 112 per 1000 live births and maternal mortality is 578 per 100,000 live births (URT, 2005). Life expectancy is 48 years (WHO, 2002; 2006). Despite these poor indicators, there have been improvements in some areas. Vaccination coverage for infants and children under five met the target goal of 90 percent set by the government in 2005.

¹ Wagstaff et al. (2001) explain Gini coefficient measures inequality in income. Its ranges from zero that represent perfect equality and one representing perfect inequality.

1.5.4 Health system structure

The public health system in Tanzania is decentralized starting from the Ministry of Health to the primary care levels (see Figure 1.1).

Figure 1.1: The organization of the Tanzania public health system



Source: MOH, 2002

The first levels are the referral hospitals. This is the highest level of hospital services in the country (MOH, 2002). The referral hospitals cater for different ranges of specialties. The second level is regional hospitals responsible for providing advanced levels of health care services and supervising policy implementation in the districts and the primary levels. The third level constitutes districts hospitals which are the first level of referrals. Each of the district hospital serves over 100,000 people each. The primary health care is the lowest level and comprises health centres, dispensaries and health posts. According to the MOH guideline

(2004), health centres and dispensaries serve a population of 50,000 and 10,000 respectively which charges also user fees.

1.5.5 Health facilities in Tanzania

Tanzania's health care system consists of 12 referral hospitals, 17 regional hospitals, 112 district hospitals 424 health centres and 4,672 dispensaries (see Table 1.1).

Besides the public facilities, there are also private and faith based health services. However, the government is the main provider. The Government owns about 64 percent of health facilities in the country (MHOSW, 2006). The next largest number of health facilities is owned by religious/voluntary organizations (19%) and the private sector (15% of health facilities) (MOHSW, 2006). Health facilities have increased from 5,237 in 2000 to 5,284 in 2006, equivalent to an increase of 1.8% (Mtei et al., 2007; URT, 2000; URT, 2005).

Table 1.1: Health facilities in Tanzania 2006

Facility	Agencies			TOTAL
	Government	Private	Religious/Voluntary agencies/parastatal	
Consultants hospitals	4	4	4	12
Regional hospitals	17	0	0	17
District hospitals	66	33	13	112
Health centre	331	39	54	424
Dispensaries	3038	733	901	4672
Total	3456	809	972	5,237

Source: URT 2000 ; URT, 2005; Mtei et al, 2007

1.5.6 Health sector and health care financing reforms in Tanzania

1.5.6.1 Health sector reforms

1. According to Semal (2003), health sector reform aims at implementing fundamental changes in the health sector which are purposeful and sustainable. In Tanzania, the reform was undertaken in order to address issues related to poor performance in the health sector. These included inefficiency in the allocation of health care resources, inequitable distribution of resources, lack of community involvement and lack of

political commitment in supporting health care delivery. The main objectives of health sector reform were to improve effectiveness and quality of services, to promote equity by improving access for the poor and to improve efficiency in the allocation of resources. Health sector reform processes were divided into four stages (Newbrander et al, 2000; URT, 2005b). These were:

Stage I

- 1880-1961: Decentralization to local authorities that had both judicial and executive authority to run social services including health. Local government authorities established rural primary health care services which were supervised by DMOs.

Stage II

- 1961-1972: Free and fair allocation of resources (financial, human resources, etc) policies in the health sector was implemented.

Stage III

- 1971-1982: The emphasis was to increase available resources to the rural areas so as to achieve the equity objective. Since the local government had failed to provide social services, the central government assumed the role of providing health services in the district. However due to economic decline and budgetary shortfalls, the government was unable to finance health care services in the districts, resulting in declining quality of care.

Stage IV

- 1983-1993: During this stage, the government considered various financing strategies including user fees for increasing revenue. This will be discussed in the next section.

1.5.6.2 Health care financing reforms

1.5.6 2.1 Sources of health care financing

Presently, health services in Tanzania are financed from several sources. General taxation and donor support are the largest sources of financing, together accounting for approximately 80% of the total financing (Table 1.2). About 5% comes from user fees or out of pocket

payments in public and private health facilities. Social health insurances (NHIF, CHF, and NSSF) contribute 8%. Other sources contribute about 5%.

Table 1.2: Sources of health care financing in Tanzania

Source	Percentages
General tax	40
User fees	5
Donors	40
SHI	8
NGOs	4.6
CBIS	<1
PHI	<1

Source: Sendoro, 2007; WHO, 2007; Mmbuji et al, 1996

Since 2000, annual GDP growth has increased from 5.1 percent in 2000 to 6.9 percent in 2005 and 7.1 percent in 2007 (see Table 1.3) (URT, 2007). However, total expenditure on health as a percentage of GDP had only slightly increased from 4.1 percent in 2000 to 4.2 percent in 2005 (WHO, 2001). Moreover, expenditure on health as a percentage of General Government Expenditure has declined from 11.2 percent in 2000 to 8.8 percent in 2005. Clearly, the Government of Tanzania is below the 15 percent expenditure target agreed to in terms of the Abuja Declaration signed in 2001 (Mtei et al, 2007).

Table 1.3: National expenditure on health 2000-2005

Year	2000	2001	2002	2003	2004	2005
GDP growth rate	5.1	5.9	6.0	7.1	6.4	6.9
Total Expenditure on health as % of GDP	4.1	4.1	3.9	3.8	4.0	4.2
General government expenditure on health as % of THE	43.9	43.3	43.9	42.3	43.6	48.0
General government expenditure on health as % of GGE	11.2	11.2	11.1	9.3	8.5	8.8

Source: URT, 2007; WHO, 2007; MOHSW, 2007; WHO, 2006

1.5.6.2.2 Introduction of user fees in Tanzania

User fees were introduced in Tanzanian public health facilities in 1993 following a study commissioned by the MOH (1994) on willingness to pay (Mushi, 2007). The findings revealed that 80 percent of the people in Tanzania were willing to pay user fees for improvements in health care services.

The user fee policy was implemented in phases. The first phase was between July 1993 and 1994 and involved the implementation at the referral and regional hospitals. In 1996 fees were introduced in district hospitals (McIntyre, 2007; URT, 1993; MOHSW, 2006). Between 1996 and 2008, user fees were gradually introduced in lower health care facilities (health centres and dispensaries). At the time of study, there are no documents from the Ministry of Health which clearly indicates the actual amount that people pay for care in the public health facilities. However, the study by Laterveer et al (2004) estimated that the hospitals charge an overall average of 1,300² Tanzania shillings (Tshs) per patient per visit. At the health centre a patient will pay 500 Tshs which does not include medicine. At the dispensary level, a patient pays 50 Tshs excluding the cost of medicine

The main purpose of introducing user fees in Tanzania was to generate additional revenue for various primary health care programmes, which were previously under-funded. User fees charged at both primary levels and hospitals in 2005 accounted for 2 percent of total public sector financing. The revenue is mainly spent on purchasing drugs and medical supplies (Msambichaka et al, 2003; Mushi, 2007; MHOSW, 2006).

1.5.6.2.3 Exemptions and waivers

Exemptions and waivers are defined as exemptions. Whereby exemptions permanently referred as free health care services to groups based on demographic and diseases characteristics. This includes pregnant mothers, under five children and people with chronic diseases such as HIV/AIDS and cancer. Waivers are temporarily granted to people who are not able to pay for health care services and are granted free health care (MOHSW, 2005). In addition, the international literatures reviewed referred similar definition particularly

² One US dollar is equivalent to 1,300 Tanzanian shillings (Tshs)

waiver that give the poor access of free health care services (Burns & Mantel, 2006; Mamdani & Bangser, 2004 ; Hutton et al, 2005; Newbrander et al, 2000; Mtei et al, 2007).

Exemptions and waivers were introduced in Tanzania in 1993 (Hutton et al, 2005). Approximately 5% of the country's population is classified as poor or vulnerable and requiring exemptions and waivers (Kilama, 2007). More details of these terms will be discussed in chapter two.

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CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In this chapter, key concepts exemptions and waivers under a user fee system are discussed. In this part, user fees as a health care financing option are considered. Furthermore, the chapter deals with exemptions and waivers which includes definitions, characteristics and key problems arising in their implementation. Finally the chapter is concluded by providing a conceptual framework underpinning this study which outlines the relationship between policy makers, implementers and beneficiaries as well as non beneficiaries of exemptions and waivers.

2.2 Health care financing

Health care services in many developing countries, including Tanzania, are financed by four main sources namely general tax, health insurance, out of pocket payment including user fees and donors (McIntyre, 2007; MOHSW, 2005). General tax is often a major source of revenue and is generated from direct and indirect taxes such as personal income tax value added tax (VAT) and customs and excise duty. Revenue arising from taxes and the level of funding allocated to the health sector will depend on the level of economic growth of a particular country. WHO (2007) estimated that the total health expenditure as a percentage of total government expenditure in developing countries from general tax revenue ranges between 5 and 10 percent. However, according to the Abuja Head of States declaration in 2001, total health expenditure as a percentage of total government expenditure should be approximately 15% by 2015 (Goldsbrough et al, 2007).

In many developing countries, out of pocket payments, which are direct payments to health care providers, form a major part of the health care financing. According to WHO (2007) and Hurley (1998), out of pocket payments contribute up to 40 percent of the total health expenditure in developing countries. In many developing countries, there are inadequate measures for protecting the poor from catastrophic health spending (McIntyre, 2007).

Donor funding plays a critical role in health financing in developing countries. According to COWI/EPOS (2007), donor support accounts for approximately 40% of the health sector's budget in Tanzania.

2.2.1 Why user fees?

According to McIntyre (2007), out of pocket expenditures include direct payments made to public and private health providers. User fees are out of pocket payments made to public care health facilities. User fees were introduced in many African countries in the context of an economic recession experienced between the 1980s and 1990s. During the recession, many affected countries adopted economic structural adjustment programmes (SAP) policies which not only reduced the allocations to health and other social sectors but also introduced fees for previously free public sector health care services (Russell & Gilson *et al* 1995; World Bank, 1996; Whitehead *et al*, 2001).

The main purpose of introducing user fees was to generate additional revenue for various primary health care programmes, which were under-funded. Another objective of user fees was to strengthen the referral system, reduce the tendency among parties to by-pass lower level facilities and discourage frivolous use of health care services (Mmbuji *et al*, 1995; Newbrander *et al*, 2000). It has also been argued that user fees improve access to quality of health care services by ensuring the availability of drugs, medical supplies and other health care services (Mmbuji *et al*, 1995). In addition, user fees promote a sense of ownership, efficient consumption patterns and the use of cost effective health services. For this reason, it was recommended that income generated from user fee revenue should be retained at the facility level and mainly used for purchasing drugs and medical supplies (Mamdani, 2005).

The management, fee structure and implementation of user fees differ from one country to another. Usually fees are charged according to level of care and type of care per item consumed. Fees might vary by the type of hospital from tertiary hospital charging higher fees and regional and district hospitals charging low fees. These are related to differences in personal costs, laboratory investigations and the type of drugs prescribed.

In many low-income countries revenue generated from user fees has not exceeded 5% of the total health expenditure (Newbrander *et al*, 2000; Save the Children, 2005b). Therefore, user fees do not contribute significantly to addressing the resource gap in many low-income countries.

2.2.2 Impact of user fees on utilization of health care

Health services utilization is influenced by two types of factors which can be broadly classified as price and non-price factors (McIntyre, 1997; Russell & Gilson, 1995; Nyonato, 1999; Yates, 2006; Culyer, 1998). Non price factors include distance, cultural practices, and perceptions of quality of care, beliefs about illness and demographic characteristics. Price factors include user fees, and the opportunity cost of time, which relate to the loss of income and travelling costs associated with obtaining health care.

It has been argued that user fees inhibit necessary demand and keeps health service use below the social optimum, particularly among the poorest and vulnerable in society. This has been revealed by a number of studies that have been conducted within African countries on the impact of user fees on utilization (Bitran & Giedion 2003; Hutton, 2002; Save the Children, 2005; Russell and Gilson, 1995).

A study conducted in several African countries by Save the Children (2005a) found that user fees reduced utilisation and contributed to elevated mortality. In Nigeria for example, following the introduction of user fees, maternal deaths increased from 41 to 56 per 100,000 live births in 2006. In addition, there was low use of delivery services in hospitals. The dramatic reduction in the use of services was also seen in Zimbabwe, Ghana, Burundi and Liberia when user fees were introduced (Save the Children, 2005). Laterveer et al (2004) found similar evidence from other low and middle-income countries (Tanzania, Uganda Indonesia, Guinea, Kenya etc). In Guinea and Indonesia the main reason given by the poor for not seeking care at the government facilities was the high cost of treatment. Similarly, in Kenya it was found that when user fees were introduced in 1989, the utilization levels in facilities charging fees fell by 52% (Mwabu & Mwangi, 1986; Mwabu et al, 1995; Huber, 1993; Mwabu, 1986). In similar studies by Save the Children (2005) and Mushi (2007) in Tanzania, it was found that utilisation dropped by about 50 percent in public health facilities after the introduction of user fees.

In contrast, the removal of user fees in public health facilities has often led to an increase in utilisation, particularly among the poor. A study conducted in Uganda on the impact of the abolition of user fees found that there was a 70 percent increase in utilization for children. In

addition, morbidity in children and adults decreased by 3 and 1.5 percent respectively. The percentage of households with sick members who reported not having utilized health services due to high costs decreased from 50 percent in 1999 to about 35 percent in 2002 following the removal of user fees (Deininger & Mpunga, 2004). Similar results were found in Kenya, where following the abolition of fees, utilization increased by 41 percent (Mwabu et al, 1995; Russell & Gilson, 1995). In South Africa, following the removal of user fees for children less than 6 years and pregnant women in 1994, utilisation of curative services increased by 77 percent. Based on those findings the Government of South Africa decided to abolish user fees for primary health care in 1997 in order to expand services (Yates, 2006).

2.2.3 Household's impoverishment

There is a growing body of evidence on the impact of health care costs in contributing to the impoverishment of households (McIntyre et al, 2005; WHO, 2008; WHO,2003). In order to pay for health services, when cash is not immediately available the poor borrow money, draw on savings and, they sell their valuable assets and land to pay for the costs of health care (McIntyre et al, 2005). Such expenditure is considered catastrophic when expenditure on health care reduces spending on other basic goods (e.g. food, education etc.) and households are forced to sell their assets and/or incur debt and as a result is pushed deeper into impoverishment (Xu et al, 2003; WHO, 2005; McIntyre et al, 2005). According to Russell (2004), malaria for example poses a serious threat to poverty reduction strategies in low and middle-income countries. In his study conducted in developing countries it was revealed that the economic burden of malaria was catastrophic for households and the costs reported by households exceeded 10 percent of monthly income. Similar results were found from a study in urban Sri Lanka by Russell (2005).

For poor households, increases in debt as a consequence of health care costs leads to the “medical poverty trap” (Whitehead et al, 2001). This was also supported by Mwabu (1986) who conducted a study on health care decision making at the household level in rural Kenya. It was found that poor households may be forced to deny treatment for sick members, even household heads, because they cannot afford paying for the services. Sick household members may no longer be able to contribute to supporting the household, thereby pushing the household further into poverty. Also user fees might create long term impoverishment in poor households. Households with members suffering from chronic diseases need medical

care throughout their lives. Households may be forced to spend on health care and might have to draw on and deplete savings and incur debt as a result.

2.3 Exemption and Waivers

In order to ensure that the introduction of user fees do not result in financial barriers for the poor and vulnerable people, exemptions and waivers are often introduced alongside user fees (World Bank, 2003; Bitran, 2002).

2.3.1 Exemptions

According to Tanzania MOH (2002), an exemption is a “statutory entitlement to free health care services, granted to individuals who automatically fall under the categories specified in the manual”. The aim is to encourage certain categories of people to use health care services. These categories include pregnant women, children under the age of five years the elderly, specific diseases (chronic diseases, TB, leprosy, cancer, HIV/AIDS etc) and may be restricted to certain types of services (e.g. inpatients and outpatients) (Manzi, 2005; Newbrander et al 2000; Hutton et al 2005; Tien & Chee, 2002; Hutton, 2002).

An exemption system is relatively simple to implement compared to waivers as it is automatic and involves minimal decision making and therefore, reduces leakages (Mamdani & Bangser, 2004; UNICEF, 2008). Leakage occurs when the non-poor receive benefits intended for the poor, resulting in the problem of charging people less than they can afford to pay (Newbrander et al, 2000). Beneficiaries of exemptions are identified either through their clinic cards (e.g. pregnant women and children under five) or based on their diagnosis. However, problems can arise in the implementation process. For example, admissions clerks might find it difficult to provide an elderly person with an exemption if the elderly person is unable to show proof of age. In addition, health care providers might be reluctant to provide exemptions since it might lower their revenues (Mamdani & Bangser, 2004).

Mamdani & Bangser, (2004) found in Tanzania that exempted patients complained of lack of respect and discrimination by health care providers. The study quoted one mother who reported her six month old baby who died because she was reluctant to seek care on account of fear of being ignored by health care providers due to her inability to pay. Some identified exempted groups are not benefiting due to a different set of factors. These include unclear

policy and the wide range of exemptions categories. According to Newbrander et al, (2000), there is wide and complex range of exemption and waiver categories. It is costly to maintain these categories in terms of time and resources available. In addition, it seems to be difficult to establish criteria for exemptions among some targeted populations (Garshong et al, 2001; MOH, 2002; MOH, 2004). In addition, poor management, monitoring of the systems, vague guidelines and poor record keeping leads to inefficiencies in implementing the systems. In addition, if the health system is perceived to be corrupt with health care providers demanding under-the-counter payments, there will be low coverage and the poor might delay or not use services at all and seek care from alternative providers (e.g. traditional healers). In this case issues like equity and efficiency in providing exemption to the vulnerable groups will be not addressed (Mamdani & Bangser, 2004; Witter, 2009).

2.3.2 Waivers

MOH (2002, Chapter 5, p 49) defines waivers as “exemptions granted to those patients who do not automatically qualify for statutory exemptions and are classified as unable to pay”. Often, people who are eligible for waivers are assessed based on an individual’s or family income (Newbrander et al, 2000; Tien et al, 2002). In Tanzania, people who qualify for waivers are identified by health care workers and community leaders. The groups eligible for a waiver include the poor, elderly above 65 years (MOH, 2002; Kilama, 2007). Community leaders issue waiver documents to qualifying individuals and this entitles them to have free health care services in the public facilities. For the purpose of this study, waiver refers to free health care services for the poor.

2.3.2.1 Implementation challenges

In low- and middle-income countries, waivers suffer from several implementation challenges including vague policy, inadequate funding and guidelines, reimbursement shortfalls and problems with identifying the poor (Manzi, 2005; Mamdani & Bangser, 2004; Bitran & Giedion, 2003; Newbrander et al, 2000; Witter & Adjei, 2007; Witter et al, 2009).

2.3.2.1.1 Identifying the poor

According to the World Bank (2003), under-coverage of waivers i.e. when poor people do not receive the benefit intended for them and either have to pay for health care or do not use at all, is high among low and middle-income countries. This arises partly from the difficulties

in identifying the poor and policies which lack clear eligibility criteria (Bitran & Giedion, 2003; World Bank 2003; Hutton, 2002 and Hutton *et al.* 2005; Bitran 2002; Tien & Chee, 2002; McIntyre & Gilson, 2002; Mamdani & Bangser, 2004; Burns & Mantel 2006). Moreover, the definition of poor differs from one country to another. In Kenya for example, beneficiaries of waivers are those experiencing financial hardships and without enough food to eat (Bitran & Giedion, 2003). In Uganda for example, people who are waived from paying for user fees are known as very poor and in Ghana are ³‘destitute’ (Tien & Chee, 2002).

Another challenge arises from the highly decentralized administrative process for granting waivers (Russell & Gilson, 1995). In Tanzania for instance, the granting of waivers depends on the discretion of authorities at two levels namely the health facility and community. At the health care facility the patient’s case is reviewed by the social welfare officer, matron or health care manager. At the community level, the poor are identified by community leaders and provided with a document indicating that they should receive a waiver. This document then has to be reviewed by the relevant officer at the health facility before a waiver is granted. Due to the bureaucratic nature of this process and the time required, under- coverage arises (Manzi, 2005).

2.3.2.1.2 Reimbursement shortfalls

There can be a disincentive for health facilities to grant waivers and exemptions especially if the revenue shortfall is not likely to be fully reimbursed by the health care system. In many African countries that have implemented exemptions and waivers, the inadequate reimbursement system is widely reported (Mamdani & Bangser, 2004; Primer, 1999; Witter *et al.*, 2006).

In Ghana, the MOH (2002), in its Health Sector Review reported that insufficient funds were allocated to the regions to meet the shortfall arising from exemptions and waivers. It was estimated that although 44 billion Ghanaian cedi was needed to meet the revenue shortfall, only 10 million was allocated. Moreover, there was a delay in the allocation of funds, in some instances up to 8 months. This leads to avoiding of granting waivers by some facilities.

³ According to Ghanaian context, destitute is a term used to define people who are very poor and cannot pay for their health services (Tien & Chee, 2002)

A study by Msambichaka et al. (2003) found that the failure of the MOHSW to compensate the loss of revenue from exemptions and waivers had implications in terms of health care delivery, reluctance of health care staff to grant waivers, shortage of drugs and poor quality of care resulting in delays in seeking care on the part of the patients.

Similar results were reported by Mamdani & Bangser (2004) in an evaluation of the impact of reimbursement shortfall in Tanzanian health facilities. It was found that health care providers were reluctant to grant exemptions and waivers, which impacted significantly on health care access for the vulnerable and poor.

2.3.2.2 Implications for health care providers

Health care providers report problems in implementing the waivers. These include lack of clear guidelines and awareness of the guidelines and implementation (Mamdani & Bangser, 2004).

Granting waivers by health staff without using defined clear criteria, was seen as a difficult activity. They urged that since there are no defined criteria they might end up granting waivers to people who are not in need and therefore, in practice health care workers are not motivated. The same finding was reported by Tien & Chee (2002; Witter et al., 2007). However, the study also revealed that the same system works in Ghana and Zambia and Thailand. Income is often used as criteria for waivers. In Zambia for-example, poor people who have to be waived user fees are those who earned 15,000 and below Kwacha per month and Thailand are those who earn less than 2000 Baht per month (Tien & Chee (2002).

Awareness rising amongst health care providers can be achieved through distribution of documents and workshops, information letters, routine facility meetings and on the job training (Barns & Mantel (2006).

In a review of exemption schemes in rural primary facilities in Kilombero District in Tanzania, Manzi (2005) found that poor training of health care providers regarding exemptions and waivers was a key implementation problem. Although, the operation of exemptions and waivers is guided by a set of policy principles and guidelines the effectiveness and success of its implementation largely depends on the interpretation of the

guidelines and level of understanding by the staff at the facility level. Granting of a waiver at the facility level for example, is supposed to be done by trained personnel (social workers) but due to a lack of skilled personnel this is not the case (Mamdani & Bangser 2004). In practice, the granting of waivers at the facility level is often carried out by a health care provider resulting in leakages and under- coverage (Bitran, 2000; Garshong et al 2001; Mamdani & Bangser 2004).

2.3.2.3 Implications at the community level

Problems of implementing waiver systems were also observed at the local community level (Russell & Gilson 1995). In some instances community leaders granted waivers to friends and relatives, who did not necessarily deserve it, leaving out the true, intended beneficiaries, thereby affecting utilization and access for vulnerable groups. However, according to Tien & Chee (2002), REPOA (2007), Russell (2004) using communities to identify individuals eligible for waiver has worked well in Ghana.

2.3.2.3.1 Lack of awareness

The poor perceive that the existing poor relationship between clients and health care workers particularly in public health facilities is reserved for those who are unable to pay (REPOA, 2007). They may qualify to be waived for free health care but the public health care facility is far from home of the needy person. How would they get there when since poor have no fare for transport? This was also reported by Save the Children (2005) and Mamdani & Bangser (2004).

It has further been argued that awareness of the exemption and waiver systems among patients is very limited in Tanzania (Mamdani & Bangser 2004). Awareness is needed for patients to be able to demand their rights. Possible ways for improving awareness include educational and information sharing efforts by health care providers, health programme events such as AIDS days, media (televisions, radio), community initiatives, council health service boards(CHSBs), facility governing committees(FGCs) and local meetings) (Manzi, 2005; Newbrander et al, 2000; Picazo, 2005). Furthermore, regardless of the available means of creating awareness on the exemptions and waivers mentioned by the above study, the systems are still not effective.

Below are some of studies on exemption and waivers conducted in middle and low income countries.

2.3.3. Gaps in the literature

Before the study was proposed, an intensive literature review was conducted to determine the need for this study. The literature review conducted including in house studies (Tanzania), Africa and Asia. The main focus areas in the literature were methodology whereby whether a study involved qualitative or both qualitative and quantities approaches. Since a proposed study intended to focus only on qualitative approach, it was a bit easy to identify the gap. Secondly, a review of the literature looked at the areas where a study was conducted. The reason for this was to draw a comparison between rural and urban as it was proposed in the study.

The findings were different depends on the focus of the study. Some studies focused only on rural facilities and were lacking beneficiary's views. The study mostly employed both qualitative and quantitative approaches that focused at the institution set up issues and leave out health care providers and beneficiaries views at the primary facilities (dispensaries). In addition, the review of the studies ignored communities' views that are not benefiting exemptions and waivers. In order to have peoples' views the best approach recommended to enquire information is through qualitative method. In this case the gaps indicated above brought a need to conduct this study (see table 2.1).

Table 2.1: Some of the studies on user fees/ exemption and waivers conducted in low and middle income countries

Study	Methods	Key findings	Focused area	Gaps
User fees: Paying for health services at the point of use-Tanzania Save the Children by Lagarde, 2005	Focus group discussions (Quality approach)	-User fees have the worst impact on women and children as they do not have control over household expenditure. -User fee delay in attending the health facility	Rural Primary health facilities including DDH Mtwara Region northern part of Tanzania.	The study based on rural facilities only
Equity implication of health sector user fees in Tanzania: Do we retain the user fee or we set free REPOA by Laterveer, Munga, Schwerzel (2004).	Focus group discussions - health workers, key people in the MoH, NGOs and FBOs (both quantitative and qualitative approach)	-Low collection rate -Lack of equity in the distribution of resource -Exemption and waiver system problems are under debate in Tanzania	Urban/ rural Dar-es-salaam and Kagera- Tanzania	The study looked at many aspects under equity not exemption and waivers only
Health financing workshop, Tanzania, May 2005- A synthesis of key points	Presentations	-A better information system on user fees in the health sector is needed -A need for strengthening exemption and waivers system	National workshop conducted in Tanzania	The findings that lack beneficiaries' views.
Gender dimension of user fee: Implication for women utilization of health care By Nanda (2002) Angola	Interviews approach	-There is little incentive to providers to apply exemption policy	Rural area facilities in Angola	-Urban facilities were excluded -Lack of views of the beneficiaries
Review of exemptions and waivers Tanzania by Burns & Mantel (2006)	Secondary source Discussion groups with health faculty workers, hospitals, regional level	-Exemption benefit better off than poor -stigmatization - poor financial management	Urban and rural in Tanzania	The study focused more on policy issues rather implementation difficulties

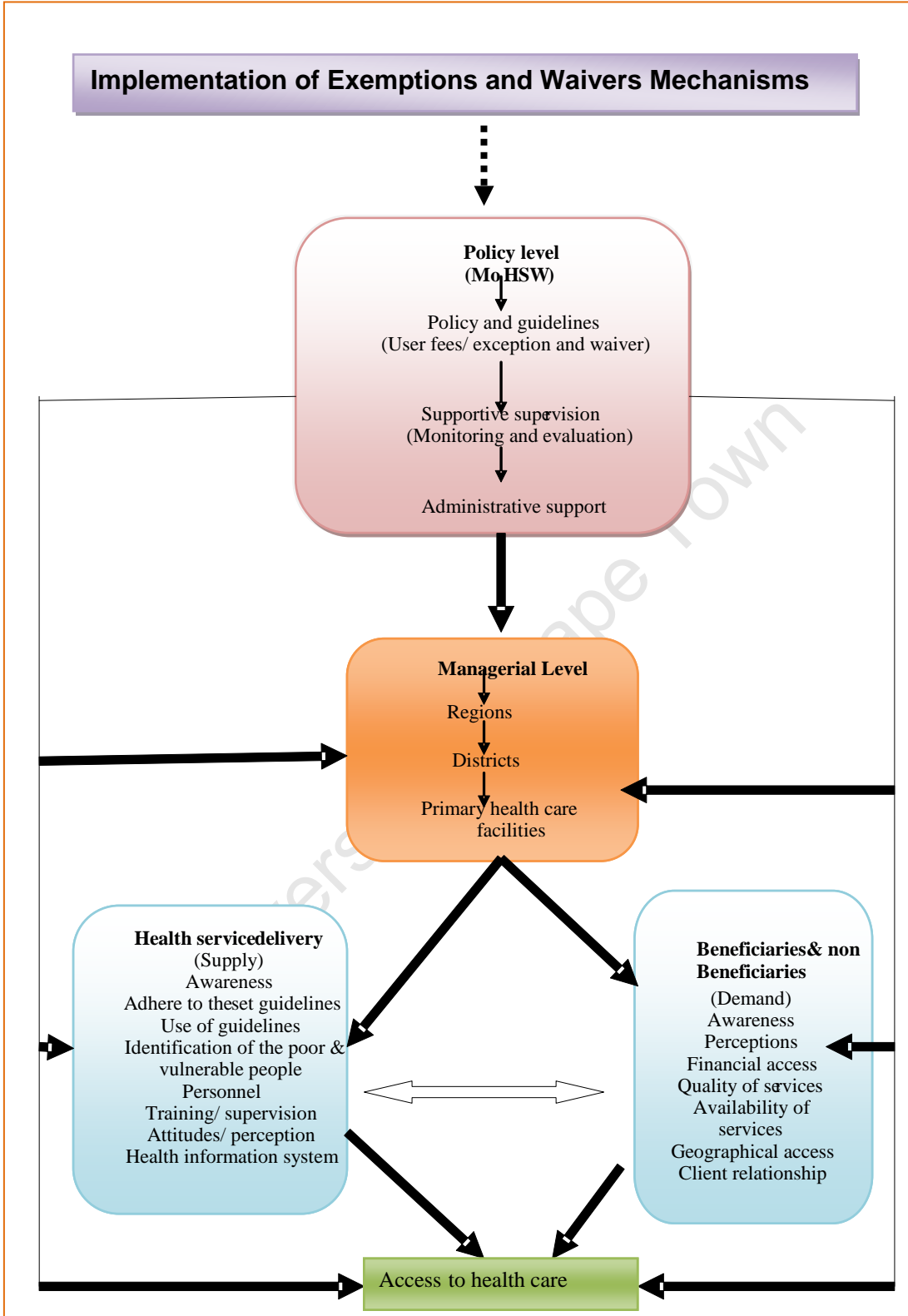
	and officials Quantitative and qualitative approach	-Poor identification of waivers -Conflicting roles among social groups		
The performance and future potential of the user fee exemption and Waiver mechanisms Dar-es-salaam public health delivery system-Tanzania by Hutton, et al., 2004	Exit Interviews- clients waiting for services in different health facilities	-Poor exemption policy -low motivation of health workers to implement exemptions -Poor access of free services for exempted waivers	Urban facilities in Tanzania	Conducted in urban health facilities
Ensuring Equal Access to Health Services: User Fee System and the Poor by Newbrander, Collins & Gilson (2000) .	Survey study using questionnaires	-Poor delay in seeking health care when they fall sick due to lack of money to pay for the services -Choice of particular type of facility public/private - Poor accessibility due to distance Poor identification of waivers	District hospitals Regional hospitals Referral hospitals Tanzania, Kenya, Guinea, Ecuador and Indonesia	The study focused more on institutions set up but not implementation challenges at community level (beneficiaries and non beneficiaries)
The Tanzania policy on health-care fee waiver and exemption in practice as compared with other developing countries: Evidence from local studies and international literatures by Mubyazi (2004) .	Review of documents (reports and researches)	-Lack of knowledge -Institutional bureaucracy -Lack of eligible criteria for identifying the poor -Conflict between revenue collection and protecting the poor	Evidence from local and international studies	No views from beneficiaries and non beneficiaries elicited
Learning from Experience: Health care financing in low and middle- income	Both qualitatively and quantitatively	No country has single health care financing mechanism however, Lack of eligible	Case study country wide in low and middle countries	The study focused more on policy level and leave

countries by McIntyre, 2007		criteria for identifying the poor and lack of knowledge of exemption and waivers.	including; DRC, Colombia, Thailand, Ghana, Sri-lanka, Bangladesh, Costa Rica, Nigeria, South Africa, Uganda	out lower level facilities (dispensaries)
The revenue generating potential of user fees in Kenya Government health facilities by Ellis (1987)	Both quantitative and qualitative approach used	-Reduction in demand for health care -Poor exemption of selection services from any fee -Poor exemptions for un able to pay -Linkage of revenue due to bribes	Rural/Urban facilities in Kenya	The study focused more revenue potentials and leave out implementation processes
User Fee Policies to Promote Health Services for the Poor: A wolf in Sheep's Clothing. 26 low and middle income countries by Russell & Gilson (1997)	Survey Questionnaires	Lack of significant criteria for exemptions for the poor were identified -27% of the countries surveyed had no policy to exempted the poor	International study in the low and middle income countries	-Used only one type of data collection method -Lack of views of beneficiaries and non beneficiaries

2.4 Conceptual Framework

This conceptual framework which underlies the research design was guided by the literature review and the aim and objectives of the study.

Figure 2.1: Conceptual framework



Source; Adapted from (Garshong et al, 2001)

The focus of this study is on the assessment of implementation of the exemptions and waivers policy and its implications in terms of access and utilization health care service by the poor. This study adopted a system's approach in reviewing the implementation of exemptions and waivers and its implication for access of health care.

The first level is that of policy at the Ministry of Health. If the policy and guidelines are not available, they would pose a challenge for implementers at the lower levels and could contribute towards problems of under-coverage and leakage.

The second level is the managerial level (region, districts and primary health facilities) that oversees and monitors the implementation process in health facilities. The third level is that of health service delivery at the facility level, where exemptions and waivers are granted. If the policy and guidelines are not well understood by health care providers, could contribute to problems such as failure to adhere to guidelines, difficulties in identifying the poor, negative attitudes and poor recording of information pertaining to the exemptions and waivers system. In addition, general health system challenges (e.g. drug and supplies availability, working conditions, salaries etc.) influence health providers' attitudes and overall quality of care and can deter patients from seeking care and impact on health care access.

On the other hand, beneficiaries of exemptions and waivers may face several barriers including lack of awareness of exemptions and waivers and the process for obtaining them. Another implication of poor awareness of exemptions and waivers for beneficiaries is that they (i.e. beneficiaries) might continue to pay for care received when they should not. This situation might also arise when providers either have a poor understanding of the exemptions and waivers system or do not apply them consistently.

In addition, other barriers which they face and impact on their access and utilization include remaining financial barriers (e.g. costs of transport etc.), geographical access, and perceptions of quality of care might also discourage them from seeking care. These issues will be explored more in Chapter four of this study.

CHAPTER THREE: METHODOLOGY

This chapter describes the methods used to investigate the study objectives. More specifically, it provides a detailed description of the study design, study area, sampling procedure, sample size, data collection methods and data analysis procedures. In addition, ethical considerations followed to conduct the study are described.

3.1 Study area and selection criteria

The study was conducted in Bagamoyo Town Council (urban) and Mtwara District Council (rural) in Tanzania. The two locations differ from one another in terms of socio-economic indicators and infrastructure. Due to limited resources and time constraints it was not possible to cover more than two districts for this study. The choice of the two districts was made for the purpose of comparing implementation, awareness, attitudes and perceptions of exemption and waiver mechanisms between rural and urban settings. Additional characteristics of the two locations are:

- ... Both have high infant and maternal mortality rates (112 and 120 per 1000 live births respectively), high levels of poverty and low utilization rates of health care services.
- ... Both have poor infrastructure including roads which is a geographical barrier to health care access. In addition, the two districts have high illiteracy rates. According to *National Bureau of Statistics* URT (2007), Bagamoyo district has a higher rate of school attrition (249 compared to 122 respectively annually) compared to Mtwara rural.

3.1.1 Location of study sites

Bagamoyo Town Council is situated in the Coast Region and lies approximately 80 kilometres from Dar es Salaam (see Figure 2). The region comprises of four other district councils; Kibaha, Rufiji, Kisarawe and Mkuranga. The total surface area of Bagamoyo Town Council is approximately 9,842 km². The district shares borders with Tanga Region in the North, Morogoro in the West and Dar es Salaam in the Eastern part. It has experienced economic growth due to its proximity to neighbouring regions and key economic activities include fishing, tourism and agricultural.

Mtwara District Council which is located in Mtwara Region, approximately 600 kilometres from Dar es Salaam City, in the southern part of the country (see Figure 3.1). The region is made up of five districts, of which Mtwara rural is the second largest, and Masasi being the largest. Others districts include Mikindani, Newala and Tandahimba. The district shares borders with the Indian Ocean to the East, Ruvuma/ Mozambique to the South, Newala to the West and Lindi region to the north. The district is relatively inaccessible and can only be reached from Dar es Salaam through Kibiti-Lindi. Moreover, during rainy the season, only 5 percent of roads are accessible. Due to its relative inaccessibility, Mtwara has suffered economically.

Figure 3.1: Tanzania map showing the study locations



Source: DHS, 2005

3.1.2 Socio-economic and demographic characteristics of the study sites

According to the 2005 census Bagamoyo Town Council has 230,164 inhabitants which account for approximately 23.4 percent of the regional population (URT, 2007). Twenty five percent of the population is under the age of five and 19 percent is between the ages of 11-49 years (URT, 2007). The majority of the population is Muslim and they speak Swahili and Zaramo since they originate from the Zaramo tribe. Poverty is a major problem in Bagamoyo town council. It's estimated that 41% of the population are considered as poor. This is a major factor hindering health care access.

Mtwara district council has a comparably large population of 203,480, which accounts for 23.2 percent of the regional population. Here again, twenty five percent of the population is under the age of five and 22 percent is between the age of 11-49 years (URT 1997). Similar to Bagamoyo town council, the majority of the population are poor, estimated to be 47%. The majority are Muslims. They speak Makonde and Swahili, and they originate from Makonde the tribe.

3.1.3 Economy

About 75 percent of the Bagamoyo economy is based on agricultural and fishing (URT, 2007). Productive land in Bagamoyo is 75,360 hectares which is about 6.7 percent of the total arable land (836,570 hectares). Major food crops in the district include maize, rice, sorghum, cassava, sweet potatoes, legume and pulse. Cash crops are cashew nuts, coconuts, sesame and fruits (mangoes and oranges).

Agriculture is the main economic activity in Mtwara district council. The main food crop is maize. Cash crops are mainly cashew nuts and groundnuts. Approximately, 21.5 percent of the region land area is allocated to agricultural and economic activities. Other economic activities include marine and air transport, fishing, beekeeping products and mining of gemstones which are excavated along the Indian Ocean and are used for house decoration (URT, 2007). However, due to poor infrastructure and the problem of accessibility the economy remains under developed.

3.1.4 Health facilities

In both districts, health facilities comprise of mainly public and to a lesser extent private health facilities (see table 3.1). The population use mainly public health facilities since the public health facilities are close in proximity (i.e. within 5 kilometres) and are less expensive than private facilities (MOHSW, 2006).

Table 3.1: Health facilities in Bagamoyo and Mtwara Districts 2007

	Hospital		Health Centres		Dispensaries	
	Public	Private	Public	Private	Public	Private
Bagamoyo(U)	1 (regional)	0	4	1	38	11
Mtwara (R)	1 (regional)	0	3	1	33	0

Source: URT, 2007

3.1.5 Burden of diseases

According to the district medical officer URT (2007) for Bagamoyo, malaria continues posing a high burden of disease in both districts and contributes to 29 percent of mortality in Bagamoyo town. On the other hand, the following diseases also impact on the Bagamoyo people's health: tuberculosis, HIV/AIDS, pneumonia, anaemia, pregnancy complications, diarrhoea, ARI and hypertension. The diseases are arranged from the highest to the lowest rank. Similarly, the major diseases that cause death in Mtwara rural are malaria (27.9), TB and HIV/AIDS which rank the highest. Others include tuberculosis, diarrhoea, pneumonia and eye infection and worms which differ from Bagamoyo. At the time this study was being carried out the actual burden of each of these conditions were not found.

3.2 Methodological approach

This study was conducted between December and February, 2008 in the Bagamoyo town council and Mtwara district. A study involved largely qualitative methodology because of the need for in-depth, open ended questions to elicit information from respondents reflecting concerns, feelings and experiences. Very little quantitative method was used where necessary. This gave enough flexibility to collect information from the tools. This flexibility is not always possible with quantitative predominantly close-ended questionnaires (Patton, 2002; Neuman, 2003; Strydom & Delpont, 2002). Given the qualitative research design data was collected through comprehensive literature review (reading publications, national policies, research papers and grey documents), in-depth interviews with resource persons

from policy level and government health care providers and focus group discussions with beneficiaries as well as no-beneficiaries and community members. Due to the nature of the study, small samples of respondents were chosen from both districts.

3.2.1 Sampling technique

According to Miles and Huberman (1994), sample size depends substantially on the research design and data collection approach that each researcher wishes to apply. For example, qualitative data collection approaches which are descriptive and exploratory in nature often require fewer individuals or respondents. In qualitative research sample size should be as small as possible to allow room for critical analysis of the sample selected (Todres, 2005; Kitziaga, 2005). In this study, respondents for in-depth interviews and focus group discussions were selected purposefully. A total of 16 in-depth interviews with key informants and 12 focus group discussions were held (table 3.2).

Table 3.2: Summary of the in-depth interviews and FGDs conducted

LEVELS	In-depth interview	FGDs
MOHSW	2 senior civil servants	
Regions	1 senior civil servant(RHMTs)	
Coast	1 RMO	
Mtwara		
Districts	-DED(2)	Community
Bagamoyo and Mtwara	-Hospital managers(2)	Hospitals (4)
	-Guarantor exemptions & waiver(2)	2 FGDs were held with beneficiaries in two districts
	-Chairperson (CHSBs) 2	2 FGDs were held with non beneficiaries in two districts
Health centres	1 Health care provider from one health centre in each of the districts were interviewed (2)	Community members (4)
1 & 2 Bagamoyo & Mtwara		2 FGDs, one with beneficiaries and the other with non beneficiaries were held ⁴ in each of the district.
Dispensary	Health care providers from one dispensary in each of the districts were interviewed(2)	Community members (4)
1 & 2 Bagamoyo & Mtwara		2 FGDs, one with beneficiaries and the other with non beneficiaries were held in each of the district.
Total	16	12

⁴ The following acronyms means; RHMT- Regional Health Management Teams
RMO-Regional Medical Officers
DED- District Executive Directors
CHSBs- Council Health Service Boards
FGDs- Focus Group Discussions

In-depth interviews were held with policy makers, health managers and health providers at all levels including the Ministry of Health, regions, districts, health centres and dispensary levels. The reason for inclusion of all levels was to capture a range of perceptions and ensure representation of a variety of views. The views of beneficiaries and non beneficiaries were captured through FGDs held in each level (hospitals, health centres and dispensaries).

3.2.2 Sampling procedure

This study employed a purposeful and convenient sampling approach. For the in-depth interviews, key informants were selected based on their involvement in exemptions and waivers which could be in terms of policy development, management of the implementation process or as implementers.

3.3 Data collection tools

The data collection tools included in-depths interviews and FGDs.

3.3.1 In-depth interview

The in-depth interviews used open ended questions (Appendix 1) and ranged between 45 minutes and one hour. Participants were drawn from the following levels:

- **Ministerial level:** two senior civil servants responsible for overseeing the implementation of exemption and waivers.
- **Region level:** two RMOs responsible for coordinating the implementation of exemption and waivers in the two regions.
- **District level:** two district executive directors (DED), two hospital managers, two guarantors of exemptions and waivers, 2 chairpersons (CHSB) in the two regions.
- **Health centre level:** managers of health centres in each of the two districts.
- **Dispensary level:** managers of dispensaries in each of the two districts.

3.3.2 Focus group discussion (FGDs)

As noted earlier, a total of 12 FGDs were held with health care providers (Appendix 2), beneficiaries (Appendix 3) and non beneficiaries (Appendix 4) at 6 health facilities (hospitals, health centres and dispensaries).

The FGDs ranged between one and two hours. Most of the FGDs took place in the afternoon hours. The size of the groups was between 5-8 participants. Participants for FGDs were drawn from patients and service providers. With regard to patients, both the beneficiaries and non beneficiaries were invited to participate. FGDs were held at the facility during working hours between 9.00 and 3.30. Health care providers and key informants were selected on the basis of their involvement in granting exemptions and/or waivers and availability. Health care workers were willing to participate since they were eager to share their experiences with regard to exemptions and waivers.

3.4 Data Recording

The FGDs and in-depth interviews were tape recorded. In addition, the researcher and research assistants took detailed notes throughout the duration of the fieldwork.

3.5 Field-work Training

Two research assistants who were university students were hired. During their training, the researcher explained the purpose of the study and the data collection tools. The research assistants were also taught how to organize and conduct focus group discussions and take notes.

3.6 Gaining access

The researcher liaised with the Ministry of Health Tanzania, Regional and Districts authority to obtain permission to carry out the study in the chosen facilities.

3.7 Ethical considerations to the study sites

The study had received ethical approval from University of Cape Town (UCT). Since the study was conducted in Tanzania, ethical approval was also sought from relevant authorities (MOHSW, regions and districts).

3.7.1 Anonymity and Informed consent

Informed consent was obtained from the participants before proceeding with the in-depth interviews and FGDs (Appendix 5). Consent forms were signed by both the participants and the researcher. Each participant received an information sheet which explained the nature and purpose of the study, the participant's rights to privacy, anonymity and decision not to participate. It was also emphasized that participation was voluntary and that they could

therefore withdraw at anytime without compromising the health care they were receiving. The information sheet was translated into Swahili since this is the first language of the participants (Appendix 7). In case of illiteracy where respondents could not sign the consent forms a researcher explained in detail the purpose of the study to the group of participants. After explanations the participants were given time to re-think and decide to participate or not to participate in the study. Fortunately, all participants decide to participate in the study.

3.8 Data analysis

This study used an inductive approach for analysing the data. This approach uses content analysis which includes the steps of transcribing the information, coding, data reduction, data display and interpretation of themes. (Greef, 2002) Content analysis is the process of quoting respondent's expressions from the research question and objectives.

3.8.1 Transcribing of the data

All field notes and tape recording of the in-depth interviews and FGDs were transcribed using MS word. Since Swahili was the main language for both in-depth interviews and FGDs, it was necessary to translate these discussions into English with the assistance of a translator. The translation was then compared with the transcripts in Swahili to see if there were discrepancies.

3.8.2 Reading of the transcribed data

The transcribed data was read and re-read to acquire a general sense of the overall data. The process was continued until the researcher was satisfied that significant statements and phrases which had implications for the study objectives had been identified. All significant phrases were then marked off with coloured pens.

3.8.3 Coding

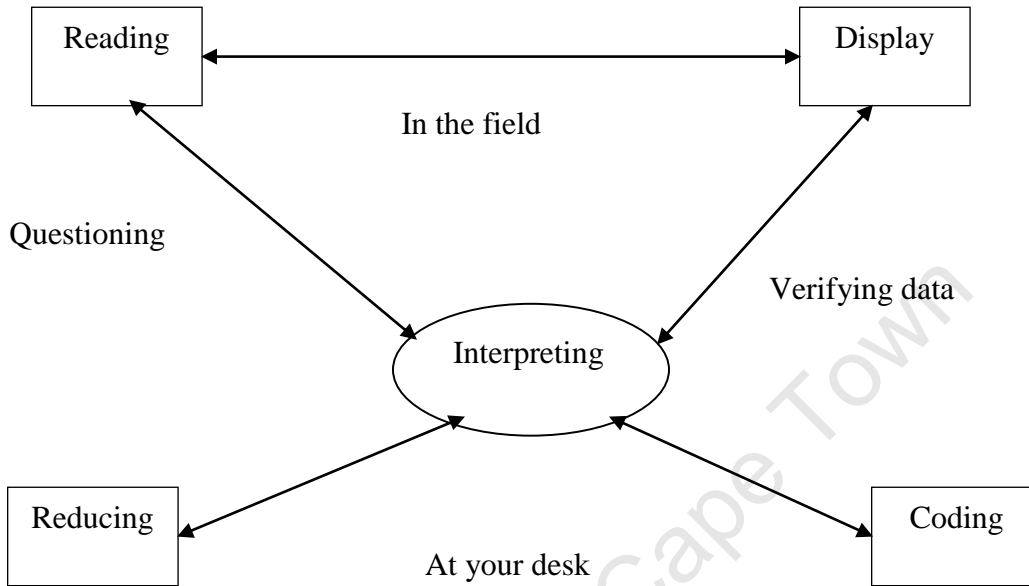
Different colours were used for grouping themes according to their similarities from the in-depth interviews and FGDs.

3.8.4 Data reduction

This is the process of filtering the information focusing on the most essential concepts and their relationship with themes (Ulin et al, 2005; Radnor, 1994). In this study key themes from both issues emerging from the interview and FGDs were related back to the study objectives.

The next step was to analyse the data captured under the various themes, to identify variations and similarities in the responses and identification of subcategories and or sub themes followed.

Figure 3.2 Summary of the data analysis process



Source: Adopted from (Ulin et al, 2005 pp 144)

3.9. Field editing

This is the process that involves systematic and coherent process of data collection, storage and retrieval. In this study the principal investigator was personally involved in data collection and editing. This made it easier to do spot checks and solve any problems which came up in relation to data collection. Data were recorded onto MS word every day following interviews and FGDs to ensure that any challenges and problems relating to that data were identified as early as possible.

3. 10 Limitations of the study

3.10.1 Predominance of women participants

In this study, most of the participants were women and might be due to the fact that predominantly, women and children use health facilities more than men.

3.10.2 Information bias

The in-depth interviews were conducted only with policy makers, directors, managers of the health facilities who are involved in the overseeing and implementation of exemption and waiver systems. It is possible that they would respond in a manner that shows their performance in a positive light. With regard to FGDs, since these were conducted at the health facilities, the participants might not have been very open in expressing their views on the health facilities since they might have felt that it would in some way influence the care they received.

University of Cape Town

CHAPTER FOUR: RESULTS AND DISCUSSIONS

Introduction

This chapter presents key findings based on the objectives of the study as outlined in Chapter One. To start with, there is a description of the study sample of the two regions using key characteristics such as age, gender, employment opportunities etc. It also describes study sites including health facilities visited in each of the regions. Thereafter, there is an analysis of the issues raised in the discussions with key informants, health care providers as well as beneficiaries and non-beneficiaries with regard to the implementation of exemption and waiver systems in public health facilities. The key findings/issues that emerged from in-depth interviews and FGDs are considered in four main categories. These were:

- Awareness of exemptions and waivers among policy makers, hospital managers and health care providers
- Awareness of exemptions and waivers among beneficiaries and non-beneficiaries.
- Experiences and perceptions of the implementation of exemptions and waivers among policy makers, hospital managers and health care providers
- Experiences and perceptions of beneficiaries and non-beneficiaries in the implementation of exemptions and waivers

4.1 Characteristics of the study population.

4.1.1 Policy level (MOHSW)

Two key informants from the Ministry of Health and Social Work (MOHSW) were involved in this study. The participants came from the department of Policy and Planning; they are responsible for coordination of the implementation of the user fee policy in the public health care system.

4.1.2 Coast region

Bagamoyo town council was selected for Coast region. There were nine participants involved in in-depth interviews of which five were males and four were females. All key informants were formal government employees. Unfortunately, the study could not gather information regarding number of years of service for each key informant. It was assumed that people with long service in the public health facilities would be more aware of the exemption and waiver

guidelines compared to those with few years of service. In the focus group discussions, there were 20 beneficiaries who participated, including seven males and 13 females. In addition, non-beneficiaries comprised of 18 people, most of whom were self employed as peasants and small business owners; and for the case of beneficiaries, most were pregnant mothers' women or mothers of children under five who were found in the health facilities.

4.1.3 Mtwara region

Mtwara rural district was selected for Mtwara region. There were eight participants involved in in-depth interviews. They were six males and two females. All key informants were formal employees of the government. In the focus group discussions, 18 beneficiaries were involved in the study. These were beneficiaries of exemptions and or waivers of which five were males and 13 females. On the other hand, there were 19 non-beneficiaries, where 7 were males and 12 were females. Slight differences were observed particularly for the FGDs' participation in the two districts due to the fact that the discussions were conducted in different environments.

4.2 Description of the study areas and health facilities

The selected districts in the study had rural and urban characteristics. The selection criteria of the two sites were purposely made in order to compare the implementation of the exemptions and waivers policy in the health facilities located in urban and rural areas.

4.2.1 Bagamoyo town council health facilities

Bagamoyo town council has a total of 23 health facilities. The distribution is as follows: one district hospital, two health centres, and 20 dispensaries. In order to establish a sample size, a list of all 23 health facilities was established. Only 5 facilities were selected from the list of 23 health facilities in the district. In this case, a simply random selection method was used and the procedure was as follows: One hospital picked because it was the only hospital in the district. One health centre was picked among the two for the reason that, it serves bigger population compared to the other and easily reachable. One dispensary was picked among 20 dispensaries in the district for the same reason as in the case of health centres. The population served by the facilities differed depending on the size of the facility. For example, a district hospital serves about 100,000 people, a health centre serves about 50,000 people, and a dispensary serves about 10,000 people. Moreover, the size of population served by these facilities might be less or more depending on geographical and social characteristics of the

catchment area. However, the study could not establish the actual size of population served by each specific facility.

During the data collection process, observation was made on general functioning of health facilities. All health facilities opened at 8.00 am and closed at 4.00pm except for the hospitals where services were provided 24 hours a day. The opening time was not in line with normal working hours in government offices which open at 7.30 am. It was noted that the number of patients who visited the district hospital were high compared to other facilities. There were long queues along the hospital benches at the OPDs as compared with queues observed at lower level facilities. The majority of patients attending the facilities were women and under five children. Pregnant mothers and under five children usually attended special clinic services at the hospital, although some of them were seen at the OPD. Patients in lower facilities (health centres & dispensaries) were attended to in doctors' consultations rooms. Generally the environment of the visited facilities was clean. Unfortunately, it was not possible to go around inspecting the toilets or wards (in the case of hospitals) across the surveyed facilities.

The process of implementing exemptions and waivers systems in the health facilities was observed. At the hospitals, exemptions for pregnant mothers and children under five were identified directly at the respective clinics by health care providers. For other exemptions, the patients reported to the district nursing officer's office located at the OPD for identification. Patients provided with exemptions were those with chronic diseases such as diabetics, high blood pressure and HIV/AIDS. They were identified through presenting clinic cards to the officer. The officer stamped and signed the cards to allow them to receive free services. The waiver process for the poor was not easily observed at hospital level.

At the health centres and dispensaries, exemptions and waivers were granted by in-charges/managers of the facilities in the consultation rooms. Health care workers were the responsible officers for granting waivers. They were also busy with other clinical duties. Around district hospitals in Bagamoyo town council, there were posters that explained free health services for pregnant mothers and under five children. However, similar posters were not found in health centres and dispensaries.

4.2.2 Mtwara district council health facilities

Mtwara district council has a total of 37 health facilities. The distribution is as follows: One regional hospital referred as district hospital, three health centres and 34 dispensaries. Only five facilities simply random selected out of 37 were included in the study. The population served by the facilities differed depending on the size of the facility. The facilities visited in Mtwara district council were reachable by road but with some difficulties. There was no reliable public transport to reach the facilities, which was not the case in Bagamoyo, particularly the two health centres and dispensaries visited.

During the data collection process, observation was made on the general functioning of health facilities. Similar to Bagamoyo, all health facilities in Mtwara district council opened at 8.00 am in the morning and closed at 3.30 in the evening except for the hospitals where services were provided for 24 hours. It was noted that the number of patients who visited the district hospital in Mtwara was high compared to Bagamoyo district hospital. This was due to the fact that the hospital serves two purposes, as district as well as regional hospital. There were long queues of patients along the hospital benches at OPDs as compared to queues observed at lower level facilities.

Compared to Bagamoyo, the general environment at the regional hospital was not very clean. The dustbins were full of hospital supplies and seem not to be regularly emptied. Unfortunately, there were no posters around the hospital or in the lower level facilities that advertised free health services for pregnant mothers and under five children.

4.3 Results and discussions

4.3 .1 Level of awareness among policy makers, hospital managers and health care providers

The aim of this sub-section is to assess participants' understanding and views on the following; the differences between exemptions and waivers , groups receiving exemption and waivers, process of granting exemptions and waivers, linkages between user fees and exemptions and waivers and feedback/ communication flow to health care workers as well as to the beneficiaries.

4.3.1.1 Knowledge and application

Knowledge in this study is referred to as the capacity to acquire, retain and use of information (Bandason, 1995). It was noted in another study that practice means the application of rules and knowledge that leads to action (Bandason, 1995). Practice is linked with knowledge and is executed in an ethical manner. All public health facilities were implementing the exemption and waiver policy in both districts except few facilities in Bagamoyo for political reasons. This was reported by the health care providers interviewed in both districts. However, according to the discussion held in Bagamoyo, district there were health facilities in the district which were not implementing user fees and therefore, all beneficiaries in the catchment area are still accessing free health care services. This was reported to be due to political reasons which the CHMT team were unwilling to explain clearly to the researcher. The findings also revealed some practical problems that hinder health workers in the application of rules and knowledge in implementing the exemption and waiver policy. These were: staff capacity, poor record keeping and lack of a reimbursement system.

In relation to staff capacity, most of the health care providers interviewed reported that there was not enough staff in the rural health facilities in the two districts visited. The shortage of skilled staff in the health facilities has implications for the ability of the facility to serve patients adequately. Their concerns were: health care providers are untrained and face time constraints in executing additional responsibilities. These include operating and supervising exemptions, recommending patients for waivers, preparing and maintaining records on exemptions and waivers, including monetary value, and compiling reports for exemptions and waivers and sending them to the authority responsible. As there are few health care workers in the health facilities, it is difficult to accommodate the exemption and waiver policy in an efficient way. There is a need to plan in the future to have a social welfare unit in health care facilities so that the grating of waivers is dealt by social welfare professionals. In addition, health workers were not trained on the execution of the waiver policy, which makes it very difficult for them to practice efficiently.

“I was working as a nurse in this hospital... One day I received a call from the medical director who told me that from that day I should work as a guarantor for exemptions....with no training..... Yet I work”Health care provider, hospital.

Shortage of staff was also noted by the study conducted by Garshong et al, (2001) in Ghana. The study revealed that in rural facilities, there are few health staff and this makes it difficult for them to carry out the required duties.

According to the MOH (2005), one health centre is supposed to serve a population of 50,000. The staff include: one Assistant Medical Officer (AMO), three clinical officers, four nurses grade A, four nurses grade B, two Maternal and Child Health Aids (MCHA), four medical attendants, one medical laboratory technician, one dental therapist and other auxiliary staff. At the dispensary level, the staff required included: two clinical officers, two grade B nurses and a medical attendant. However, under normal circumstances the staffing capacity in health centres and dispensaries are not as indicated above. For-example, in all rural health centres visited there were only one clinical officer and one medical attendant. In all dispensaries, there was only one medical attendant.

In relation to monitoring of exemptions and waivers at the facility level, the interviews conducted with health care providers indicated that there are no records for waivers. The findings were consistent with those of Mamdani & Bangser (2004) which revealed poor recording system of waivers in the health facilities visited.

According to the MOH guideline (1993pp 21), waivers should be recorded on a special form called “temporary exemption from”. This form has five sections that explain the patient’s personal particulars, historical background of the patient, reasons for exemption and the signature of the officer granting the exemption. The guideline does not include clear information on how to prepare a comprehensive quarterly or annual report of the entire health facility. However, a study by Tien & Chee (2002) suggested that the proper records for exemption and waiver records should include: number of exemptions and waivers issued and their categories, reason for exemptions, health facility information and background of the patient.

Lack of reimbursement of user fee revenue lost through exemptions and waivers by the MOHSW was also reported as one of the key elements in changing health care workers' attitudes. Most health care workers in the two districts and at the policy level reported having such problems in the facilities. Their concern was about the Government implementing an exemption and waiver policy since 1993 and yet no funds were set aside for compensation. The respondents from districts reported lack of seriousness by the Government in supporting the policy. However, the informants at policy level reported a lack of resources necessary to support the implementation of exemptions and waivers. In addition, it was reported that the government of Tanzania had an intention to start the reimbursement system in the 2008/9 financial year. Msambichaka et al (2003) previously recommended reimbursement of revenue lost through exemptions and waivers can raise staff morale and improve their performance. However, due to the time limit the study was not extend to review the annual financial statement and therefore it was difficult to establish how much revenue was lost.

“Think of the staff who does grant exemptions and waivers and there is no reimbursement..... and they do not know anything about the system..... It is discouraging to continue providing the service.....In fact MOH has realized and is now working on it to see the possibility of introducing a reimbursement system in the financial year 2008/9, Policy level.”

A component of a successful exemption and waiver system for the poor is a concurrent mechanism to pay for revenue foregone when providing free services to the poor and other vulnerable groups. Health staff concerns with raising revenue contributed to a reluctance to grant waivers and reveal information about exemption and waivers to patients and their relatives. Health staff who rely on the revenue cannot be expected to grant waivers consistently and fairly unless there is funding to reimburse.

4.3.1.2 Difference between exemption and waivers

According to in-depth interviews conducted with policy makers and health care providers at the regional and district levels, participants had different responses. Policy makers at the ministry level had good knowledge of the differences between the two concepts. There was a similar understanding at regional level (Bagamoyo and Mtwara). The concepts were differentiated in relation to cost sharing policy. This was in line with what has been stated in

the Cost Sharing guideline of 1993. Based on same guideline, waivers are temporarily relief that is provided to patients who are unable to pay for health care services. One of the respondents' explained:

“Exemption and waiver is an impact of the cost-sharing policy to protect public interests by providing free health care services to poor people and it is explained in chapter 5 of cost-sharing policy.” respondent from MOHSW.

Hospital managers and health care providers at district level had a different understanding of the two concepts. In Bagamoyo town council, health care providers were more knowledgeable on the difference between exemptions and waivers. However, the knowledge reduced as you move down to the lower facilities. In Mtwara district, which is a rural setting, there was a problem in general understanding of the difference between exemption and waiver systems. Respondents particularly from health centres and dispensaries had little understand the difference. Lack of understanding among health care workers can lead to lack of acceptance of exemptions and waivers by health care providers in the health facilities. The findings were similar across the district health facilities visited to the study by Mamdani & Bangser (2004). The study revealed that having knowledge of something leads to its acceptance and some respondents had the following to say.

“Exemptions means free health care services for some identified people e.g. pregnant mothers, children and the elderly” Health care provider, Dispensary’.

*“It is not well known but, what I understand is that there are free health care services for some identified people, that is, pregnant mothers, and children.”*Health care provider, from a health centre’.

Policy makers seem to assume that health care providers have knowledge about the exemption and waiver system. This is not the case. There is a need to provide training to health care providers on the importance of the exemption and waiver systems. It was reported by health care workers that no training was conducted on the implementation of the exemption and waiver systems. Training provides understanding about the purpose and eligibility criteria for exemptions and waivers and can promote the collection of data for monitoring purposes.

4.3.1.3 Groups receiving exemptions and waivers

The study was also interested in assessing whether the groups that are entitled to receive exemption and waivers were well known by policy makers, hospital managers and health care providers. These groups include: pregnant mothers, under-five children, people with chronic diseases, elderly and the poor. There were similar findings at the regional level and are in line with that provided in the cost sharing guideline of 1993. At district level, managers of the hospitals, health centres and dispensaries in Bagamoyo had similar responses. However, in Mtwara district participants from the hospital were aware of the eligible groups. In the health centres and dispensaries participants were aware of only two groups: pregnant mothers and children under the age of five years.

The FGDs conducted with health care providers in two district hospitals revealed that, there was a good understanding of the groups receiving exemptions and waivers. However, at lower facilities (dispensaries), only two major groups were mentioned i.e. pregnant mothers and under five children. The findings were common in all lower level facilities in Bagamoyo and Mtwara. Part of the possible explanation for this finding is that some of the groups eligible for exemptions and waivers were not known (e.g. people chronic diseases) who are treated at the hospital level. However, it is of concern that the poor were not mentioned as being eligible for waiver. There is a need for training and advocacy on this issue to promote access to health care services for the poor.

4.3.1.4 Process of granting exemptions and waivers

In-depth interviews with policy makers at the MOHSW revealed awareness of the process for granting exemptions and waivers to the beneficiaries. The process was explained with regarding to two environments: exemptions provided at health facilities and the other one at community level. At the health facilities, exemptions are provided by health care providers while at the community level, they are provided by community leaders. This is in line with Chapter 5 of the Cost Sharing guideline. There were similar findings at the regional level and with managers of hospitals, health centres and dispensaries.

In the FGDs with health care providers in the hospitals, health centres and dispensaries, participants mentioned three major ways of identifying groups entitled to exemption and

waivers. These were: clinic cards for pregnant mothers, documents from local authorities and personal discretion by social workers or managers of health facilities. The findings were similar in all facilities in Bagamoyo and Mtwara. It was reported by Mtwara regional hospital that a document from local authorities did not guarantee patients free health services. The patient has to undergo some evaluation at the hospital by health care providers. The facility evaluation attempts to confirm that a person is poor to address the problem of local leaders granting waivers to people who are not poor. This was not the case in Bagamoyo town council. Health care providers at hospitals, health centres and dispensaries also indicated their concern that they face difficulties in granting waivers due to the lack of national standard criteria for identifying the poor. It was noted that the waiver system is more cumbersome than exemptions. To make things clearer, there is a need to have clearly stated process and standard criteria for identifying the poor in cost sharing guideline.

The findings were in line with the study conducted by Russell & Gilson (1995). The authors noted that health care workers were committed to helping patients who came to the facility, but it was difficult for the providers to assess household or individual income particularly where there was no information on employment status or support by the extended family (Russell & Gilson, 1995). Experiences indicate that other African countries implementing a waiver policy, such as Zimbabwe, Kenya, Zambia, Ethiopia, Cambodia and Cameroon. Practically, making a decision about waivers for the poor in the rural health facilities remains a challenge. The findings were similar to other studies on exemptions and waivers conducted in the low income countries by Mubyazi (2004), Newbrander et al. (2000), Mamdani & Bangser (2004), Garshong et al. (2001), MOH, 2004; Tien & Chee, 2002; Enginda & Mariam, 2002; Khun & Mandason, 2008).

4.3.1.5 Information for health care providers

Policy makers mentioned during in-depth interviews that guidelines, radio, posters, and local newspapers were used as means of informing health care workers of the exemption and waiver system. At the regional level, it was a bit different. In Coast region for example, only the distribution of guidelines was used as a means of providing information to health care workers. However, it was difficult to find existing exemption and waiver guidelines in the office. However, in Mtwara, at the regional hospital it was possible to find the exemption and waiver guideline.

According to the health system structure of Tanzania, information about health policies like that of exemptions and waivers is usually provided by the Ministry of Health and Social Welfare. The Ministry uses the media and local newspapers to educate people about health matters. Also health care workers expect to receive written formal communication from the Minister responsible for health matters on issues that need attention in the implementation levels. However, this does not occur in practice.

According to MOH (2005) information comes from three major sources. It is expected that information for health care workers should be available in the form of training, advocacy and the use of guidelines. There is also formal and informal communication. Formal communication includes written guidelines, health circulars or proceedings of the meetings and workshops held in their health facilities and information disseminated by senior leaders like executive directors or regional medical officers, media reporters and so on. Informal communication includes: verbal communication through senior staff, speeches by political leaders such as the President of the United Republic and ministers.

According to the Ministry of Health and Social Welfare, cost sharing guidelines were issued for implementation on a regular basis although it was difficult to provide information on the distribution of guidelines to the districts and lower facility levels. Health care workers who were interviewed reported that the guidelines were not available except at Ligula hospital in Mtwara region and were not sure who was responsible for providing them with those guidelines. Health care providers also reported that although they usually request for guidelines from the Ministry of Health and Social Welfare, they never get feedback. For example, one of the key informants said:

“I don’t know who coordinates policies at central level.....We do see people from the Ministry coming for other issues like immunization campaigns , HIV/AIDS advocacy but not for exemptions and waivers.....It is better you have come, your visit will shed light about that” Health care provider, Health Centre.

From the findings it was noted that the lack of communication has created a gap in understanding of the exemption and waiver policy as in terms of who are the key actors in the implementation process. Communication provides openness and transparency in the work

place. There is a need to improve communication systems to inform and update policy makers and health care providers on the exemption and waiver system, as this may improve access to health care services for the poor.

4.3.1.6 Linkages between user fees, exemptions and waivers

The study was also interested in learning how health care providers link exemptions and waivers with the user fee policy. According to in-depth interviews conducted with key informants, two things were reported regarding the link. All key informants linked exemptions and waivers with equity. They reported that exemption and waiver systems increase accessibility of health care services to the poor. The poor are protected in a transparent manner particularly through waivers. However, some of the informants linked exemptions and waivers with revenue collection. The respondents argued that in Tanzania, almost 60% of the population are exempted from paying user fees. According to the respondents, revenue collection from user fees does not fulfil the objective established during introduction of user fees, which is to fill resource gaps in government funding so as to improve the quality of health care services to the Tanzanian population. The findings were similar with other studies conducted by (Mamdani, 2005; Manzi, 2005; Munga, 2003; Msambichaka et al, 2003; Newbrander & Sacca, 1999; Msambichaka et al, 2003).

4.3.1.7 Monitoring of exemptions and waivers systems

Monthly and quarterly supervision through Health Information Management System (HIMS) reported as means for monitoring exemptions and waivers at all health facilities. It was difficult to provide evidence on when supervisory visits took place. One of the respondents at the policy level revealed that supervision is conducted when financial resources were available.

“Sometime we take even a year without visiting the districts due to lack of financial resources”. Respondent at MoHSW.

From regional levels, hospital managers and health care providers declared that there was no support from the ministry. Lack of a link between the ministry, regions, districts, and health centres was a major concern. There are many implementation problems with the exemption and waiver systems which need to be clarified by the Ministry of Health. Without this, health

care workers fail to execute their duties and there are no follow-ups. Similar views were expressed across all facilities in the districts.

The in-depth interviews conducted with key informants in the district revealed that the DMO and hospital managers of the facility were the ones responsible for policy implementation and monitoring of exemptions and waivers. The key informants argued that however the coordination role was the responsibility of specific officials who hold certain position but, the end of a day, the DMO and managers of health facilities are aware of which patients were exempted from paying user fees. Also, DMOs and managers of health facilities should compile exemption and waiver reports and send these to the responsible authorities. The findings were similar in all facilities in the two districts and were consistent with those of Manzi (2005) who acknowledges that under good monitoring system, exemption and waiver systems under a user fee policy are good for protecting the poor but there is a need to improve its coordination at all levels.

According to the health system structure in Tanzania, implementation of exemption and waiver mechanisms are coordinated by the Department of Policy and Planning at the ministry level. At the regional level, RMOs are fully involved in overseeing the implementation and at the district level coordination is done by DMOs and managers of respective hospitals. The results from the in-depth interviews carried out at the MOHSW, regional and district levels showed that participants were aware of what the coordination system should consist of, including supportive supervision and monthly reports. However, there is a gap in coordinating exemptions and waivers which needs to be addressed to have a more effective system.

4.3.1.8 Feedback mechanisms

The study was also interested in looking at how the policy makers get feedback on implementation of exemptions and waivers in health facilities. Two types of mechanisms (Health Information and Management System (HIMS) and supportive supervision) were mentioned by informants at ministry and regional level. It was reported that the reports about exemption and waiver implementation were not copied to the RMOs office. It was also stated that political leaders went directly to health facilities and complained about poor services.

Another mechanism was direct complaints from those who are meant to benefit from exemptions and waivers. However it was reported that people feared to provide feedback so as to avoid misunderstandings with health care providers who may in future neglect them. The findings were similar in all health facilities in the two districts. These findings are in line with results from Buse *et al.* (2005), which noted that a successful policy formulation and implementation requires a process that involves stakeholders at all levels of society. In this case, the exemption and waiver policy was developed and implemented without adequate involvement of the local communities particularly the intended beneficiaries. For-example, some enquiries asking for their view from the communities regarding the development of the policy was not done. This study suggests local communities should be involved in various health reform processes so as to have more ownership and acceptance. This could reduce unnecessary challenges among health care providers in implementing the exemption and waivers policy in the country.

4.3.2 Awareness of exemptions and waivers among beneficiaries and non-beneficiaries.

The study was also interested in eliciting information about knowledge on exemptions and waivers from both beneficiaries and non-beneficiaries. In this case three aspects were discussed. These were: differences between exemptions and waivers, source of information and the process of obtaining exemptions and waivers at different levels.

Beneficiaries in this study are referred as those groups that benefit from exemption and waiver system as stated in Chapter 5 of cost sharing guideline. Non beneficiaries are people who are not entitled to exemptions and waivers as they do not belong to the groups identified in the cost sharing guideline. They normally pay for health care service through user fees or through insurance schemes.

4.3.2.1 Difference between exemptions and waivers

The FGDs conducted with beneficiaries at different levels of implementation revealed that there was a lack of understanding about exemptions and waivers. Participants at the hospital level in Bagamoyo town council showed their ability to differentiate the two concepts according to the process they had to follow. For-example, a waiver process was linked to local leaders since they granted waivers at local community level. However, participants at

lower level health facilities were not able to explain the differences. Similarly, there was better understanding of the differences at the hospital level in Mtwara district. Participants at the hospital level stated that exemptions were automatically provided in the health facilities but waivers required documentary proof from local leaders. At the lower facilities (health centres and dispensaries), the majority of the beneficiaries were not able to distinguish between exemptions and waivers or explain what was covered under exemptions and waivers.

“There is no difference... all exempted groups are attended in the same hospital...., unless you explain to us the difference now.... Participants from Health Centre”.

Another beneficiary from a health centre said,

“No difference at all.... both are exemptions, how can somebody differentiate, I see people directing each other to the matron’s office... ”.

Similarly another beneficiary participant from a dispensary said,

“Every sick person at the hospital is attended by health care providers..... whether is exempted or not....”

A non-beneficiary from a health centre started that,

“It is very common for a health facility to be out of drugs and medical supplies for a very long time”.

In addition, the FGDs conducted at the lower facility levels in all districts revealed that pregnant mothers and under five children are groups known to be exempted. In the hospital level the poor people were also identified at the district level. In comparison hospital levels, participants cited elderly people in exemption groups (see table 4.1). Some of the groups were not cited at all, these included people with chronic disease particularly TB and HIV/AIDS. Beneficiaries also cited other groups not covered by the policy such as orphans, disabled and emergency services

Table 4.1: Awareness of exempted groups by beneficiaries and non-beneficiaries

Hospitals (all)	H/centres(not all)	Dispensaries(not all)
Pregnant mothers	Pregnant mothers	Pregnant mothers
Under five children	Under five children	Under five
Elderly		
Poor		

Similar results were indicated in health centres and dispensary levels, indicates that there was not only a lack of knowledge about the differences about exemptions and waivers but a lack of knowledge of who the intended beneficiaries of the policy were involved.

The findings were similar to those found by Hutton et al., (2005) conducted in urban health facilities in Tanzania on health information matters. The study revealed that communities and public at large receive information about health matters through formal communication such as radio, newspapers, posters in the health facilities and village meetings

According to the MOH (2005) informal and formal communications are two ways in which beneficiaries could get information about exemptions and waivers. Formal communication includes radio, newspapers, television programmes, posters in the facilities and village meetings. However, some of the formal communication tools are expensive and not reliable everywhere, particularly in the rural areas. For example, not every citizen has a radio or television or is able to read from the posters. Informal communication is through friends and relatives.

According to the findings of this study, beneficiaries and non beneficiaries of exemptions and waivers receive information about health matters and programmes through basically formal and informal ways. Informal campaigns increased their awareness about waivers, particularly eligibility and the process of identifying the poor. Formal campaigns ensure that communication is disseminated correctly and reinforces the message to health care workers and others who were involved in implementing the policy. However, extensive awareness of the general public should be strengthened as a key component in implementing the policy. Similar results were found in the studies by Msambichaka et al, (2003), Mamdani & Bangser (2004), Manzi (2005) Burns & Mantel (2006). Therefore, more sensitization is needed so as to create more awareness to the intended beneficiaries of exemption and waivers. This will increase access to health care services by the poor in rural areas.

4.3.3 Process of obtaining exemptions and waivers at different facility levels

Information was also elicited in relation to how exemptions and waivers were obtained in the health facilities and at the community level. Participants in the FGDs in the hospitals, health centres and dispensaries were able to explain that the implementation of exemption and waiver procedures was being adhered to in the public health facilities but not at the

community level. The participants across all levels were aware that pregnant mothers and under five children were granted exemptions by health care providers at facility levels. It was difficult to explain the process at the community level where waivers was mainly carried out. It was revealed that the process was rather cumbersome since waivers are granted by different people or authorities and not well understood by communities. Two major difficulties that hinder the implementation were also identified. These include the difficulty in the process of identifying the poor and the poor quality of care. The beneficiaries interviewed complained that some patients demanded waivers while they could afford to pay for health services. This was due to lack of explicit information on how the identification process was carried out. In regarding to quality of health care, both beneficiaries and non-beneficiaries argued on lack of medicines and medical equipment in the public health facilities. It is difficult for the excepted groups to be taken care under such situation. One beneficiary from a dispensary had the following view:

“It is better for exemptions to be for everybody..... I don't understand why others are made to suffer!”

4.4 Experiences and perceptions of the implementation of exemptions and waivers among policy makers, facility managers and health care providers.

4.4.1 Ministry of Health and Social Work

In-depth interviews with key informants at the ministry level revealed that exemptions and waivers policy had been implemented in public health facilities in every district. It was also stated that in every hospital, there should be an officer responsible for social welfare activities. This was seen as indication of the official commitment to support the policy. It was also reported that a review of the guidelines had been conducted. However, the last review took place in 1999. In addition, it was reported that monitoring and evaluation, such as through supportive supervision, has been conducted centrally and reports on exemptions and waivers at the central level have been compiled since the policy came into effect. An example of evaluations conducted between 1996 and 1999 were shown to the researcher. These included an evaluation by Mmbuji and others (1996). The evaluation revealed that in referral and tertiary hospitals, there was a permanent staff who was granting exemptions and waivers. Furthermore, there were reports on the number of exemption and waivers granted. There were 103,913 exemptions and waivers granted people at the central level in 2007.

However, it was difficult to establish the appropriateness of the individuals provided with waivers since there were no standard criteria to identify them.

The Ministry of Health and Social Welfare is responsible for the formulation of health policies such as the exemption and waiver policy by issuing for guidelines/ regulations and for designing a monitoring and evaluation mechanism to ensure proper implementation of the policy to improve the well being of the population (MOH, 2005). To meet such obligations, efforts have been made to integrate this policy in different departments at the ministry level. The departments include: the Department of Policy and Planning and the Department of Curative and Preventive services. Both departments are committed to providing guidelines and advocacy to the levels where implementation happens such as regions and districts. In advocating for a health policy, the Ministry usually uses the news media to create awareness among the public at large. These departments are responsible for supportive supervision to implementation levels to ensure the smooth provision of services. Additionally, the departments are supposed to review the existing policy to address challenges and weaknesses that might be facing the implementation levels and take corrective measures in order to improve performance. Feedback should be provide to the responsible authorities to clarify any issue that are unclear, as identified by different stakeholders implementing or benefiting from the policy, to bring a common and better understanding for everyone. The process was being coordinated within the departments by a focal person that oversees the general implementation of the user fee system in the country.

4.4.2 The regions experiences

The results from the in-depth interviews conducted in the two regions of Coast and Mtwara indicated that coordination, supervision and training tasks were the main activities conducted by regional health offices. However, they were not able to explain how these activities were carried out. For example, they were not able to explain how exemptions and waivers in the facilities were supported by regions. The respondents from Coast region reported there was no focal person who oversees and ensures the smooth implementation of this policy in the districts and health facilities. No copies of reports on exemptions and waivers were available in either of the region visited. If this is the situation at the regional level, this indicates that there was no link terms between this policy to the lower levels of implementation and the

regional level. In contrast, Mtwara region documentation of exemptions and waivers were available.

These findings were consistent with the study by Hutton (2002). This study revealed that by 1999, most of African countries had a national system of user fees in place but some of them had minimal or poor coordination at various levels, particularly in terms of exemptions and waivers. The study also reported poor record keeping about waivers in the regions of Uganda.

To ensure proper implementation of health programmes, the regional medical officers are responsible for overseeing and coordinating the functioning of the health system in the regions. Regions act as a link or bridge between the Ministry and the districts, and should include ensuring that the health policy and guideline documents are available at the implementation levels (the districts and primary health care facilities).

4.4.3 Facility managers

Results from interviews conducted at the district level revealed that all public health facilities in their respective districts were implementing the exemptions and waivers system. Exemption and waiver mechanisms were implemented in the two district hospitals as well as primary health facilities (health centres and dispensaries). The participants also reported that there were focal people in the district hospital that were coordinating the systems. Bagamoyo urban was coordinated by the matron of the hospital while Mtwara rural was using a social development officer at the district health office and a nurse at the hospital. At the primary care facilities, there were no specific people to coordinate the programme. According to the cost-sharing guideline, facility managers were responsible for coordinating the system.

The health system structure in Tanzania describes clearly that the districts should be the main implementer of exemption and waivers mechanisms as an integral part of the user fee scheme (see Figure 1.1, p 6). Community leaders grant waivers according to their discretion or personal judgment after patients provide them with a document or self explanation regarding their inability to pay. To ensure coordination and smooth implementation of health programmes, the districts medical officers (DMOs) are responsible for ensuring that exemption and waiver activities are being implemented according to the issued guideline

(MOH, 2005). At the district level, general supervision should be conducted on a monthly basis and exemption and waiver aspects are part of supervision checklists. However, during interviews it was difficult for them to provide a supervision time table and checklists to the researcher as evidence, that this visit actually took place.

Two respondents from Bagamoyo district gave different views as to who was responsible for ensuring the proper implementation of exemptions and waivers at the district level and primary care facilities. The two respondents explained that there was confusion particularly at the district and community levels between the DMO and CHSBs as to who supervised health matters in the districts. The same situation prevailed between health facility in-charges and the facility governing committees. However this, was not the case in Mtwara district where according to the health structure, the DMO was the one to coordinate health matters in the districts. To reveal their concerns, one of the key informants had this to say:

“We do receive direct complaints from clients but where do we report the problems? To DMO, Community leaders or CHSB? Community member, Bagamoyo town council.

Additionally, informants were confused about responsibility for monitoring and supporting the implementation of exemptions by the lower levels. No single supervisory visits were conducted by the Ministry in 2007. This was the common view in all health facilities visited in all districts. Regarding the availability of data, only district hospitals had data on exemptions and waivers. The lower facilities had no data of exemption and waivers at all. These findings were in line with those by Newbrander & Sacca (1996) where a few hospitals had exemption and waivers records. In explaining their views, one of the key informants had this to say:

The findings indicated that the organizational structure of the health system in the country is not well understood by some health care workers or by the community. They do not understand who does what to ensure proper provision of health care services to the district population. The ineffective use of exemptions and waivers has been documented by many studies conducted in African countries who are implementing a user fee policy (Hutton, 2002; REPOA, 2007; Newbrander et al, 2000; Manzi, 2005). It is necessary for high time for the districts to clarify and realize their responsibilities in order to actively implement this policy.

4.4.4 Perception of the level of success of the exemption and waiver systems

Generally, perceptions on the level of success of the systems were similar across all levels, including the policy levels, facility managers and health care providers. Exemptions for pregnant mothers and under five children were reported to be more successful than waivers (see Appendix 13). The participants reported unclear policy, lack of standard criteria for identification of the poor and negative attitudes by health care providers as some of the problems regarding the waiver system. Other complicating issues were identified as low awareness, design of the system and quality of services.

4.4.5 Lack of awareness

Lack of awareness of the schemes by the community was mentioned as a major barrier for successful implementation of exemptions and waivers. Many people do not know about this policy, particularly in the rural areas, leading to low utilization of health services as the majority are not aware of their entitlements to exemptions and waivers. Generally there has been a gap in improving awareness within the health sector. This was also noted in the studies by Newbrander et al, (2000), Burns & Mantel (2006). The study noted that the average level of knowledge particularly on waivers in the community was lower than among the health care workers. There was no systematic means of communicating information about the scheme. This remains a challenge to effective implementation of the scheme.

4.4.6 Implementation of the system

The aim of introducing the exemptions and waivers scheme was to increase accessibility of health care services for the poor. But, the schemes have some challenges which need to be addressed in order to be effective. At the policy level it was reported that the exemption and waiver guideline needs some improvement to make clearer for the users. The area of improvement reported was to establish standard criteria for granting waivers. The views were similar at the regional levels, and health facilities. The findings were also observed in the lower facilities (hospitals, health centre and dispensaries). The participants in health facilities commented on the need to have separate guidelines of granting waivers to people who cannot pay for health care. According to these findings, exemptions and waivers were perceived to be a good approach for promoting equity under the user fee policy in Tanzania. However, there were concerns about improving the design and issue new guidelines in the near future

particularly in the area of standard criteria for granting waivers. This finding was in line with results by Mubyazi (2004), which revealed the same problems in implementing exemptions and waivers in public health facilities.

4.4.7 Impact of policy in the health facilities

In relation to the use of the cost sharing fund, most of the health care workers interviewed argued that if user fees revenue was retained at the facility level, they could raise the quality of health care. It was difficult to establish how much do they collect from user fees since the data were not available. In the studies conducted by (Save the Children (2005); Laterveer et al (2000), Mwabu & Mwangi (1986), Huber (1993), Mushi (2007), Kiwara et al, (2006), Legge (2003), MOH(2002/3), MOHSW(2006/7), Rusell (1996)) on user fee policies, they argued that the negative impact of the introduction of user fees in public health facilities is exceeds the benefits. However, the evaluation by Mmbuji et al (1996) and Nanda (2002) revealed that user fee revenue collected at public health facilities was used to improve quality of health care by ensuring a constant supply of drugs and medical supplies. According to the Ministry of Health cost sharing guideline, revenue collected from user fees should mainly be used for: generating additional revenue for financing health service provision by being integrated into the regular budget allocation for the health sector; rationalizing of health services by ensuring availability of health care services at all levels of the health system and to improve the quality of health services by using the retained user fee revenue facilities for purchasing additional drugs and medical supplies.

Some health workers had the opinion that providing exemptions and waivers would reduce their ability to provide quality health care services. This was the case in Mtwara district. One of the key informants' expressed his views by saying:

“I don't think exemptions are good..... It reduces revenue..... How are we going to improve services if we don't get money from patients”Health care provider, Health Centre.

An emphasis on the generation of revenue from user fees may influence the attitude of health care providers and they end up not granting waivers to the poor. Therefore, this reduces access to health care services to vulnerable groups. According to the World Bank (1996), this also happened in Cameroon where exemptions were rare as staff needed to recover health

costs. In Ghana, health workers argued that if patients do not pay they cannot replenish drugs and medical supplies. In Thailand such staff attitude had an impact on the low income groups. This is still a big challenge in the implementation of exemptions and waivers for countries implementing a user fee policy. There is a need to continue providing more information and training to health care providers on the importance of exemptions and waivers under a user fee system. This may reduce the resistance of the health care providers to implement the policy.

4.4.8 Key implementation obstacles

Challenges around exemptions and waivers seem to be similar at all levels of implementations. They can be grouped into five categories: unclear policy, human resource crisis, poor quality of services, and lack of awareness and provider client relationships (see Table 4.2).

Table 4.2: Summary of implementation challenges at various levels

Policy level	Facility managers	Other care providers
Unclear policy	Unclear policy	Unclear policy
Lack of official criteria for identifying the poor	Level of poverty in Tanzania	Human resource constraints
Human resource constraints	Human resource constraints Poor quality of services	Lack of official criteria for the identification of the poor
Lack of reimbursement system	Negative attitude of health care workers Poor management of the system Lack of government commitments Negative perceptions about the policy Lack of compensation system	Poor conceptualization of policy Poor quality of services Poor client relationship Low sensitization and awareness Level of poverty in Tanzania

4.4.9 Suggestion for improvements

From the depth interviews conducted at the policy level, and with facility managers and the FGDs with health care providers, many difficulties facing the implementation of exemptions and waivers were identified such as unclear policy guidelines, bureaucracy in granting waivers to the poor, lack of standard criteria in identifying the poor etc as outlined earlier. Those at the policy level and health care providers in the hospitals, health centres and dispensaries in the two districts involved in the study were aware of these difficulties but felt there were no mechanisms in place to address these problems. This raises the question: How can the exemptions and waivers scheme be made more effective? The following suggestions for improvements were put forward at the different levels.

4.4.9.1 Policy level

At the policy level, various suggestions were provided in order to improve the exemption and waiver system. Exemptions and waivers are stipulated in the legislation and it is clearly stipulated that they should be implemented at district level. There is a need for monitoring and follow-up at the implementation level, particularly at districts. In doing so, early implementation problems can be detected and solved. Another suggestion was to encourage partnership with donors in financing health services in the country. In particular, it was suggested that more donor partners should be encouraged to join hands to fund important schemes such as exemptions and waivers, by enrolling vulnerable groups into insurance schemes. There are partners who are doing good job such Save the Children, Pact Tanzania, Care International and others. This could create some kind of motivation for health care providers to accept and implement exemptions and waivers in an effective manner. The other suggestion was to promote prepaid schemes such as insurance schemes. In Tanzania the existing insurance scheme that could be serving the majority of the population including the poor is the Community Health Fund which was established in 2001. In this way, the poor could be insured and avoid paying using fees when they use a health service.

4.4.9.2 Facility managers and health care providers.

Facility managers and health care providers provided their suggestions in relation to how to address the implementation obstacles provided in Table 4.1 above. The participants explained that since there are many obstacles facing the system it's difficult to take them all on board. They suggested that two issues should be worked on. Firstly, they suggested

extending exemptions to the whole population. The participants from Mtwara district had a feeling that without this some people will suffer if they are not exempted from paying user fees. The suggestions came specifically from Mtwara which has a very high level of poverty compared to Bagamoyo. Secondly, they recommended a review of exemption and waiver guideline. It was explained that if the existing guideline could be reviewed and the confusion within the guideline clarified, the implementation would be simple and effective.

Generally the discussions on this issue revealed a need for the review of the cost sharing guideline by the Department of Health Planning and Policy (MOHSW). The major aspects to look into are the protection of the sick- poor and enforcement of the existing policy in a transparent manner.

4.5 Experiences and perceptions of beneficiaries and non beneficiaries in the implementation of exemptions and waivers systems.

4.5.1 General perception of implementation process

During focus group discussions conducted with beneficiaries and non-beneficiaries in the two districts participants provided their perceptions regarding the introduction of the exemptions and waivers system. All participants from Bagamoyo and Mtwara at all levels had generally had a positive view of having the schemes in place (Appendix 13). The participants commented that it was good to have these schemes since they improve the conditions of the poor and disadvantaged groups.

4.5.2 Lack of mechanisms for addressing implementation challenges

The FDGs identified many difficulties regarding the two systems which have already been discussed in the previous sections. Participants stated that they have not seen any indication of efforts of improving these systems. The comment was common across all district levels in Bagamoyo and Mtwara (Appendix 13). Participants indicated that there was a communication gap from the policy level to lower health facilities. There should be strategies for informing communities of any initiatives by the government for improving exemptions and waivers. Beneficiaries should be involved in the review of the exemption and waiver guidelines since they are among the most important stakeholders. Additionally, in order to make the systems more effective, the following questions should be addressed: How

communities' awareness of exemptions and waivers is improved? How can exemptions and waivers be effectively implemented?

4.5.3 Key difficulties in obtaining exemption and or waivers

Beneficiaries were asked to provide their views regarding difficulties in obtaining exemption and waivers. All participants across all levels involved in the study cited two major difficulties facing beneficiaries at the moment; few staff and limited awareness of the scheme in the rural population. The lack of staff was seen as a major problem in granting exemptions and waivers in public health facilities. Limited awareness of the scheme by the community was mentioned as another barrier to obtaining waivers. Participants commented that many people know nothing about the policy particularly in the rural areas. This may contribute to low utilization of health services as the majority are not aware of their entitlements.

4.5.4 Quality of care issues

The participants also shared their perceptions in relation to quality of care. The participants revealed that there is poor quality of services in public health facilities. Views on quality of services are particularly influenced by the availability of drugs and medical supplies. Participants were of the view that quality of care is crucial for promoting equity in the provision of health care services and therefore needs to be strengthened particularly in rural health facilities. This view was common across all levels involved in the study in Bagamoyo and Mtwara.

With regard to poor quality of services, all respondents across all districts were concerned about the lack of drugs, medical supplies and professional health staff in public health facilities (see appendix 13). Several participants revealed that these issues were now a crisis in the country. They further explained that if a patient is exempted and there are no drugs in the facility, the patient is told to buy the drugs from a private pharmacy. One might have this question to ask: Is this really a free service? This issue needs to be addressed, otherwise the objective of increasing access to health care services by the poor will never be met.

4.5.5 Successfulness of the system.

The study went further by asking community members about the success of the systems. Participants provided their views by categorizing the groups that receive exemptions and

waivers. The categories were perceived as follows: exemptions particularly for pregnant mothers and children less than five years old were viewed as more successful. This view came from all participants at the district levels in Bagamoyo and Mtwara. Participants at the health centre and dispensary levels had the same view that exemptions are successful. In contrast, had problems in judging whether waivers were successful or not. They further explained that the waiver system is not well known by the people and therefore it was difficult to comment. However, participants put forward the suggestion of improving the design and guidelines in the near future.

4.6 Summary

In summary, this chapter has presented the results and discussion of the exemptions and waivers policy in Tanzania. The analysis provides insight into the functioning of the exemption and waiver systems, indicating some shortfalls such as in the policy design, lack of monitoring and evaluation, lack of awareness of the policy and difficulties in identifying of the poor.

Generally, these findings clearly indicate that exemptions and waivers are perceived to be a good approach to promoting equity under the user fee policy in Tanzania. What the study noted in rating these two systems is that: Firstly, most of the participants are satisfied with the exemptions system which is widely more understood and has been more successfully implemented. Secondly, the waiver system is not performing well and remains a challenge to the Government of Tanzania).

There are two options to be considered: to improve the system by working on the challenges identified above or to drop the strategy and introduce some mechanism for protecting the poor. For-example, Ghana and Thailand have moved to providing universal cover for all citizens through a mandatory health insurance system with the contributions of the poor being paid from general tax revenue. However, they still face the challenge on how to identify the poor to receive this benefit. The suggestion for improving the systems will be discussed in Chapter 5.



CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

Exemption and waiver systems are the mechanisms implemented to protect vulnerable groups under the user fee policy in Tanzania. Their objective is to ensure equity in the health services delivery. The general aim of this study was to explore the effectiveness of exemption and waiver mechanisms embedded in the user fee system in public health facilities. Specifically, the study assessed the implementation of the exemption and waiver from the perspective of policy makers, health care providers and patients in public health facilities. It analyzed the level of awareness, perceptions and experience of implementation of the exemption and waiver systems. To achieve this, a qualitative methodological approach, which involved in- depth interviews and FGDs, was employed.

The study involved two different localities, a town council and district council, and the findings revealed that the exemption and waiver systems were found to be poorly implemented and understood by beneficiaries and non-beneficiaries in both areas. This might be the reason that exemptions and waivers are not clearly differentiated across the country. The major problems identified in this analysis include: poor policy, design of the systems, lack of information, lack of monitoring and evaluation, difficulties in identifying of the poor and poor quality of services. The study noted that communities lack knowledge about the exemption and waiver systems which could have enabled them to access health care services as well as to demand their entitlements. There was also a lack of monitoring and evaluation at all implementation levels, particularly in the districts. The most likely factors contributing to these problems include lack of commitment by the central ministry in supporting the implementations of the policy at facility levels, poor communication between levels of implementation and lack of policy guidelines in facilities.

In addition, it was difficult to establish clear evidence that the quality of health care has improved due to the introduction of user fees. Rather shortages of drugs and medical supplies, and few medical personnel were reported to still be major problems in public health facilities.

Of greater concern is that the implementation problems in the existing exemption and waiver policy means that the poor are not being protected. Little or no efforts have been extended by the government in responding to the problems raised by health care providers as well as by communities in order to achieve the intended objectives. The aim of the exemption and waiver policy is to increase access to health services by the population. The policy explicitly indicates that it is intended to be a pro-poor policy. In reality, the policy being implemented is not actually practical in a way that is responsive to the needs of the poor.

A lot of reviews have been conducted inside and outside the country on the implementation of protective mechanisms for the poor in accessing health care services when user fees are charged. Recommendations for improving the systems are presented below. Greater efforts are needed by the government; without implementing the exemption and waiver systems properly, this policy cannot succeed in responding to the needs of the poorest population.

5.2 Recommendations

Results from the study revealed that there is a great need to work on the exemption and waiver challenges in order to protect the poor and to enable them to access quality health care services. Therefore, in order to strengthen the systems, the following are recommended:

5.2.1 Policy level

The exemption and waiver systems are not understood well by health care providers or by communities. Therefore:

- The Government should continue educating health care workers as well as the community through proper advocacy mechanisms that reach the majority of the population.
- The MOH should review the waiver guidelines, particularly in terms of mechanisms and criteria for identifying the poor, to make it clearer for the users. General statements need to be avoided as they bring multiple interpretations and consequently lead to differences in the exemption and waiver practice.
- The MOH should ensure availability of and adherence to the exemption and waiver guidelines in health care facilities.

- The MOHSW should introduce reliable reimbursement of revenue lost through exemptions and waivers in public facilities which will improve the attitude of health care providers in providing exemptions and waivers to vulnerable people
- By: Revising the exemption and waiver policy and make it clearer, particularly the waiver system. Provide national standard official criteria for identifying the poor.
- The MOH should put in place a monitoring and evaluation system to assess the implementation of exemptions and waivers in the health sector particularly in relation to the goals of efficiency, quality of care and sustainability.
- The regions should also ensure that hospital and district management teams have capacity to plan, set targets and implements the plans.

5.3 Participants' recommendations

5.3.1 Health care providers

- Introduce a reliable reimbursement system in public health facilities, decentralize the funding of reimbursements and send them directly to the facility level.
- Establish social welfare units at the facilities to deal with the exemption and waiver systems.
- Introduce good monitoring system to check and verify implementation exemption and waive systems in public health facilities.

5.3.2 Beneficiaries and non beneficiaries

- Increase public education to boost transparency and accountability on the policy. Exemptions and waivers are not favours granted by health care providers and community leaders but are rights of the poor and vulnerable groups.
- Improve the advocacy system for health care providers to aid effective public education.
- Encourage health care providers to implement the policy according to the guideline
- Impose penalties on health care providers who treat the patients poorly.
- Improve the availability of drugs and medical supplies in public health facilities.
- Clarify the policy for the elderly, by creating more awareness in the rural community.

- Policy makers should not only focus on the technical aspect of the quality of services provided but should also respect consumer perceptions and seek to deliver effective, improved and equitable health care throughout the country.

5.4 Recommendations for future research

Although this study attempted to assess the implementation of exemptions and waivers as part in the user fee system, as the way of protecting vulnerable groups, there are other areas which should be researched in order to address equity challenges. These are:

- Since the protection of the poor in the user fees policy using exemptions and waivers alone may not ensure access to health care services for the poor, a study is needed to address non-financial factors like distance and cultural habits that hinder access to health care for the poor.
- Since government is the major provider of health services in the country, further research on the opportunities and the involvement of the private sector in the provision of health care services by the poor could be valuable.

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University of Cape Town

APPENDICES

APPENDIX 1

IN-DEPTH INTERVIEW GUIDE

Respondents

1. Senior manager responsible for overseeing the implementation of the exemption and waiver policy (MOH)
2. Senior staff and managers responsible for implementing exemption and waiver policy

(regions, districts authorities, hospitals, health centres and dispensaries)

Introduction to the study (from the information sheet and consent form)

Institution.....

Date.....

1. What do you understand by the exemption and waiver policy?
2. Describe how it is being carried out
3. What is the difference between exemptions and waivers?
4. Which groups receive exemptions and waivers?
(e.g. pregnant mothers, under-five children, the elderly, people with chronic diseases)
5. How are these groups identified?(with documents, automatic etc)
6. Who is responsible for coordinating and monitoring this policy?
7. What methods do they employ in no. 6? (supervision of checklists, reports etc)
8. How are the people informed about exemption and waivers? (People for whom the policy is intended e.g. pregnant mothers, under-five children, elderly, people with chronic diseases)
9. How do health care providers link exemptions and waivers with the user fee system?
10. At each level of health care delivery, who is responsible for the policy implementation?
(Regional, district, health centres and dispensaries).
(Intended for MOH)
11. What are the channels for getting feedback on the exemption and waivers policy from users?
(E.g. complaints system, surveys, client satisfactions, FGCs etc)
12. Based on the discussions with implementers, what difficulties and challenges do they experience?(**Intended for MOH, regions and districts**)
13. What do you see as the main difficulties and obstacles with the system?
14. What is your perception of these difficulties and obstacles and how can they be overcome?
15. How would you rate the system?
(Successful i.e. benefiting the poor and other groups, unsuccessful, etc)

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APPENDIX 2

FOCUS GROUP DISCUSSION GUIDE WITH HEALTH CARE PROVIDERS

Respondents

1. Health care providers from the health facilities (hospitals, health centres and dispensaries)

Name of the facility.....

Date.....

Number of the respondents.....

Introduction to the study (from the information sheet and consent form)

1. What do you understand by the exemption and waiver policy?
2. Describe how it is being carried out and monitored in your facility
(e.g. hospitals, health centres and dispensaries,) .
3. Which groups are exempted and receive waivers?
(e.g. pregnant mothers, under-five children, elderly, people with chronic diseases)
4. What is the difference between exemptions and waivers?
5. How do you identify these differences?
6. How do you make decision on the exemption and waivers?
7. What type of information do you need in order to make decisions?
(e.g. any document, verbal communication etc)
8. How do you link the exemptions and waivers with user fee?
9. What are the challenges and experience in implementing exemption and waiver mechanisms? (e.g. adequate training, policy review, management support, resources, health infrastructure etc)
10. If you have problems with the policy where do you get clarifications?
11. What are your perceptions of the system? (working well, not well)

12. How would you rate the system?

(successful i.e. benefiting the poor and other groups etc)

University of Cape Town

APPENDIX 3

FOCUS GROUP DISCUSSIONS WITH BENEFICIARIES

Respondents

1. Beneficiaries for exemptions and waivers from catchments areas (Hospitals, health centres and dispensaries)

Name of facility.....

Date.....

Number of respondents.....

Introduction to the study (from the information sheet and consent form)

1. What do you understand by the exemption and waiver policy?
2. What is the difference between exemption and waivers?
3. How were you informed about exemption and waivers?
4. How are you are treated compared with those who pay user fee?
(Better, worse treatment etc)
5. Do you feel that exemption and waivers benefits you? (if yes, how and if not, why?)
6. What is the experience in using these mechanisms?
(Do you face any difficulties?)
7. What is your perception of these mechanisms?
8. How do you judge the system?
(Successful i.e. benefiting the poor and other groups, unsuccessful etc)

APPENDIX 4

FOCUS GROUP DISCUSSIONS WITH NON-BENEFICIARIES

Respondents

2. People who do not benefit from exemptions and waivers from
Catchments areas (hospitals, health centres and dispensaries)

Name of facility.....

Date.....

Number of respondents.....

Introduction to the study (from the information sheet and consent form)

1. What do you understand by the exemption and waiver policy?
2. What is the difference between exemption and waivers?
3. How do these systems work?
4. How do you feel about the benefits?
(The same benefits with those exempted, different etc)
5. What has been your experience in implementing these mechanisms?
(Any difficulties, challenges etc)
6. What are your perceptions of the difficulties and challenges in implementing the exemption and waiver mechanisms?
7. How would you rate the system?
(Successful, i.e. benefiting the poor and other group, unsuccessful etc)

University of Cape Town

APPENDIX 5

CONSENT FORMS FOR PARTICIPATION IN THE STUDY (IN-DEPTH INTERVIEWS)

I am Victima Munishi, a student of the Masters Programme in Public Health/Health Economics at the University of Cape Town. I am gathering information on the equity implication of the exemptions and waivers in Tanzania. I am conducting an assessment of your perceptions and experience in the implementation of these mechanisms in the public health facilities. I would like to ask you some questions, which will take one hour of your time. Whatever information you give will not affect your work directly but the information I collect will help us to improve the services that you provide at the facility.

The Government of Tanzania is implementing exemptions and waivers to the identified vulnerable groups since the introduction of user fees. I would also like to hear your perceptions and experience of this policy. I would like to know your experience on the benefits of this policy to the poor. Whatever is discussed is strictly confidential and no name will be included in the report. The information will be used for research and we hope to address some of the issues that are being experienced in some areas concerning the policy implementation.

There is no right or wrong answer. I request you to feel free and express your views. Your participation is voluntary and you may choose not to take part in the study. You may also withdraw from the study at any point.

Are you willing to participate? Please sign the following form.

Thank you.

APPENDIX 6

CONSENT FORM FOR PARTICIPATION IN THE STUDY (FOCUS GROUP DISCUSSIONS)

I am Victima Munishi, a student of the Masters Programme in Public Health/Health Economics at the University of Cape Town. I am gathering information on the equity implication of the exemptions and waivers in Tanzania. I am conducting an assessment of your perceptions and experience in the implementation of these mechanisms in the public health facilities. We would like to discuss with you the experiences in the implementation of the exemption and waiver mechanisms which will take two hours of your time. Whatever information you give will not affect the service or care you receive from the facility. The information I collect will help us to improve the services that you receive at the facility.

The Government of Tanzania is implementing the exemptions and waivers to the identified vulnerable groups since the introduction of user fees. We would also like to hear your perceptions and benefit of this policy to the poor. I hope you will allow us to conduct the discussions and record on tape so that we do not lose any of the important information that we gather here. Although, I cannot guarantee the confidentiality of the information gathered here but, I request you all to respect each other by not disclosing what is talked about to anyone outside the group. The information will be used for research and we hope to address some of the issues that are being experienced in some areas concerning the policy implementation.

There is no right or wrong answer. You may have different views from those of your other friends here but, it will be equally important. I request you all to feel free and express your views. Your participation is voluntary and you may choose not to take part in the study. You may also withdraw from the study at any point.

Are you willing to participate? Please sign the following form.

Thank you.

APPENDIX 7

**STUDY TITLE: Assessment of equity under user fees system in Tanzania:
Implementation of exemption and waiver mechanisms**

PRINCIPAL INVESTIGATOR:
Victima Munishi, Student
University of Cape Town
Tel: 0724247480
E-mail: mnsvic002@uct.ac.za

The research has been explained to me and I understood its meaning. The research team lead by Mr/Mrs _____ answered all questions and I am satisfied. I also understood that I have the right to withdraw from the study at any time without being penalised.

_____ Agrees to participate in this study.

Printed name of participant

Signature

Interviewer's name

Signature

Date: _____

APPENDIX 8

(SWAHILI VERSION)

FOMU YA HIARI YA KUSHIRIKI KWENYE UTAFITI

Naitwa Victima Munishi, mwanfunzi wa shahada ya pili katika fani ya afya ya jamii/ uchumi katika chuo kikuu cha Capetown Afrika ya Kusini. Nakusanya taarifa juu utekelezaji wa sera ya msamaha wa matibabu kwa watu wasio na uwezo wa kulipia gharama za matibabu hapa nchini. Nataka kujua ufahamu na uzoefu wako juu ya utekelezaji wa sera hii katika katika vituo vya afya vya serikali. Nitakuuliza maswali ambayo tutachukua kam saa moja hivi ya muda wako. Unaweza kukubali au kukataa kushiriki katika utafiti huu. Nakuhakikishia kuwa taarifa yeyote utakaonipatia haitaathiri utendaji wako wa kazi au huduma ya afya upatayo katika kituo hiki.

Serikali ya Tanzania inatekeleza sera ya msamaha kwa watu wasio na uwezo wa kulipia huduma za afya tangu kuanzishwa kwa mpango kuchangiaji. Napenda kupata mawazo yako juu utekelezaji wa mpango huu. Natumaini utakubali kuulizwa maswali na nitaweka kumbu kumbu kwa njia ya redio kaseti ili tusipoteze kumbukumbu ya aina yeyote tunayopata hapa. Jambo lolote litakalozungumzwa hapa ni siri na hakuna jina litakaloonyeshwa kwenye taarifa ya mwisho. Taarifa hii ni kwa ajili ya kukamilisha utafiti huu na kusaidia kuelimisha ezoefu wenu wa utekelezaji wa sera ya msamaha katika maeneo mengine ya nchi. Nafahamu unaweza kutofautiana katika kutoa maelezo lakini yote nitayachukua kama maelezo muhimu. Ushiriki wako ni wa hiari na unaweza kujitoa katika ushiriki muda wowote. Naomba kibali chako nitege radio kaseti nichukue maelezo na kumbukumbu pale inapobidi.

Je, unakubali kushiriki? Tafadhali jaza fomu hii.

Asante sana.

APPENDIX 9

ENEO LA UTAFITI: Utafiti juu utekelezaji wa sera ya msamaha kwenye kuchangia huduma za afya Tanzania.

PRINCIPAL INVESTIGATOR:
Victima Munishi, Student
University of Cape Town
Tel: 0724247480
E-mail: mnsvic002@uct.ac.za

Maelezo niliyopata juu ya utafiti huu nimeelewa vizuri. Kiongozi wa utafiti huu Bibi/Bwana _____ amejibu maswali yote yaliyoulizwa na nimeridhika. Pia naelewa kuwa nina haki ya kukubali au kutokukubali kushiriki kwenye utafiti huu bila masharti yeyote.

_____ Nakubali kushiriki.

Jina kamili

Sahihi

Jina la mtafiti

Sahihi

Tarehe : _____

APPENDIX 10

University of Cape Town

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH

Telegrams "AFYA"
Tel: 255-022-2120261 General
(All letters should be addressed to
The Permanent Secretary)



P.O. Box 9083,
DAR ES SALAAM.
3 January 2008

In reply please quote:

Ref BC.395/505/01/8

Ms Victima Munishi,
Student, University of Cape-town South Africa

Dear Madam,

**Re: Permission To Conduct A Study on Evaluation of the Equity Implications of the
Exemption and Waiver Mechanisms in Public Health Facilities in Tanzania.**

Reference is made to the above heading and your letter of 27th December, 2007.

On the behalf of the Ministry of Health and Social Welfare I am glad to inform you that you have been granted a permission to conduct the above-mentioned study in Bagamoyo and Tandihimba districts from January to April, 2008.

With this letter the Ministry is requesting relevant authorities in selected districts to provide necessary assistance and cooperation.

The ministry is looking forward to utilise the findings to strengthen its health delivery systems in the country.

Josibert J. Ruboba
For Permanent Secretary



UNIVERSITY OF CAPE TOWN

Health Sciences Faculty
Research Ethics Committee
Room F43-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone (021) 406 5338 • Facsimile (021) 406 5411
e-mail: Larsen.Hippelley@uct.ac.za

07 November 2007

REC REF: 469/2007

Ms. Wioleta Muszkiel
Public Health and Family Medicine
Faculty of Health Sciences
University of Cape Town

Dear Ms Muszkiel

**AN EVALUATION OF THE EQUITY IMPLICATIONS OF THE EXEMPTION AND WAIVER
MECHANISMS IN PUBLIC HEALTH FACILITIES IN TANZANIA**

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has formally approved the above-mentioned study.

Please note that the ongoing phase one part of the study retains the responsibility of the principal investigator.

Please quote the REC REF in all your correspondence.

Yours sincerely

A/PROF. M. BLOGEMAN*
CHAIRPERSON, HSR/HUMAN ETHICS

h/bbc

MARKED KEY CONCEPTS AND DEVELOPMENT OF THEMES

RESPONSES NO 1 MALE, ADULT (MOHSW) INTERVIEW

1. **Impact of the cost-sharing policy to protect public interests by providing free health care services to poor people (explained in the cost-sharing policy chapter 5)"**

- To ensure equity in providing health care services
- Health service is a basic need for every Tanzanian

2. Implementation of exemptions and waivers is within user fee policy in the health facilities.

Phases;

Phase I, grade 1 and 2 in the referral and regional hospitals (1993)

Phase II grade 3 implemented in all regions and referral hospitals 1993/4

Phase III implemented in district hospitals 1994/5

Phase IV- exemptions and waivers under CHF schemes in the lower facilities health centres and dispensaries. Some districts were implementing user fees against policy.

3. The different between exemption and waivers;

Exemptions- statutory, permanent defined clearly in the cost sharing guideline (1993/1997). These includes children under five years, pregnant mothers permanent diseases such as HIV, TB diabetes etc

Waivers- temporarily granted by health facilities or authorized local authorities to poor people or unable to pay. This includes also emergency services.

4. Exempted groups;

- Pregnant mothers
- Children under five year
- People with chronic/ permanent diseases
- Adult over 60 years
- Unable to pay

5. Identification of exempted and waived groups

- Clinic cards- pregnant mothers and children
- By health care providers specifically in the health centres and dispensaries
- At the hospital by focal person-social workers/ community development officers
- Documents from local authority offices.

6. Responsible for coordinating and monitoring of the policy;

APPENDIX 13

SUMMARY OF KEY FINDINGS TABLE

Objective 1: Assess the level of awareness about exemption and waiver systems among health care services providers							
Issues raised	Policy level	District 1 (Bagamoyo)	District 2 Mtwara Rural	Health Centre1 (chalinze)	Health Centre 2 (Nanguruwe)	Dispensary 1 Kilomo	Dispensary 2 (Ziwani)
1. Knowledge and understanding of exemption and waivers systems							
<ul style="list-style-type: none"> What is the difference between exemption and waivers? 	<p>Exemptions; Its statutory, permanent defined clearly in the cost sharing guideline.</p> <p>Waivers; Temporarily granted by health care provider or authorized</p>	Both are exemptions implemented in the same place (health facilities). However Exemptions are more explanatory, permanent defined in the cost-sharing guideline. Waivers are temporarily granted and taken care in different levels. The interviewers in the district level had the same feelings.	It was difficult to establish the differences but with the same feeling as district Exemptions is a policy defined in the cost-sharing guideline where as waiver is defined as a temporarily exemptions granted to people an able to pay for health services.	No difference, this was a view from all interview conducted	There is no difference at all. Views from the interviews conducted	No difference. Views from all interviews conducted	No difference at all. This was revealed from both interviews conducted
<ul style="list-style-type: none"> Which groups receive exemption and waivers? 	<ul style="list-style-type: none"> -Pregnant mothers -Under five children -People with chronic diseases -Adult over 60 years -Un able to (pay) 	<ul style="list-style-type: none"> -Under five children - Pregnant mother -Chronic diseases -Emergencies Elderly 	<ul style="list-style-type: none"> -Pregnant mothers -Under five children -People with chronic disease- -Unable to pay -Elderly over 60 years <p>Findings from all respondents</p>	<ul style="list-style-type: none"> -Pregnant mother- -Under five children -People with chronic diseases e.g. cancer, diabetes, HIV etc - Elderly <p>Findings from all respondents</p>	<ul style="list-style-type: none"> Pregnant mothers -Under-five children -Elderly - Chronic disease <p>Revealed by all respondents</p>	<ul style="list-style-type: none"> -Pregnant mothers -Under five -Elderly <p>Revealed by all respondents</p>	<ul style="list-style-type: none"> -Pregnant mothers -Under five -Elderly <p>Revealed by all respondents</p>
<ul style="list-style-type: none"> How are the groups identified?(documents, automatic etc 	<ul style="list-style-type: none"> -Through clinic cards - By health care providers/ community development officers - Documents from local authority offices. <p>The findings were</p>	<ul style="list-style-type: none"> -Automatic by health care providers(sometimes they do not need proof of documents - Waives through proof of document from local authorities - Social health care workers <p>The respondents had the feeling that waiver group</p>	<ul style="list-style-type: none"> -Value judgments -Clinic cards for pregnant mothers and children -Social workers -Guarantors for exemption and waivers -Through documents from local leaders -By health care provide <p>The respondents had the feeling that waiver group were difficult to identify</p>	<ul style="list-style-type: none"> - Using clinic cards - Health care providers -Through local leaders <p>The respondents had the feeling that waiver group were difficult to identify due</p>	<ul style="list-style-type: none"> Automatic by health care providers (pregnant mothers and children Using clinic cards -Documents endorsed by local leaders <p>The respondents had the feeling that waiver group were</p>	<ul style="list-style-type: none"> -Using clinic cards in case of mothers and under-five children -Though local leaders in case of waivers <p>The respondents had the feeling that waiver group were difficult to</p>	<ul style="list-style-type: none"> -By health care providers -Through community leaders <p>The respondents had the feeling that waiver group were difficult to identify due complexity (lack of criteria</p>

	revealed by MOHSW, and the two regions.	were difficult to identify due complexity (lack of criteria)	due complexity (lack of criteria etc)	complexity (lack of criteria	difficult to identify due complexity (lack of criteria	identify due complexity (lack of criteria	
2. How the public informed about exemption and waives?		-Local meetings -Radio in some cases although not everyone has it	-Posters available at health facilities -Health education provided by health care providers in the clinics every day -Local meetings -Direct complaints to local authorities -Political leaders - Local newspapers	-Posters -Local meetings -Political leaders -health education provided in the health facilities -Radio and televisions.	Through health care providers -Local meeting -Health campaigns on reducing maternal mortality	- Health care providers -Local meetings -Political leader (councilors during)	-Local meetings -Health care providers through health education -Political leaders during election campaign
3.Key actors in the implementation of exemption and waivers	MOHSW, regions districts, and some donors	MOHSW, hospital, health centers and dispensaries	DMO. Medical officer in charge, hospitals, health centres and dispensaries, Local leaders	Government, DMO, RMO, Local leaders	DMO, Local leaders, health care providers	DMO, Local leaders, health care providers	DMO. Medical officer in charge, hospitals, health centres and dispensaries
<ul style="list-style-type: none"> At each level of health care delivery who is responsible for policy implementation? 	Department of health planning and policy, Hospital services department	-Region, RMO -Districts –DMO -Medical officer in charges in the hospitals, health centers, and dispensaries.	DMO, MOH, Health care providers, RMO, In charges of the facilities	Health care providers, DMO, RMO, MOH	RMO, DMO. In charges of the facilities	MOH,RMO, DMO, health care providers	DMO, MOH, Health care providers, RMO, In charges of the facilities
<ul style="list-style-type: none"> Who is responsible for coordinating and monitoring this policy 	Department of health planning and policy. However the respondents were not able to mention specific persons responsible but their positions. (people change over time	DMO, Hospital directors. This was a view of all respondent	DMO, community development officer Most of the respondents mentioned DMO and few mentioned development officers	In charge of the facility This was a view of all respondent e facility	In charge of the facility This was a view of all respondent	DMO, in charge of the facility This was a view of all respondent	DMO, in charge of the facility This was a view of all respondent
4.Feedback mechanisms	-Through DEDs, RMOs -Using management information system(HIMS) - Monthly and quarterly reports.	-HIMS reports -Facility Governing Committees meetings Ward development committees -Other council meetings -Direct complaints to the health facilities, district authorities -Exit interviews during supervisions -Radio and television -Suggestion box -Direct calls in the phones	-Direct complaint to the council leaders -Local meeting - Radio	-Direct complaints to the health facilities, district leaders - Through FGCs and ward development meetings	-Direct complaints to health staff, councilors	-Direct complaints to health staff, councilors -Through suggestion box	-Direct complaints to health staff, councilor

5.Perception of the effectiveness of the system	-To strengthen exemption, there is need to promote prepaid schemes -Encourage partnership in financing exemption and waivers (This was view from policy level(MOHSW)	-It is a good plan only if the implementation challenges will be addressed properly This was a view of all respondent	It is a good plan only if the implementation challenges will be addressed This was a view of all respondent	It is a good plan only if the implementation challenges will be addressed properly This was a view of all respondent	-The system is very successful to pregnant mother and children but not for waivers. -It is a good plan only if the implementation challenges will be addressed properly This was a view of all respondent This was a view of all respondent	It is a good plan only if the implementation challenges will be addressed properly This was a view of all respondent	-It is a good plan only if the implementation challenges will be addressed properly (this was a view from all respondents) Pregnant mothers and children are benefiting but not for the remaining group(It was a view of few respondents
Objective 2:Assess the level of awareness about exemption and waivers among patients i.e both beneficiaries and non beneficiaries in the public health facilities							
Issues raised							
1. Knowledge and understanding of exemption and waivers system							
<ul style="list-style-type: none"> What is the difference between exemption and waivers? 		<p>Beneficiaries Exemption are automatic(not necessarily with a proof of document) provided in the health facilities but waiver depends on people's desecrations . - Majority of the respondent had this view -Few respondents had different idea (no difference at all)</p> <p>Non beneficiaries -No difference at all as both are exemptions. This was a view of all non beneficiaries interviewed.</p>	<p>beneficiaries Exemptions are automatic but waivers are personal judgment from different authorities (local leaders) Non beneficiaries No difference View of all respondents</p>	<p>Beneficiaries No difference -View of all respondents Non beneficiaries No difference View of all respondents</p>	<p>Beneficiaries No difference View of all respondents Non beneficiaries No difference View of all respondents</p>	<p>Beneficiaries No difference View of all respondents Non beneficiaries No difference View of all respondents</p>	<p>beneficiaries No difference View of all respondents Non beneficiaries No difference View of all respondents</p>
<ul style="list-style-type: none"> Which groups receive exemption and waivers? 		-Pregnant mothers -Under five children	-Pregnant mothers -Under five children	-Pregnant mothers -Under five	Pregnant mothers -Under five children	-Pregnant mothers -Under five	-Pregnant mothers -Under five children

		<ul style="list-style-type: none"> -Elderly above 60 years -People with chronic diseases(HIV/AIDS, diabetes, cancer e. t.c) -Orphan and disabled -View of all respondent s both beneficiaries and non beneficiaries 	<ul style="list-style-type: none"> -Elderly above 60 years -Emergencies (accidents) -People with chronic diseases(HIV/AIDS, diabetes, cancer -Orphan and disabled - View of all respondents including non beneficiaries 	<ul style="list-style-type: none"> children -Elderly -People with chronic diseases(HIV/AIDS, diabetes, cancer e.t.c - Unable to pay -View of both respondents 	<ul style="list-style-type: none"> -Elderly above 60 years -People with chronic diseases(HIV/AIDS, diabetes, cancer e.t.c -View of all respondents 	<ul style="list-style-type: none"> children -Elderly above 60 years View of all respondents 	<ul style="list-style-type: none"> -Elderly above 60 years View of all respondents
2. What are the source of information about exemption and waivers?		<ul style="list-style-type: none"> -Health care providers -Radio -Television - Local newspapers - Health -Education provided in the health facilities - Posters view of both participants 	<ul style="list-style-type: none"> -Health care providers - Radio - Local newspapers -Posters found in the health facilities view of both participants 	<ul style="list-style-type: none"> -Health care providers -Political leaders -Local meetings Friends - Special campaign eg immunization view of both participants 	<ul style="list-style-type: none"> -Health care providers -Political leaders - Local meetings view of both participants 	<ul style="list-style-type: none"> -Health care providers - Local leaders - Friends view of both participants 	<ul style="list-style-type: none"> -Health care providers -Local meetings -Friends view of both participants
3.Perceptions towards the systems		<ul style="list-style-type: none"> Good systems but need some improvements Difficult to obtain waivers than exemptions View of both beneficiaries and non beneficiaries 	<ul style="list-style-type: none"> Good systems but, need some improvements in the designing process -Difficult to obtain waivers than exemptions View of both beneficiaries and non beneficiaries 	<ul style="list-style-type: none"> Good systems but need some improvements in the guidelines -Difficult to obtain waivers than exemptions View of both beneficiaries and non beneficiaries 	<ul style="list-style-type: none"> -Good systems Need some improvement -Difficult to obtain waivers than exemptions View of both beneficiaries and non beneficiaries 	<ul style="list-style-type: none"> Good systems but with many problems in the implementation process (need improvement) -Very difficult to obtain waivers than exemptions View of both beneficiaries and non beneficiaries 	<ul style="list-style-type: none"> The systems have many problems/ Challenges in the implementation process (e.g unclear guidelines, lack of drugs) -Very difficult to obtain waivers than exemptions View of both beneficiaries and non beneficiaries
4.The effectiveness of the system/ rating of the system (the participants were told to be flexible in rating the systems. Some were using percentages, some provided their view in wording , some used both.) It will be explained more in the result chapter		<ul style="list-style-type: none"> -Effective in such that , pregnant mothers and children are benefiting than the remain group -Waiver not effective View of both non and 	<ul style="list-style-type: none"> Effective only for some groups (pregnant mothers and children) View of both non and beneficiaries 	<ul style="list-style-type: none"> Beneficiaries Exemptions system is very effective but waiver not Non beneficiaries 	<ul style="list-style-type: none"> -Exemption is effective View of both non and beneficiaries Waiver rated to be 	<ul style="list-style-type: none"> -Effective View of both non and beneficiaries Waivers were rated as not effective 	<ul style="list-style-type: none"> -Effectiveness Exemptions is effective View of both non and beneficiaries

		beneficiaries	Waivers were rated to not effective	Waivers system is unfair(few people are benefiting	not effective		
Objective 3: Assess the experience of health care providers in the implementation of exemption and waives systems in the public health facilities							
Issues raised							
1.Main difficulties and obstacles with the system The same issues were raised across different levels due to the fact that exemption and waiver policy has common interest across the country (promoting accessibility of health care services to vulnerable group and the poor)		<ul style="list-style-type: none"> -Poverty which covers 40% of the Tanzanian population -Resource constraints to cover the poor -Lack of health personnel in health facilities -Poor quality of services -Negative attitude of health care provider towards exemption and waiver systems -Unclear guideline over the systems particularly the waiver -Lack of direct feedback of hoe system operates and its challenges -Lack of a standard criteria for identifying the poor - Poor management, commitment to the system by health care providers. Lack of compensation/ reimbursement 	<ul style="list-style-type: none"> -Poverty that contribute 40% of the Tanzanian population -Resource constraints to cover the poor -Lack of health personnel in health facilities -Poor quality of services -Negative attitude of health care provider towards exemption and waiver systems -Unclear guideline over the systems particularly the waiver -Lack of direct feedback of hoe system operates and its challenges -Lack of a standard criteria for identifying the poor - Poor management, commitment to the system by health care providers. -Lack of compensation/ reimbursement 	<ul style="list-style-type: none"> -Level of Poverty that covers 40% of the Tanzanian population -Resource constraints to cover the poor -Lack of health personnel in health facilities -Poor quality of services -Negative attitude of health care provider towards exemption and waiver systems -Unclear guideline over the systems particularly the waiver -Lack of a standard criteria for identifying the poor - Poor management, commitment to the system by health care providers. -Lack of compensation/ reimbursement 	<ul style="list-style-type: none"> -Majority of Tanzanian are poor -Resource constraints to cover the poor -Lack of health personnel in health facilities -Poor quality of services -Negative attitude of health care provider towards exemption and waiver systems -Unclear guideline over the systems particularly the waiver -Lack of direct feedback of hoe system operates and its challenges -Lack of a standard criteria for identifying the poor -Lack of compensation/ reimbursement 	<ul style="list-style-type: none"> -Resource constraints to cover the poor -Lack of health personnel in health facilities -Poor quality of services -Negative attitude of health care provider towards exemption and waiver systems -Unclear guideline over the systems particularly the waiver -Lack of direct feedback of hoe system operates and its challenges -Lack of a standard criteria for identifying the poor - Poor management, commitment to the system by health care providers. -Lack of compensation/ reimbursement 	<ul style="list-style-type: none"> -Level of poverty -Resource constraints to cover the poor -Lack of health personnel in health facilities -Poor quality of services -Negative attitude of health care provider towards exemption and waiver systems -Unclear guideline over the systems particularly the waiver -Lack of a standard criteria for identifying the poor - Poor management, commitment to the system by health care providers. -Lack of compensation/ reimbursement
2.Mechanisms that address the problems In the implementation		Nothing in place View of all respondents	No any mechanisms in place View of all respondents	None View of all respondents	None View of all respondents	None View of all respondents	None View of all respondents
3. Linking of exemption and waivers with	-Exemption and	-The systems complement	-The systems protect the	Exemptions	Exemptions and	Exemptions and	Exemptions and

user fees system	<p>waivers are there for protecting the poor who cannot afford to pay for health care (equity)</p> <p>-People perceive the systems differently particularly in provision and access of health care services</p> <p>Views of the most of the respondents</p>	<p>each other</p> <p>- The system address equity among the population in receiving health care services</p> <p>Views of the most of the respondents</p>	<p>poor form paying user fees</p> <p>Views of the most of the respondents</p>	<p>protect the poor for paying user fees</p> <p>Views of all respondents</p>	<p>waivers maintain provision of poor quality of services</p> <p>Views of the most of the respondents</p>	<p>waivers reduce revenue collection from user fees</p> <p>Views of the most of the respondents</p>	<p>user fee are two different systems but implemented in the same place(health facilities</p> <p>Exemptions and waivers reduce revenue collection from user fees</p> <p>Views of the most of the respondents</p>
4.Perception towards exemption and waiver		<p>-It is a good plan</p> <p>- The implementation challenges should be addressed properly for the benefit of the poor</p>	<p>-It is a good plan only if the implementation challenges will be addressed prop</p> <p>Exemptions and waivers reduce revenue collection from user fees</p> <p>Health care providers are not happy with the system, too much work, no incentives</p>	<p>It is a good plan only if the implementation challenges will be addressed properly</p>	<p>-The system is very successful to pregnant mother and children but not for waivers.</p> <p>-It is a good plan only if the implementation challenges will be addressed properly</p>	<p>It is a good plan only if the implementation challenges will be addressed properly</p>	<p>-It is a good plan only if the implementation challenges will be addressed properly</p> <p>-Pregnant mother and children are benefiting but not for waivers.</p>
5.The effectiveness of the system e.g rating of the systems		<p>Effective particularly for pregnant mothers and under five children</p> <p>View of all respondents</p>	<p>Effective only for some groups e.g. pregnant mother and children</p> <p>Not effective for waivers</p> <p>View of all respondents</p>	<p>effective particularly for pregnant mothers and under five children</p> <p>Not effective for waivers</p> <p>View of all respondents</p>	<p>effective particularly for pregnant mothers and under five children</p> <p>Not effective for waivers</p> <p>View of all respondents</p>	<p>effective particularly for pregnant mothers and under five children</p> <p>-Not for effective for Waivers</p> <p>View of all respondents</p>	<p>effective particularly for pregnant mothers and under five children</p> <p>Not for effective for Waivers</p> <p>View of all respondents</p>
Objective4:Assess the experience of beneficiaries and non beneficiaries with regard to the exemption and waiver							
Issues raised(beneficiaries)							
<ul style="list-style-type: none"> Health care benefits received 		No difference, all are	No difference	No difference	No difference	No difference,	No difference

with beneficiaries compared with non beneficiaries		treated in the same level View of all respondents	View of all respondents	View of all respondents	View of all respondents	treated in the same level View of all respondents	View of all respondents
<ul style="list-style-type: none"> Difficulties experienced in receiving exemption and waivers benefits 		<ul style="list-style-type: none"> -Lack of drugs and personnel - Lack of respect from health care providers- - Sometimes people are forced to pay for exempted groups -Waiver system is too political <p>Views of most of the respondents</p>	<ul style="list-style-type: none"> -Lack of drugs and personnel - Lack of respect from health care providers -Exemptions and waivers are not honored in the private/FBOs health facilities <p>Views of all respondents</p>	<ul style="list-style-type: none"> -Lack of drugs and personnel -Lack of information about how exemption are implemented - It is very difficult to receive waiver <p>Views of all respondents</p>	<ul style="list-style-type: none"> -Lack of drugs and personnel Lack of awareness - Lack of respect by health care workers <p>Views of all respondents</p>	<ul style="list-style-type: none"> -Lack of drugs and personnel - Very cumbersome to obtain waivers <p>Views of all respondents</p>	<ul style="list-style-type: none"> -Lack of drugs -personnel medical personnel Cumbersome to obtain waivers Views of all respondents
The effectiveness i.e. rating of the system		Very effective for pregnant mothers and children Views of all respondents	Successful for some groups(pregnant mothers and children Views of all respondents	Fair systems Views of few respondents Successful, views of most of the respondents	Very successful for pregnant mothers and children Views of all respondents	Very successful for pregnant mothers and children Views of all respondents	Very successful for pregnant mothers and children Views of all respondents
Non beneficiaries							
1.Perception towards exemption and waiver systems		There is lot of problems within the system which need to be addressed -Pregnant mothers are benefiting more than the remaining population Views of all respondents	It is a good system but need proper monitoring -Create more awareness to the public at large Views of all respondents	Exemption and waivers system favor most pregnant mothers and under five children Views of all respondents	Pregnant mothers and children are benefiting from the system than other groups. Views of all respondents	The systems have a lot of challenges that create many difficulties in the implantation -Lack of awareness about the systems Views of all respondents	The systems are good for protecting the poor -Lack awareness among community on how the system works Views of all respondents
2. Challenges facing the system		Lack of awareness to the public at large about how the systems work	-Lack of awareness -Lack of clear criteria of waivers	Lack of awareness -Lack of drugs -Lack of health personnel	-Lack of awareness -Lack of drugs and medical supplies	-Lack of awareness -Lack of drugs and medical supplies	Lack of awareness -lack of personnel -Lack of drugs
3.The effectiveness of the system		Effective however, there are many unsolved challenges facing the systems View of many respondents	-Difficult to judge as the systems are not known Views of many respondents	Not very successful, may be only 40% Views of many respondents	Difficult to judge, the systems are not known Views of all respondents	Pregnant mothers and children receive free health care service (60%) Views of all respondents	Successful but with many challenges which are not yet addressed. Views of many respondents

