# IMPACT OF COST SHARING IN HEALTH SERVICES IN TANZANIA: A CASE OF GEITA DISTRICT.

**BY**

**ROBERT NGELELA SHOLE**

**A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN RURAL DEVELOPMENT OF SOKOINE UNIVERSITY OF AGRICULTURE, MOROGORO, TANZANIA.**

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## ABSTRACT

A study on the impact of cost sharing was carried out in Geita District focussing on health service provision. A cross sectional research design was adopted involving administration of structured questionnaires to both primary and secondary partners, complemented by relevant documentation from various levels of stakeholders in the study area. Statistical Package for Social services (SPSS) software was employed in data coding and analysis. The study revealed that the aim of cost sharing on health service is good. But the nature of Tanzanians of being poor among the poorer and poor government procedure for sensitizing its policies before implementation impend the target and objectives of cost sharing on health service. More than 67% people earn less than 50,000 per month and more than 10% do not attend at hospital if they become sick. Also, more than 58% of people are not aware about cost sharing on health service. Nevertheless there is a slight improvement of health service as 53% appreciated that health facilities like buildings, medicines, and patient's beds are at least satisfactory. The study makes the following recommendations in order to improve health service provision under cost sharing policy. The spirit of working very hard in production activities should be done by all Tanzanians in order to reduce the poverty situation. Government should educate its people at all levels such as villages, wards, division, district, region and national in order to make them aware on any policy like cost sharing on health service. Government should set a clear procedure for cost sharing exemption for example old, children, pregnant women, and disabled people. Capacity building should be done to health workers in order to follow all the guidelines and conditions of cost sharing on health service

provision. These would extend social and economic capital base of the end-users and hence their willingness and ability to pay, which is key to partnership management of the service.

## DECLARATION

I, Robert Ngelela Shole, do hereby declare to the senate of Sokoine University of Agriculture that this dissertation is my own original work and has never been submitted for higher degree award in any other University.

_____ _____

Robert Ngelala Shole Date

(MARD Candidate)

The above declaration is confirmed

_____ _____

Prof. D.S. Kapinga Date

(Supervisor)

## COPYRIGHT

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I extend my sincere thanks to my wife for appreciating my endeavour. My special thanks and appreciation are due to my daughter, mother, sisters, brothers and relatives for their moral support during the whole period of study. Last but not least, I record my appreciation to my friends Timotheo John and Siomon Nyembe who assisted me in data collection. Finally, I thank God for all he has done to me during the entire period of this work.

## DEDICATION

This work is dedicated to my beloved parents, my late father Shole Sobaja Mag’weng’ula and my mother Martha Maduhu who laid foundation of my education.

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## LIST OF ABBREVIATIONS

| | | |
|---|---|---|
| CHF | - | Community Health Fund |
| GDMO | - | Geita District Medical Officer |
| HRDS | - | Human Resources Development Survey |
| IMF | - | International Monetary Fund |

| | | |
|---|---|---|
| MOH | - | Ministry of Health |
| MOHSW | - | Ministry of Health and Social welfare |
| NESP | - | National Economic Survival Programme. |
| NHIF | - | National Health Insurance Fund |
| NHIS | - | National Health Insurance Service |
| SAP | - | Structural Adjustment Programmme. |
| SPSS | - | Statistical Package for Social Sciences |
| UNDP | - | United Nations Development Programme |
| UNESCO | - | United National Educational Scientific and Cultural |
| UNFPA | - | United Nations Fund for Population Activities |
| UNICEF | - | United Nations International Children Emergency Fund |
| URT | - | United Republic of Tanzania |
| UW | - | University of Washington |

# CHAPTER ONE

## 1.0 INTRODUCTION

### 1.1 Background Information

The health of every body is the major factor that determines power of someone to think and act upon the piece of work. A human being is the centre of all development; the human condition is the only final measure of development in any society (The 1988 Khartoum Declaration). Governments are responsible in making sure that citizens in their respective countries are provided with social services. These services may be provided to people using two ways; free provision through public subsidization or through contribution from both citizens and respective governments for the purpose of bringing about community development.

The design and implementation of SAPs in sub-Saharan Africa have come under criticism for not protecting the most vulnerable groups against their adverse impacts. The IMF and World Bank adjustment programmes have, for a long time, ignored such issues on the basis that they should be exclusively the prerogative of domestic policy makers (World Bank, 1993). The World Bank (1989b), for instance, concedes that “the impact of SAPs on macro performance, including GNP growth, will continue to be limited unless the fundamental constraints on growth and development are addressed: health, education, population growth, technological improvement, infrastructure, institutional strengthening, and governance”. Among the agencies that have been emphasising this message for a long time is UNICEF that stresses the need for “adjustment with a human face” *by* focusing on poverty

alleviation programmes and improving the productivity and incomes of the poor as well as strengthening essential services such as health (Cornia,. et al, 1987).

Considering that governments in Sub-Saharan Africa, including Tanzania, have the social responsibility to assure the availability to their population of quality and affordable social services including health. Tanzania used to provide basic social services to all citizens free of charge. The government was the major provider of all health care services and non-governmental (voluntary) agencies like missionaries were running a substantial number of health care units in rural areas on token fee. But following serious economic difficulties, which faced Tanzania during 1980s, traditional donors acquired a new habit of asking for stamp of good economic conduct. This forced Tanzania to devalue her currency, reduce government expenditures, control credits, raise interest rates and remove subsidies. Due to this almost all government owned health centres and dispensaries had no drugs or diagnostic equipment and maternal mortality rates were on the increase (UNICEF, 1990); health workers' morale was at its lowest while attrition was at its highest.

In an attempt to arrest the crisis the government introduced National Economic Survival Program (NESP) in 1981 for exploitation of local resources and then Structural Adjustment Program (SAP) in 1982 in which under the economic reforms, the cut backs on social sector expenditure were effected. NESP and SAP of 1982 were internal initiatives and they failed due to lack of resources. The SAP which began in 1986 was imposed by the World Bank and IMF which carried with it various conditionalities including cost sharing in major social services: health and

education (Kiwara, 1994).Later in 1991, private practice was officially allowed and government accepted to introduce user fee in all health care providing units under the cost sharing policy.

According to Mujinja and Mabala, (1992) 59% rural population were in extreme poverty in 1990s while health services are worse in rural than urban areas. In rural areas they found that 42% failed to meet the need for cost sharing. Therefore, it is important to examine the impacts of SAPs policy instruments such as cost-sharing. Such an analysis is timely in the light of rising poverty levels in the country as well as Geita District.

**1.2 Problem Statement**

Improving health is an important part of a poverty reduction/alleviation policy. Better health outcomes, in the form of fewer or shorter illness episodes, better treatment and health knowledge, better nutrition, lower child or infant mortality, higher life expectancy are all part of higher well-being for individuals. Better health also provides a high economic return in the form of a more productive labour force, with fewer days lost due to illness. However, health status in Africa is among the most deplorable in the world. Also, current levels of health services in Africa appear to be insufficient in coverage and quality. Structural Adjustment Policy based on cost sharing introduction and low economic growth have put increasing pressure on government finances. Governments and donors are looking for alternative, sustainable sources of funding (World bank, 1994).

Cost sharing in Tanzania started in 1991, it intended to reduce government spending and encourage self-reliance (Abel-Smith and Rawal, 1992). This study is going to see what is done to those who cannot afford cost sharing (children of the poor, disabled, the elderly and poor). According to UNDP (1995), more than 50% African population including Tanzania constitutes children under 15 and old people of over 64 years. Also 44% had no access to health services (Mujinja and Mabala, 1992)).

Since the current cost sharing plan is based on the assumption that with improved finances, the supply of drugs service will improve and the public system will win back patients. This fact is contrary to the current situation in Geita District in which drugs service, public system does not win back patients and finances have not improved. Hence, discrepancy or gap of the study, since the aim of this study is to assess the impact of cost sharing in access to health care. Also there are inadequate data about this in Geita District and Tanzania in general.

### 1.3 Problem Justification

There is a need for this research because of the following reasons:

- The change from free medical service to cost sharing system might bring about changes on availability, composition, conduct and improved health services to the people.
- So far Tanzanian society, specifically the community in Geita District there are poor and rich people; cost sharing might influence differently the utilization of health services by different classes.

- Since cost sharing started in Tanzania in 1992, no study has been undertaken to determine it's importance on health service delivery in Geita District.
- Results will be useful for different policy makers, planners and programme managers on health care programmes who seek to develop guidelines for health care improvement as to prevent big loss of manpower.
- Also the study is in line with Millennium Development Goals number 4, 5, and 6.

## 1.4 Research Objectives and Hypotheses

### 1.4.1 General objective

The main objective of the study was to assess the impact of cost sharing on access to health care services in Geita District.

### 1.4.2 Specific objectives

To identify accessibility and affordability of the people on health service under cost sharing.

To find out if there are people who are denied health service under cost sharing for lack of funds.

- To identify preferential treatment if any; for the old, children, and disabled on health service under cost sharing.
- To establish if cost sharing has improved health care delivery (availability of medicines, equipment, personnel morale and improved health facilities).
- To identify Public attitudes toward cost sharing in health service provision.

### 1.4.3 Null hypothesis

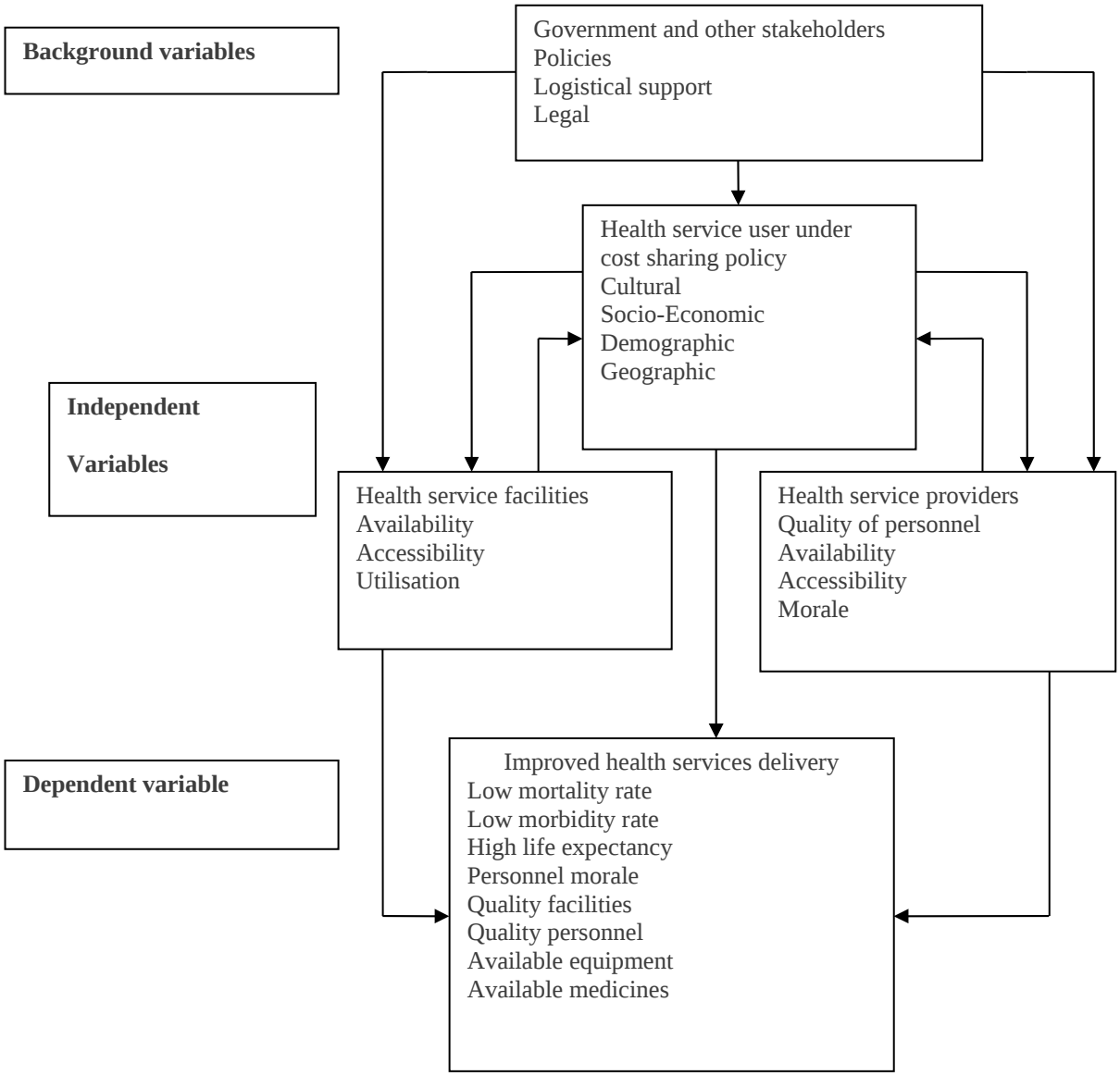
Cost sharing is not significantly associated with accessibility and affordability of health service delivery.

### 1.4.4 Research questions

- What are the incomes of rural and urban people in Geita District?
- Is cost sharing in health services affordable and accessible to every person?
- Does the income of persons correspond with existing cost sharing on health services?
- How ready people are in paying cost associated in health care services provision?
- Is there any preferential treatment for the poor, old, children, and disabled on health service?
- What is the attitude and opinions of people on cost sharing of health care services?
- Has cost sharing managed to improve health providers' delivery (availability of medicines, equipment, personnel morale and improved health facilities)?

### 1.4.5 Conceptual framework

The information on stated specific objectives and operational variables definitions for data collection as well as the relationship between variables is stipulated in the conceptual framework presented here under.


Background variables
Government and other stakeholders
Policies
Logistical support
Legal
Health service user under
cost sharing policy
Cultural
Socio-Economic
Demographic
Geographic
Independent
Variables
Health service facilities
Availability
Accessibility
Utilisation
Health service providers
Quality of personnel
Availability
Accessibility
Morale
Dependent variable
Improved health services delivery
Low mortality rate
Low morbidity rate
High life expectancy
Personnel morale
Quality facilities
Quality personnel
Available equipment
Available medicines

### 1.4.5.1 Definition of variables

| Variables | Indicators |
|---|---|
| Health facilities | Foundation by stone, wall by firebrick, stone, roofing by iron (std) |
| Personnel with morale | Commitment of doctors, nurses and attendants (scale score by patients) |
| Low infant and maternal mortality rate | Number of deaths |
| High life span | Age lived by person |
| Income | Money earned per month |
| Personnel | Number of doctors, nurses, attendants |
| Logistic support | Distribution of drug and equipment |
| Government policy | Cost sharing economic reform programme |
| Accessibility | Ability to reach health services (>=5 km “nearby, <5 km “far away” |
| Availability | Existence of medicine and equipment (demand and supply) |
| Education level | Education category attained by respondents as none, primary etc. |
| Training level | Professional training category attained as certificate, diploma etc. |
| Socio cultural | Norms and belief; cultural and traditions |
| Behaviour of staff | Personal being of honest, tolerant, respect to the patients |
| People perception | Attitude as proxy variable |
| Size of staff | Number of staff per health facility |
| Household size | Number of persons at households (1-3 “small”, 4-6 “medium, 7 and above “large” |

### 1.4.6 Organization of the dissertation

This dissertation is organized in five chapters. The first chapter covers the introductory part; the second chapter presents a review of existing literature on the impact of cost sharing policy implementation on health service. The third chapter presents the research methodology, highlighting the location and characteristics of the study area, types and source of data, sampling techniques and dada analysis. Chapter four presents the discussion on the results and findings emanating from

primary data as collected from head of household and health workers. Conclusion and recommendations drawn from the study are given in chapter five. A list of references cited in the text is presented at the end of this work.

# CHAPTER TWO

## 2.0 LITERATURE REVIEW

### 2.1 Definition of Terms

#### 2.1.1. What are the rural areas?

Rural areas are the localities that exist or primarily depend on agriculture and /or natural resources based production for their livelihood. A relatively low population density, with threshold of 5,000 – 10,000 square kilometres in most countries, usually characterizes them. In many developing countries, rural areas also generally

experience relatively high level of poverty, illiteracy and declining employment opportunities (World Bank, 2000).

### 2.1.2 Who are the poor?

One approach of identifying the poor is based on level of annual income. This, therefore, necessitates effort to reduce poverty to primarily involve increasing average income levels (Johnson and Rogaly, 1997). Nevertheless, the above concept on poor people has been strongly challenged by Sen (1981) by suggesting that the important cause of chronic poverty to be entitlement failure. The poor are therefore defined as those who are the most vulnerable to entitlement failure.

The definition and measurement of poverty has evolved overtime. Earlier definitions focused on cost of meeting basic needs necessary for maintaining minimum standard of life. Recent definitions have been made to include socio-economic indicators of well being. These include; morbidity and mortality, prevalence of malnutrition, illiteracy, high infant and maternal mortality rate, low life span, poor quality housing, poor social services, inadequate clothing, low per capita income and poor infrastructures,. Other factors included are high fertility, low technological know how, lack of access to safe and clean water, industrial level, poor education and health services (URT, 2002).

Therefore, these features can be used to identify poor and non-poor individuals, households and societies or communities. However, recently, definition of poverty has been further broadened. New definition incorporates problems of self-esteem,

vulnerability to internal and external risks, and exclusion from the development process and lack of social services (URT, 2002).

The prevalence of income poverty in Tanzania remains high (URT, 2005). Poverty remains overwhelmingly situated in the rural areas where 80% of the country's poor live and is most prevalent in households that are dependent on subsistence farming. As the population of Tanzania increases, the absolute number of poor remains an increasing cause for concern. There is also a significant disparity between urban and rural poverty in terms of both food and basic needs poverty, rural people produce food and sell it to urban people as a result food shortage in rural area is high compared to urban areas in which they can buy food from anywhere, while rural people are not able due to low income status they have.

**2.2 Welfare**

Welfare implies the level or standard of living of an individual, household or community. There are two definitions of this concept; the first defines welfare, as needs satisfaction. The more an individual, household or community satisfies its needs, the higher the level of welfare and vice versa (URT, 1999). The second defines welfare as household's command over resources. This is in terms of health, food, money, property, schooling, working conditions, housing, security against crime, means of transport, communication and liberty, which enable individuals to lead their lives and satisfy their needs (URT, 1999).

## 2.3 Income

Income promotes access to basic human needs such as food, shelter and clothing. With the current policy reforms, access to health service depends on the earnings of a household, due to introduction of cost sharing. Lack of income and production is the major cause and manifestation of the rural poor (URT, 1999).

## 2.4 Health

Health service is a very worth investment because of its direct relationship to production and service delivery; hence to poverty reduction. Only a healthy body can be productive.

Before economic liberalization, Government and Voluntary Agencies were the main providers of health service. Nowadays cost sharing for health service has been introduced (Kapinga, 2007).

However, health outcomes in Africa are among the poorest in the world. Also, current levels of health services in Africa appear to be insufficient in coverage and quality (World Bank, 1994).

Tanzania has focused much on curative rather than preventive measures. This can be justified by the fact that after independence, there was rapid increase in number of rural health centres and dispensaries and the increase in number of medical assistants, nurses and health assistants (URT, 1991).

Therefore due to more effort on curative rather than in preventive measures, it is obvious that majority of Tanzanians might be affected more with health problems. ‘Among the common health problems in Tanzania are malaria, bacteria and viral infectious diseases affecting all age groups and are responsible for morbidity and mortality. Other problems are such as infestation by hookworms, bilharzias, sleeping sickness and ascaris which cause substantial morbidity, disability and mortality in Tanzania’ (Kiwara, 1994).

‘Malaria and diarrhea diseases and respiratory infections are top causes of hospital attendance in Tanzania and are closely associated with problems of poverty, water, hygiene and sanitation or generally poor social economic conditions’ (Kiwara, 1994).

## 2.5 Structural Adjustment Programmes and the Introduction of Cost – Sharing

The design and implementation of SAPs in sub-Saharan Africa have come under criticism for not protecting the most vulnerable groups against their adverse impacts. The IMF and World Bank adjustment programmes have, for a long time, ignored such issues on the basis that they should be exclusively the prerogative of domestic policy makers (World Bank, 1993).

### 2.5.1 Arguments

The equity argument is quite strong. Sceptics state that fees affordable to most Africans will not generate enough resources, resulting in a deficit since

administrative costs will offset revenues. They further argue that fees will seriously reduce the access to health, especially for the poor, with important negative effects on health status (Creese, 1991). Also Gertler (1987) concludes in his study about user fees in Peru that the introduction of user charges reduces access proportionally more for the poor than for the rich, and that they are in that sense regressive. He further argues that while user fees would generate substantial revenues, they would also generate substantial reductions in aggregate consumer welfare with a heavier burden of the loss on the poor. This view is consistent with one of the principles agreed by donors in the Addis Ababa Consensus: "Efforts to reduce costs in the delivery of social services, as well as to increase the efficiency in resources allocations to the primary level, must be considered prior to the introduction of cost sharing" (Ruttens and Dercon, 1998).

From research conducted in Kondoa District, if a maternity patient fails to pay the said amount, the normal procedure is that the patient will be given delivery services but will not be discharged until costs are met (TGNP and GBI research, 1997).

In a country like Tanzania where communication is difficult, household surveys are expensive and cannot be done every day. Yet those few which were done show important trends. The most recently available is the Tanzania Human Resources Development Survey (HRDS) 1992/94 used by the Social Sector Review of the World Bank (1996). This survey showed that people were alienated by poor services especially shortage of drugs caused partly by mismanagement and scarcity of funds. Health workers attempted to supplement their wages through drug sales.

## 2.6 Cost Sharing in Health Services

Cost sharing is the portion of project or programme cost not borne by the sponsor. The "cost share" pledge may be either a fixed amount of money or a percentage of the project costs. The term "cost matching" often refers to cost sharing where the amount from the sponsor is equal to the amount from the cost share partner. This is also known as dollar for dollar cost sharing or cost matching (UW, 2007). It is the community share of the cost of running any project. Cost sharing typically takes the form of in-kind resources includes contributed project personnel effort, manpower and cash.

Meerman (1980), noted that the cost of financing the basic human development package of education and health implies budget short falls for average developing countries as high as 17% of GNP.

Before introducing cost sharing policy, Tanzania used to provide basic social services to all citizens free of charge. The government was the major provider of all health care services and non-governmental (voluntary) agencies like missionaries were running a substantial number of health care units in rural areas on token fee. But following serious economic difficulties, which faced Tanzania during 1980s, traditional donors acquired a new habit of asking for stamp of good economic conduct. This forced Tanzania to devalue her currency, reduce government expenditures, control credits, raise interest rates and remove subsidies. Due to this almost all government owned health centres and dispensaries had no drugs or diagnostic equipment and maternal mortality rates were on the increase (UNICEF, 1990); health workers' morale was at its lowest while attrition was at its highest.

In an attempt to arrest the crisis the government introduced National Economic Survival Program (NESP) for exploitation of local resources and then Structural Adjustment Program (ASP) in which under the economic reforms, the cut backs on social sector expenditure were affected (Kiwara, 1994). Later in 1991, private practice was officially allowed and government accepted to introduce user fee in all health care providing units under the cost sharing policy.

In Tanzania, establishment of cost sharing on health services was commenced in 1991 in higher – level health facilities like district, region and referral hospitals with the intent of reducing the financing gap, improving availability and quality of health services and increasing ownership/demand/community participation. Services at lower level health facilities like health centres and dispensaries were free until 1998, when the user fees were introduced in phase in conjunction with a community health fund, where a fixed annual membership fee entitled the household to fee health services. By the end of 2003, a community health fund was introduced in 36 out of 121 districts in Tanzania. Geita District was one of them, Community Health Fund as the means of generating fund for running health services aim to collect fund and being utilized at district health facilities.

### 2.6.1 National policy of cost sharing in health services

According to the economic crisis in 1980s, costs for health services were increased. However, shortage of budget of the government and high population growth caused the government budget especially of the health sector to be dependent to the donors.

This caused the health services to be not sustainable and the community failed to own them properly. For this situation, in 1993, the government decided to participate its community in cost sharing for their health services.

The aim of this policy is to expand source of fund for health services in order to stabilize and develop source of revenue for the service provision and minimize dependent of the government on donors (URT, 2007).

### 2.6.2 Operation of cost sharing in health services

After the introduction of cost sharing, experience shows that the money was not enough hence other sources of financing the health sector are necessary. In 1990s the government initiated the health sector reform program which is geared to undergo structural and functional changes in health sector including health care financing to ensure sustainability, accessibility and affordability of the health care to the people. Various forms of health care financing such as Government revenue, NHIS, CHF, NSSF and Donor funds were introduced in the country so as to enable financing sustainability of health sector activities and ensuring access to health services by the people. The study conducted at Geita district targeted at Community Health Fund (CHF) as the cost sharing on health service. Hence more than 85 percents of Tanzanians required participating in this form of cost sharing.

As the government of Tanzania is implementing its Health Sector Reforms, it has also explored various approaches to create and to sustain the funding of its services while at the same time trying to remain firm in its commitment to equity. The

Community Health Fund (CHF) is considered a viable mechanism for providing additional funding for the health services, especially at the district and sub-district levels. The CHF is assumed to be a mechanism to ensure increased access to health services, to empower the households (which are contributors to the fund) to participate in decision - making, and to further promote the cost sharing policy with increased community participation. In a way, the CHF is a form of a voluntary health insurance, a pre-payment arrangement for health services in the event of illnesses. It also appears to be flexible in that contributors are encouraged to pay at the time of harvest, with an option of paying in instalments for those with more regular incomes. The CHF model is flexible in another way in that it allows (in principle) contributors to pre-select a public, a private for - profit or a religious organization - owned unit from a network of existing health services providers in the community in which members live. The chosen first level unit (usually a dispensary) is linked to the next level (a first referral hospital). Clients of such pre-selected units reserve the right to join another every year, in case they are dissatisfied with the services at the dispensary of their first choice (Shirima, 1996).

The Community Health Fund is designed to achieve the following objectives: to have a health- financing scheme that serves the rural population so as to balance the formal health insurance scheme for civil servants largely in urban areas. Moreover, this scheme will ensure that individuals, families, and communities participate in discussing and deciding on health matters and that community's take a larger share of responsibility for their own health than before. Not only that but also to free the Ministry of Health from many health activities and concentrate on health policy

issues, and play a supportive and coordinating role by decentralizing the financial planning and management of health services to the local level cantered at the district.

According to the Community Health Fund Regulations of 2004, the money accrued to the fund shall be used for payment of health care services provided, procurements of drugs, medical supplies and equipments based on health plans, health promotion and preventive measures, minor rehabilitation works in pre-selected government health care facilities in accordance with the approved plan and any other essential health purposes or activities as may deem relevant and approved by the Board. CHF is implemented differently from district to a district and it continues to evolve of many changing secondary objectives to core objectives. Geita District is charging Tsh. 10,000 per household per year (GDMO, 2009).

It is noted that once a CHF project has been introduced in a district, two major policy steps are taken. First, user fees become affected in a systematic way for non CHF members who seek services at the government's respective unit. Secondly, since the CHF is owned by the communities and the respective districts, relevant by-laws are passed to enable its execution. In Geita District, between 2004 and 2008 the CHF managed to mobilize membership contributions amounting to Tshs. 409,785,000. This attracted a matching government contribution of the same amount and user-fees amounting to Tshs. 194,612,700. This amount could have been much higher if the membership size were to keep on increasing systematically relative to the number of households in the respective districts. One major constraint in

executing the CHF experiment is the low level of membership strength (GDMO, 2009).

### 2.6.3 Exemption of cost sharing policy in health services

The government of Tanzania determines the presence of people who cannot afford the cost sharing in health services, people who are in special community groups such as old people who are 60 and above years old, those who have no ability to generate income, children who are under five years old, children who are at risk environment of life, pregnant women and all people who do not have power to generate income. Also, people who have the following diseases; cancer, HIV/AIDS, diabetes, blood pressure, asthma, sickle cell, TB, leprosy, and psychiatric cases. Aim of this policy is to enable all people to receive the quality and quantity health services equally (URT, 2007).

### 2.6.4 Willingness and ability of Tanzanians to pay for cost sharing in health services

The Human Development Survey of 1994 on willingness to pay for desired quality health care at low – level health facilities to assess potential regressiveness of user fees has disproportionately higher negative effect of user fees among the poor compared with the rich (URT, 2003).

Nevertheless, report on program review and strategy development by U.N.F.P.A (June, 1996) claims that, Tanzania is one of the world's least developed countries and poverty profile in December, 1993 shows that approximately 50% of all

Tanzanians live in Households classified as poor and more than a third of the total population live in the households categorized as hard core poor. Some studies asked households directly how much they would be willing to pay for better quality health care. This is an often used, even though at times problematic technique in this field. Studies in Tanzania (Abel-Smith and Rawal (1992)) suggest that typically people are willing to pay relatively modest sums for health care in return for better quality health services. They were willing to pay most for increased availability of drugs.

### 2.6.5 Ability of Tanzanians to pay for cost sharing in health services

An ability to pay for health service charges is determined by socio economic status of an individual or household, thus, the poor are not able to pay while the rich are able (World Bank 1987, 1993, 1994))). Nevertheless, report on program review and strategy development by U.N.F.P.A (June, 1996) claim that, Tanzania is one of the world's least developed countries and poverty profile in December, 1993 shows that approximately 50% of all Tanzanians live in households classified as poor and more than a third of the total population live in the households categorized as hard core poor.

A study in Tanzania showed that private voluntary hospitals and dispensaries report that 70% and 40%, respectively, of their patients may have some difficulty making full payments. Most of these facilities had some exemptions: for example, 90% of the hospitals and 20% of the dispensaries exempt the disabled; less than a fifth of hospitals and virtually no dispensaries allowed children under five, or people with chronic diseases to be treated for free (Mujinja and Mabala 1992).

A more comprehensive survey in Tanzania (Abel-Smith and Rawal (1992)) showed some of the consequences of these policies. In rural areas, for example, they found that 42 percent of users had found it very difficult to raise the money to pay for mission services; another 43 percent had found it difficult to meet the need of cost sharing due to their low income status. Similar percentages reported difficulties to pay for government services. A third of users had to borrow money to get health care; another third had to sell assets, such as animals and valuables to pay for the health care obtained. Clearly, the fact that many facilities, such as NGOs, mission posts or other private facilities charge for health care does not mean that people are able to pay for it. The problem is that determination is done at the time of service. Medicines and supplies are often not available at government hospitals, even if supposedly free, meaning that individuals have to buy from private dispensaries.

**2.6.6 Willingness of Tanzanians to pay for cost sharing in health services**

The Human Development Survey of 1994 on willingness to pay for desired quality health care at low-level health facilities to assess potential regressive ness of user fees has disproportionately higher negative effect of user fees among the poor compared with the rich (URT, 2003).

Studies in Tanzania (Abel-Smith and Rawal 1992)) suggest that typically people are willing to pay relatively modest sums for health care in return for better quality health services. They were willing to pay most for increased availability of drugs. This study will go further in determination of whether people in Geita are willing to pay for cost sharing in healthy service.

### 2.6.7 Impact of cost sharing in health services

Introduction of cost sharing for health sector therefore might have more impact on health status of Tanzanians who have to pay for treatment of various health problems that face them. According to Semboja (1994), it is widely believed that implementation of Structural Adjustment Program from which cost sharing policy was introduced has negatively affected social services provisions.

Furthermore, Structural Adjustment Program has an implication of reducing government expenditures. This study will come up with explanations on how cost sharing in Geita District reduces government expenditures. Bagachwa (1994) stated that reduction of government expenditures would have the effect of increasing poverty and its associated aspects of environmental degradation. The increase of poverty and environmental degradation will have impact on the public health status. With this fact, it is obvious that introduction of cost sharing policy might have impact in health care services delivery to Tanzanians. This study is intended to determine these impacts of cost sharing policy in health care services in Geita District whose inhabitants are mostly peasants, small miners and street vendors who get generally low income from their activities.

### 2.6.8 Achievements of cost sharing in health services

Meerman (1980), noted that the cost of financing the basic human development package of education and health implies budget short falls for average developing countries as high as 17% of GNP. In Tanzania, establishment of cost sharing on

health services was commenced in 1993 in higher – level health facilities like district, regional and referral hospitals with the intent of reducing the financing gap, improving availability and quality of health services and increasing ownership/demand/community participation. Services at lower level health facilities like health centres and dispensaries were free until 1998, when the user fees were introduced in phase in conjunction with a community health fund, where a fixed annual membership fee entitled the household to charge health services. By the end of 1993, a community health fund was introduced in 36 out of 121 districts in Tanzania (URT, 2005). Geita District was among them. Therefore, an expectation of introducing cost sharing was to improve quality of health services to the people.

An attempt to raise funding from the consumers of the public services has been initiated by the “Cost Sharing Policy” which started on a limited scale in 1993 in Tanzania. However, its impact has been less than significant as a source of revenue for health sector development. It has scored a milestone in making Tanzanians aware of the need to pay for their own health services. According to Munishi (2001),

The cost sharing revenue between 1993 to 1998 increased from 1% to about 5.8% of the total health sector expenditure in 1998. This positive development, albeit in a small way, serves to encourage policy makers to create other mechanisms, hence the motivation to focus on cases in which alternative financing mechanisms are experimented with.

The CHF is expected to mobilize funds to improve the availability and quality of health services like equipment, technology, expertise, medicines etc. at the hospital, health centres and dispensaries. It is the responsibility of the health services management to ensure that the available funds are used to meet the expectations (URT, 1999).

Generally, before cost sharing policy commencing in Tanzania, various constraints faced health services were including; Units were without adequate furniture, Medical Structures of Facilities were deplorable, some had bats flying all over, lacked essential equipment for treatment of diseases, even simple gloves, some units lacked beds and mattresses, clinical officers' and other lacked decent accommodation, personnel were incompetent and issued wrong prescriptions, attitudes toward customers were poor and rude, bribery went with service delivery to customers, health personnel had low morale at work, under dosage was a common prescription, opening and closing time depended on staff.

Also in 1980s, some units opened as late as 11 am, drugs shortage was common, drugs available at the beginning of the month, drug shortage caused, under dosage of prescription and unnecessary referrals, drug shortages caused over crowding at the time when drugs are available, limited services due to limited drugs and equipment, staff have no uniform, incompetent staff were unable to use available equipment, unmotivated staff, unofficial charges of between Tshs. 2000 to 3000 were common for services which should bear no charge, unqualified staff were employed, poor

supervisory services, little or no community public owned units and limited services mix (Urio, 1999).

Therefore, after cost sharing started in Tanzania the following achievements were observed; Health services structured were repaired and rehabilitated using the IDA supported Food and Nutrition Project fund, new latrines were constructed where they did not exist, furniture was procured, some facilities still need water and electricity, some housing units for clinical officers were rehabilitated, transfers were effected to bringing new clinical officers and nurses with more positive attitudes, operating hours change and work starts it 7.30 am instead of 10 to 11 am., and closing early, clinical officers now available day and night in some units, personnel feel motivated now with new equipment and drugs available.

Not only that but also,display of price lists exists at some units, drugs now available throughout the month, congestion at the beginning of the month not common as drugs availability is spread out, many supplies and equipment purchased, some lab work now possible, mattresses and bed sheets now available at units, needed reagents and disinfectants now available, staff have uniforms, formal opening and classing times for units are systematic and official, official price lists are now posted and adhered, waiting time is reduced by the spreading of treatment for more than 8 hours and for a whole month, orderly referral system is now being developed, ward management committees (community involvement) participate in units management (Urio, 1999 and URT, 2007).

### 2.6.9 Problems facing cost sharing in health care services

Alternative financing options in Tanzania have been difficult to execute. First, asking a people previously accustomed to free health services to pay for them creates political resentments in the sense that they think that the government is probably failing to deliver free services as it used to. Secondly a lot of education has to be done about the essence and rationale, use and management of cost sharing, including costing, accounting and exemption procedures. Thirdly, different communities of the country have different abilities to pay. Therefore a uniform system is difficult to operationalize. Fourthly, if people have to pay, they expect to pay for quality, which still needs to be improved by revenues from the cost sharing initiative itself (Munishi, 2001). The cases discussed here experiment with injecting some substantial amount of donor financing so that the almost depleted government health services facilities can have the base and a start – up energy to win back confidence of the consumers.

One of the major weaknesses of the health sector reform programmes is its top-down approach. The CHF is, in one way, a top-down initiative because the idea originated at the MOH with the support of the World Bank. In another way, the CHF is a bottom-up (if its basic principles are operationalized) because it is sold to the communities at the bottom, who then voluntarily decide to own and mange it (Munishi, 2001). The main question is, however, how to make it possible for the CHF intervention to function and to score better results.

# CHAPTER THREE

## 3.0 METHODOLOGY

### 3.1 Description of the Study Area

The study was conducted in Geita District rural and urban areas. Geita District is one of the eight districts in Mwanza Region. It is bordered by Sengerema District in the East, Chato District in the West, Bukombe District in the South and Ukerewe District in the North.

The district is between the latitudes 2◦ 8’ south of the equator and between the longitudes 32◦ 45’ up to 37◦ east of the Greenwich meridian. Administratively, the district is divided into 7 divisions namely Geita, Kasamwa, Bugando, Butundwe, Busanda, Msalala and Nyang’hwale and there are 33 wards and 187 registered villages.

According to 2002 population and housing census there were a total of 709,708 people in the district with an average of 91 people per square kilometre. The number

of households was 118,285 with an average of six people per household. Ninety percent of the population live in rural areas only 10% live in urban areas (GDC, 2009).

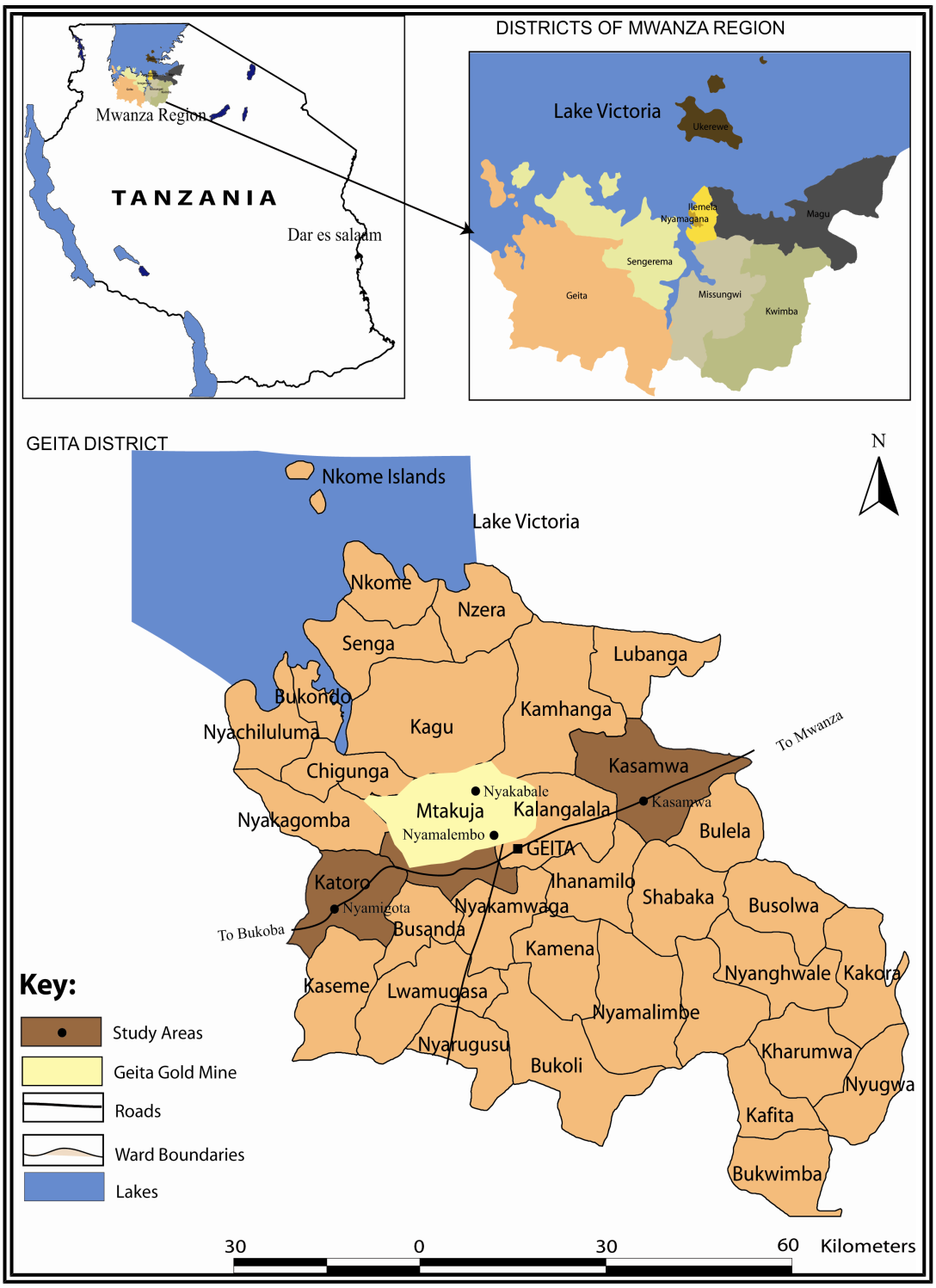



**Figure 1: Geita District Map**

### 3.2. Rationale for Choice of the Study Area

Geita District has been chosen in this study to select divisions, wards, villages and health facilities from which sample respondents was selected. The following factors were considered in reaching the decision to choose this District: (a) cost sharing was introduced in this district as pilot study area (b) logistical support.

### 3.3 Research Design and Justification

Non – experimental design was employed where a cross-sectional design was used in this study. The design allows data collection at a single point in one time (Babbie, 1990). Also the design has greater degree of accuracy and precision in social science studies than over design like observation (Casley and Kumar, 1998). Limited resources and time had been the criteria to justify the use of the selected design.

### 3.4. The Population and Sample

The population from which the sample for this study involved heads of households and health workers of both sexes from Geita District urban and rural. Four villages and four health facilities which participated in the study were randomly selected from a stratified residence, divisions, and wards.

#### 3.4.1 The sample size

The target populations were different actors such as household heads and health workers. According to Bailay (1994) minimum of 30 respondents is the bare minimum for studies in which statistical data analysis can be done. The study will selected a sample size of 96 respondents, includes 24 health workers and 72

households' heads as shown in the table of sampling technique below. Household heads were chosen to represent the community receiving health services. Health workers were chosen to represent health service providers who are providing health services in the study area.

### 3.4.2 Sampling procedures

Stratification and simple random sampling methods at different stages was employed; rural and urban strata were chosen, while the choice of 2 Divisions, 2 Wards from each Division, 1 village from each ward, 4 health facilities, 18 heads of household from each village and 6 health workers were chosen by using simple random methods to make a total of 96 respondents.

| **Residence** | | | |
|---|---|---|---|
| Urban<br>Stratification sampling | | Rural<br>Stratification sampling | |
| Geita division<br>Random sampling | | Karumwa division<br>Random sampling | |
| Kalangalala ward<br>Random sampling | Mtakuja ward<br>Random sampling | Karumwa ward<br>Random sampling | Kagu ward<br>Random sampling |
| Kalangalala village<br>Random sampling<br>18 heads of household<br>Random sampling | Mtakuja village<br>Random sampling<br>18 heads of household<br>Random sampling | Karumwa village<br>Random sampling<br>18 heads of household<br>Random sampling | Kagu village<br>Random sampling<br>18 heads of household<br>Random sampling |
| D. Hospital<br>8 Personnel<br>Random sampling | Nyankumbu H.Centre<br>6 Personnel<br>Random sampling | Karumwa H.Centre<br>6 Personnel<br>Random sampling | Kagu dispernsary<br>4 Personnel<br>Random sampling |

### 3.5 Sources of Data

#### 3.5.1 Primary data sources

Primary data related to health services provided to community, impact of cost sharing on health service delivery, people who denied health service under cost sharing for lack of funds, accessibility and affordability of the people on health service under cost sharing, public attitudes toward cost sharing in health service provision, health providers improvement delivery owing to cost sharing (availability of medicines, equipment, personnel morale and improved health facilities) and other related information was collected using a structured and pre-tested questionnaire, checklist and informal discussion for sampled individuals.

#### 3.5.2 Secondary data

Secondary data from different sources such as government offices, library, institutions, web site and live participants observations were collected and then used to complement the information obtained from sample respondents.

### 3.6 Data Processing and Analysis

Data were coded and analyzed using the Statistical Package for Social Sciences (SPSS) version (12) computer programme. Descriptive Statistics (Means, frequencies and percentages) were computed. Also statistical inferences (T-test and linear regression) were computed for hypotheses significance test. Finally, data were analysed using the probity model so as to determine the impact of cost sharing on health service.

Formulae: $Y = A_0 + B_1 X_1 + B_2X_2 + B_3X_3 + \ldots\ldots\ldots\ldots + B_nX_n + e$

Where, Y = Dependent Variables (improved health service such as availability and accessibility of quality health service provision)

$X_1, X_2, X_3 \ldots X_n$ = Independent Variables (Health service users under cost sharing with relation to belief, income, education, perception, demographic, geographic)

$A_0$ = Constant (no health provision improvement)

$B_1$, B2, B3……..$B_n$ = Constants (there is improvement of health service provision due to cost sharing policy)

e = is an error term

### 3.7 Limitation and Delimitation of the Study Methodology

#### 3.7.1 Limitations

The study was limited by the following factors.

- During the time of collecting these data many respondents especially in rural area were busy in agriculture and mining activities. This has led to some of respondents to be angry in wasting their time discussing some issue of this study.
- The majority of respondents in the study are a do not keep records on their treatment when they become sick.
- Researcher and research assistants experienced the difficulty of reaching respondents especially in rural area. This was attributed by geographical area in Geita District with a lot of mountains and forest reserves. It was hard task

of tracing them in village but researcher did not despair in tracing them.

- Despite the above limitations, the researcher was confident that the data that have been collected are reliable. They can therefore be used for generalizations as far as the study is concerned.

### 3.7.2 Delimitation

The study was conducted in only four villages/mitaa out of 187 villages of Geita District. Those villages were Bugulula,Bupamba, Bugogo and Kalangalala in Kagu, Kharumwa, Bukoli and Kalangalala wards.

# CHAPTER FOUR

## 4.0 RESULTS AND DISCUSSION

### 4.1 Overview

This chapter describes the results of the study and some observations made during the study. The results and discussion of the findings are presented in line with the study objectives (specific objectives).

### 4.2 Background Characteristics of Respondents

The table 2 gives a breakdown of background characteristics of the respondents. The parameters are including age, sex, marital status, education level and occupation.

#### 4.2.1 Age of respondents

Table 1 shows the age of the respondents. Most of the household respondents fall in the age group between 28-63 years and these represents 88 percent of the respondents while below 27 years old are 9 percent and 4 percent are people above 64 years old. This group was selected deliberately to capture the head of household and health workers who are in touch with cost sharing contribution for their health wellbeing. This shows that most health workers are employed at 28 years old and they may be active to work up to 54 years old. Young generation in Tanzania is not in favour to be the head of household as well as to be employed. This is due to the fact that they cannot afford life expenses economically, socially and psychologically. Thus, the researcher assumed that they are still immature while mature people are likely to adopt economic structural adjustment like introduction of cost sharing policy in Geita.

**Table 1: Background characteristics (N = 96)**

| Characteristics | Head of household | | Health workers | |
|---|---|---|---|---|
| **Age group (years)** | **Frequency** | **Percentage** | **Frequency** | **Percentage** |
| 19-27 | 7 | 10 | 2 | 8 |
| 28-36 | 12 | 17 | 4 | 17 |
| 37-45 | 17 | 24 | 10 | 42 |
| 46-54 | 24 | 33 | 7 | 29 |
| 55-63 | 9 | 13 | 1 | 4 |
| Above 64 | 3 | 4 | 0 | 0 |
| **Total** | **72** | **100** | **24** | **100** |
| **Sex of head of h/hold respondents** | | | | |
| Male | 59 | 82 | 14 | 58 |
| Female | 13 | 18 | 10 | 42 |
| **Total** | **72** | **100** | **24** | **100** |
| | | | | |
| **House hold size** | | | | |
| 1-3 | 11 | 15 | 5 | 21 |
| 4-6 | 36 | 50 | 12 | 50 |
| 7-9 | 25 | 35 | 7 | 29 |
| **Total** | **72** | **100** | **24** | **100** |
| **Education level** | | | | |
| Not attended any class | 5 | 7 | 0 | 0 |
| Primary | 41 | 57 | 0 | 0 |
| Secondary | 7 | 10 | 1 | 4 |
| College | 18 | 25 | 21 | 88 |
| University | 1 | 1 | 2 | 8 |
| **Total** | **72** | **100** | **24** | **100** |
| **Marriage Status** | | | | |
| Not Married | 5 | 7 | 6 | 25 |
| Married | 63 | 88 | 17 | 71 |
| Divorced | 1 | 1 | 0 | 0 |
| Widow | 3 | 4 | 1 | 4 |
| **Total** | **72** | **100** | **24** | **100** |
| **Occupation of Respondents** | | | | |
| Peasants | 45 | 63 | na | na |
| Teacher | 12 | 17 | na | na |
| Businessmen | 6 | 8 | na | na |
| Officer | 7 | 10 | na | na |
| Security | 1 | 1 | 3 | 13 |
| Nurse | na | na | 9 | 38 |
| Labolatotory technician | na | na | 3 | 13 |
| Medical attendant | na | na | 1 | 4 |
| Radiographer | na | na | 1 | 4 |
| Doctor | na | na | 7 | 29 |
| **Total** | **72** | **100** | **24** | **100** |

### 4.2.2 Marital status

Table 1 shows that most of respondents (80 percent) are married, while 4 percent are widowed. Besides, 1 percent of the respondents are divorced, and 16 percent are not married. Researcher found that marriage is an institution that has great control or influence on family matters (Mdoe and Macha, 2002). Couples are required to fulfil a number of obligations both productive and reproduction. In such situation they are involved in a number of activities so as to earn more income as compared with unmarried people.

Furthermore, women are more dominated by men. Table 1 shows that 70 percent of respondents were males and only 30 percent was females. Findings indicate that the one who is responsible to decide whether to contribute for community health fund for their family is the husband who is the head of the household or family.

This is also the case in the study area whereby husbands or men were in control of the family or household and are the one who can make the decision whether to go to hospital or not provided that who is falling sick in the family.

### 4.2.3 Education of respondents

Education always is valued as means of liberation from ignorance. It is the only principal mechanism for developing human skills and knowledge (URT, 2002). Respondents were grouped into four categories with respect to education background. The categories were none, primary, secondary and college after completing secondary education. Findings revealed that the majority of respondents

attained primary education and few have attained secondary and college education (Table 1).

It is therefore evident that most of the cost sharing beneficiaries (57 percent) had basic education and the know how to read and write. This scenario of having a big number of people who attended the primary school is expected in Tanzania because basic education is regarded basic right of every Tanzanian. It is compulsory for every child despite that nowadays this basic right of getting education is affected by other education factors such as the scarcity of education facilities. Such considerable high rate of literacy is an important input which may enable people to be aware, understand and adopt new skills more easily. According to Kashuliza et al. (1998) people with high education are expected to have better knowledge on financial procedures and skills of running economic activities. Educated people are expected to perform certain jobs and functions with higher efficiency and are more likely to adopt new technologies in a shorter period of time than uneducated ones. This is mainly because more educated people can gather, process and interpret all available information from different diverse investment areas and make decisions more early.

Lack of formal education might hinder prosperity of micro enterprises hence lower the income generation. Makauki (1999) found also that knowing how to read and write was sufficient in adoption of technology whose dissemination demanded simple leaf lets, pamphlets, posters, newspapers or other simple written materials.

According to the results of this study a large number of the respondents had attained primary education level than other levels. This means that there were relatively very few secondary and college graduates in the selected sample. This situation may be due to geographical nature of the study area which is almost rural area. In normal expectation, most of high education graduates are rarely found in rural areas. The same situation was reported in a study conducted in Dodoma Region (Mohani, 1991)

### 4.2.4 Occupation of respondents

Occupation of respondents shown in Table 1. It shows that (63 percent) of household respondents are peasants, while 17 percent are teachers, 10 percents are community officers, 8 percents are businessmen and 1 percent a secretary. Also, (38 percent) of health workers respondents are nurses, while 29 percent are doctors, 13 percent are laboratory technicians, 4 percent are medical attendants, 4 percent are radiographers and 13 percent were employed as secretaries.

The results show that apart from being employed in other employment, most respondents are engaged in agricultural activities. This is in line with other studies that concluded that, agriculture is the backbone of Tanzanian's economy. Similarly Mbwana (1994) noted that about 90 percent of the total population in Tanzania (of about 28 million people) depends on agriculture for a living and it contributes to about 40 percent of the country's GDP. Also the results are similar to observation made in the 2002 population and housing census in Tanzania where by more than 85

percents were farmers/rural population and found as the main occupation in Tanzania (URT, 2004a).

### 4.2.5 Household size

In examining this variable the respondents were asked to indicate the number of household members. The results indicate that the average household size was five members (Table1). The results reflect existence of big household sizes in the study area. This may be due to extended families which influence household size in the study area.

According to URT (2002) the size of the household can improve sharing force particularly when it indicates significantly skewed dependency ratio that over burdens the household head or major breadwinner. The number of household members has influence on income stabilization of household. Larger household size reflects demand for funds to meet family financial obligations. It is also sometimes hinders the expansion of business because income generated by business is used at home to sustain family needs hence it reduces the capacity of household to invest. These big families might become an obstacle of reducing poverty among cost sharing beneficiaries.

## 4.4 Ability of People to Pay Cost Sharing

### 4.4.1 Income of respondents

Income means a regular flow or addition to one's stock of wealth and generally one considers a person to be poor if his income is low (Hanson, 1996). According to

Ellis (2000), income comprises both cash and in-kind contributions to the materials welfare of the individual or household deriving from the set of livelihood activities in which household members are engaged. Information about household income in the study was very important as they could reveal if the community can afford and access the health service under cost sharing. During the study the respondents were asked to mention their income per month. The results indicate that the 67 percent of household respondents earns below Tsh 100,000 per month or below Tsh 20,000 per month per person/individual which is equivalent of US $ 80 per month or US $ 18 per month per household member or below US $ 0.6 per day per person (see Table 2) in which respondents were asked to estimate amount of money they earn per month. The results imply that majority of respondents are still below poverty line i.e. below one dollar (US) per day per person. The findings are in line with the report by World Bank (2000) which pointed out that 50 percent of Tanzanians live in poor household with an income equivalent of less than US $ 0.75 per day per person. It also reported that, in the year 2000 income in Tanzania was US $ 242 per capita per years. Furthermore, about 50 percent of Tanzanians live below the poverty line of Tsh 73,877 per adult equivalent per year in 1995 prices which is about US $ 0.5 per capita per day.

**Table 2: Ability of people to pay cost sharing (N = 96)**

| Monthly earned income (Tsh) | Head of households | | Health workers | |
|---|---|---|---|---|
| | Frequency | Percentage | Frequency | Percentage |
| 100,000 and below | 48 | 67 | 0 | 0 |
| 100,001-200,000 | 10 | 14 | 10 | 42 |
| 200,001-300,000 | 4 | 6 | 6 | 25 |
| 300,001-400,000 | 3 | 4 | 2 | 8 |
| 400,001-500,000 | 4 | 6 | 2 | 8 |
| 500,001-600,000 | 1 | 1 | 2 | 8 |
| Above 700,000 | 1 | 1 | 2 | 8 |
| **Total** | **72** | **100** | **24** | **100** |

### 4.4.2 Attendance of people at public health service under cost sharing

Table 3 indicates, 90 percent of heads of household respondents do not attend at public health service because of lack of funds for paying for the health service under cost sharing. This meant that majority of people in the study area do not attend at hospital for health service but they use traditional medicine for their treatment. Many people opt to go to traditional healers for treatment which is very much cheaper and payment procedure done after recovery which is contrary from health service treatment, whereby people pay before treatment take place to the patients. During the study more respondents complained about this, for example Masalu said that *"his grandmother died at Geita District hospital due to late treatment which was to be done after completion of payment cost sharing process at reception step"*.

**Table 3: People who are denied Health services due to lack of funds (N = 96)**

| Attendances of people at health service | Head of households | | Health workers | |
|---|---|---|---|---|
| | Frequency | Percentage | Frequency | Percentage |

| | | | | |
|---|---|---|---|---|
| I do attend | 65 | 90 | 24 | 100 |
| I don't attend | 7 | 10 | 0 | 0 |
| **Total** | **72** | **100** | **24** | **100** |

Source: Survey data.

### 4.5 Preferential Group for Health Service under Cost Sharing

#### 4.5.1 Availability of the old, children and pregnant women preferential for health service under cost sharing policy at Geita District.

The Tanzania national policy of exemption different special group of people from cost sharing in health service states that people who are in special community groups such as old people who are 60 and above years old, those who have no ability to generate income, children who are under five years old, children who are at risk environment of life, pregnant women and all people who do not have power to generate income. Also, people who have the following diseases; cancer, HIV/AIDS, diabetes, blood pressure, asthma, sickle cell, TB, leprosy, and psychiatric cases should be exempted from cost sharing in health services. The aim of this policy is to enable all people to receive the quality and quantity health services equally (URT, 2007).

Table 4 indicates availability of exemption of preferential group (the old, disabled, children and pregnant women) on health service under cost sharing policy. Head of household, 60 and 68 percent, mentioned that there is no exemption for health service under cost sharing to disabled and old people respectively, while 40 and 32 percent indicated that there is an exemption for health service from cost sharing to disabled and old people respectively. This meant that exemption policy for the old and disabled people is not well known to the community members that is why those

who responded yes are nearly equal to those who responded no. However, only 17 percent said that there is no exemption of cost sharing on health service for children and pregnancies women, while 83 percent indicated that there is exemption cost sharing on health service for children and pregnancies women. From this findings, it revealed that health workers are implementing at satisfactory the exemption policy for under five children and pregnant women from cost sharing in health service. From discussion group made during the study, some respondent said that exemption procedures for less than five children and pregnant women are well known implemented at community, while the rest group mentioned by exemption policy are complicated and not well known to the people. The government is responsible to make sure that all policies stated must be well known to the community and implemented properly.

The results was supported by the health workers respondents, in which 29 and 42 percent indicated that there is no exemption for disabled and old people respectively from health service under cost sharing, while 71 and 58 said that there is an exemption for disabled and old people respectively from health service under cost sharing. But, 100 percent of health workers indicated that there is an exemption for children and pregnant women on health service under cost sharing.

It was also observed that respondents who mentioned the presence of exception meant old people are those who are not able to work and generate income for the cost of their life, and who have no support from their children and relatives. Results further show that absence of exemption service is a big problem in the study area. Literature states that old, children, pregnancies women and disabled people must be

exempted from cost sharing condition on health service (URT, 2000). Therefore better health service must consider preferential group for exemption from cost sharing on health service.

Preferential group (old people, children, pregnant women and disabled people) are the part of the community. In Tanzania, it has been noted that the old, children, pregnant women and disabled people are the most vulnerable group from all life hazards in which disease is the most one. Therefore they need special health service.

It was expected that the old, children, pregnant women and disabled people would be exempted from cost sharing at heath service provision, but the findings revealed that situation of this group to be exempted is the same as other normal people. This is due to the fact that, exception for preferential group for cost sharing on health service hampered by corruption as 10 percent said while 18 percent show that, exception procedure are not clear and 39 percent show that, not all old and disabled people has no fund to pay. This explains why there is a high mortality rate in Tanzania. Lack of consideration and poor implementation of policies are the vital problem.

According to health workers in the study area, 29 percent indicated that, disabled people are not treated free at hospital because not all disabled do not have ability to pay while 42 percent indicated that, the old people are not treated free. This is because not all old people has no fund to pay for health service. It meant that, procedures for exempting preferential group are not clear to the community as well

as health workers. Lack of exemption of preferential group from cost sharing on health service is evident as shown further in Tables 4 to 5 respectively.

**Table 4: Preferential treatment identification (N = 96)**

| | Head of households (n=72) | | | | | Health workers (n=24) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Variables** | **YES** | **%** | **NO** | **%** | **Total** | **YES** | **%** | **NO** | **%** | **Total** |
| Disabled treated free | 29 | 40 | 43 | 60 | 72 | 17 | 71 | 7 | 29 | 24 |
| Children treated free | 60 | 83 | 12 | 17 | 72 | 24 | 100 | 0 | 0 | 24 |
| Pregnancies women treated free | 60 | 83 | 12 | 17 | 72 | 24 | 100 | 0 | 0 | 24 |
| Old people treated free | 23 | 32 | 49 | 68 | 72 | 14 | 58 | 10 | 41.67 | 24 |
| **Total average** | **43** | 60 | **29** | **40** | **72** | **20** | **82** | **4** | **18** | **24** |

**Table 5: Reasons why no preferential treatment for disabled, children, pregnant Women and the old people (N = 96)**

| | Head of households (n=72) | | Health workers (n=24) | |
|---|---|---|---|---|
| **Variables** | **Frequency** | **Percentage** | **Frequency** | **Percentage** |
| Exception policy is not clear | 28 | 39 | 4 | 17 |
| Not all disabled and old people have no fund | 13 | 18 | 13 | 54 |
| Corruption at hospital | 7 | 10 | 0 | 0 |
| **Total** | **48** | **67** | **17** | **71** |

### 4.6 Attitude of People towards Cost Sharing for Health Service Provision

Table 6 indicates altitude of people towards cost sharing on health service. To assess people's attitude towards cost sharing on health service in Geita District, Likert-scale interview items were used. From the interview items, respondents were expected to show positive or negative attitude towards cost sharing on health service. If respondents agree with the item, this implies that respondents do not face problem in paying cost sharing for health service and health service delivered by the

government is still not yet improved in order to meet the health service of people. If respondents disagree it means that there is poor health service delivery under cost sharing.

Results in Table 6 show that 80 percent disagree that cost sharing for health service provision is affordable, while 17 percent could not decide and 3 percent agree. This explains that, most people in the study area do not afford cost sharing for health service. Moreover, 76 percent agree that free health service is possible, while 22 percent disagree and only 1 percent of respondents could not decide if free health service provision is possible in Tanzania nowadays. On assessing the respondents if they like to pay cost sharing for health service, 67 percent disagree if they like to pay cost sharing for health service, 22 percent agree while 11 percent could not decide whether they like or not to pay cost sharing for health service. Respondents were also asked to say something if cost sharing for health service is for rich people and not for poor people, 60 percent disagree that cost sharing for health service in the study area is for rich people, 35 percent agree while only 5 percent could not decide that cost sharing for health service is for rich people. Informal discussions with the respondents revealed that cost sharing for health service is for everybody, whether your are poor or rich. This is because government has decided, if they could be asked first before starting the implementation of cost sharing for health service programme, they could reject the idea, may be if the policy could put a clear exception for the poor people who are the majority in Tanzania.

**Table 6: Public attitudes towards cost sharing (n = 72)**

| | Head of house holds | | | | | |
|---|---|---|---|---|---|---|
| **Opinion** | **Strongly agree** | **Agree** | **Undecided** | **Disagree** | **Strongly Disagree** | **Total** |
| Cost sharing is affordable | 0 | 2 | 12 | 44 | 14 | **72** |
| Free health service is possible | 39 | 16 | 1 | 3 | 13 | **72** |
| Free health service is impossible | 3 | 8 | 7 | 7 | 47 | **72** |
| Health service facilities are good | 3 | 4 | 9 | 29 | 27 | **72** |
| Buildings are satisfactory | 12 | 26 | 11 | 12 | 11 | **72** |
| Medicine are enough at hospital | 3 | 4 | 9 | 29 | 27 | **72** |
| Health workers are enough | 2 | 3 | 5 | 27 | 35 | **72** |
| Health workers are very kind | 4 | 16 | 19 | 17 | 16 | **72** |
| I like to pay cost sharing | 4 | 12 | 8 | 18 | 30 | **72** |
| Cost sharing is for rich people | 10 | 15 | 4 | 12 | 31 | **72** |
| Cost sharing excludes old, pregnant women, children and disabled people | 7 | 16 | 15 | 11 | 23 | **72** |
| Corruption exist at health service | 20 | 32 | 6 | 8 | 6 | **72** |

**Table 7: Health workers attitudes towards cost sharing (n = 24)**

| | Head of house holds | | | | | |
|---|---|---|---|---|---|---|
| **Opinion** | **Strongly agree** | **Agree** | **Undecided** | **Disagree** | **Strongly Disagree** | **Total** |
| Cost sharing is affordable | 0 | 2 | 5 | 6 | 11 | **24** |
| Free health service is possible | 3 | 4 | 4 | 1 | 12 | **24** |
| Free health service is impossible | 6 | 8 | 4 | 4 | 2 | **24** |
| Health service facilities are good | 9 | 4 | 6 | 4 | 1 | **24** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Medicines, equipments are available | 4 | 2 | 2 | 13 | 3 | **24** |
| Buildings are satisfactory | 3 | 7 | 4 | 1 | 9 | **24** |
| Health workers are enough | 0 | 0 | 0 | 9 | 15 | **24** |
| Health workers are very kind | 7 | 10 | 5 | 1 | 1 | **24** |
| I like to pay cost sharing | 3 | 10 | 3 | 1 | 7 | **24** |
| Cost sharing is for rich people | 2 | 1 | 3 | 8 | 10 | **24** |
| Cost sharing excludes old, pregnant women, children and disabled people | 9 | 5 | 4 | 3 | 3 | **24** |
| Health workers motivated | 2 | 0 | 1 | 3 | 18 | **24** |

### 4.7 Beliefs, Norms and Culture in Relation to Traditional Healers

Table 8 below shows that, 54 percent of the heads of households believe in traditional treatment services while 46 do not believe. Also, 38 percent of health workers respondents believe in traditional treatment services. This meant that, traditional healers offer good and appropriate health service in the study area. It was further observed that, most of government workers they believe in traditional treatment services. Even though the government does not appreciate this belief.

**Table 8: Belief on traditional treatment services (N = 96)**

| | **Head of households** | | | | **Health workers** | |
|---|---|---|---|---|---|---|
| **Variable** | **No** | **%** | **Yes** | **%** | **No** | **%** |
| Belief on traditional treatment. | 33 | 46 | 9 | 38 | 15 | 52 |
| **Total** | | **72** | | | | **24** |

## 4.8 Heal Service Delivery Improvement

### 4.8.1 Availability of the medicine at government health service

**Table 9: Availability of medicine at government hospital health service (N = 96)**

| Availability of | Head of households | | Health workers | |
|---|---|---|---|---|
| medicine at hospital | Frequency | Percentage | Frequency | Percentage |
| Available | 7 | 10 | 6 | 25 |
| Most of time not available | 65 | 90 | 18 | 75 |
| | **72** | **100** | **24** | **100** |

Availability of medicine is the key determinant of improved health service under cost sharing. According to the Structural Adjustment Programme, donors left medicine for the government in relation with cost sharing. Table 9 above shows that 90 percent of the head of households indicated that, medicine are always not available at government health delivery while 10 percent only said that medicine is available in which most of them were found in urban area. In rural areas medicine is not available most of the time study realised and observed. This was supported by health workers in which 75 percent indicates that medicine at government health service is not available while only 25 percent shows that medicine are always available. Moreover, further discussion by respondents, findings revealed that one person required to pay Tsh 1500 before being given any treatment and he was discovered suffering from malaria, funny enough a person was given panadol with an equivalent to Tsh 200. A person complained a lot and promised that he will never attend again at government hospital because of lack of medicine under cost sharing.

### 4.8.2 Health workers

**Table 10: Health workers (N = 96)**

| Enough health | Head of households | Health workers |
|---|---|---|

| workers | Frequency | Percentage | Frequency | Percentage |
|---|---|---|---|---|
| Yes | 5 | 7 | 0 | 0 |
| No | 67 | 93 | 24 | 100 |
| **Total** | **72** | **100** | **24** | **100** |

Source: Survey data.

During the study the respondents were asked to say yes or no whether health workers are enough at their respective health facilities. According to the results (Table 10), all health workers respondents 100 percent indicates they are not enough while 93 percent of head of household indicates that, health workers are not enough and only 7 percent shows health workers are enough at their health facilities. This meant that there is no improvement on health service on looking at health workers per person in Tanzania.

### 4.8.3 Health facilities (Buildings)

**Table 11: Health facilities (N = 96)**

| | Head of households | | Health workers | |
|---|---|---|---|---|
| **Enough building** | **Frequency** | **Percentage** | **Frequency** | **Percentage** |
| Yes | 38 | 53 | 10 | 42 |
| No | 34 | 47 | 14 | 58 |
| **Total** | **72** | **100** | **24** | **100** |

Table 11 above indicates that, 53 percent agree that there are enough buildings at their health service under cost sharing while 47 percent said there is no enough

building at health service. This meant that cost sharing is in a good way on health service improvement (53 percent), especially on buildings which was left for donors.

### 4.8.4 Personnel morale of health workers at work

**Table 12: Personnel morale (n = 24)**

| **Personnel morale of health** | **Health workers** | |
|---|---|---|
| **workers is high** | **Frequency** | **Percentage** |
| Yes | 3 | 13 |
| No | 21 | 88 |
| **Total** | **24** | **100** |

Table 12 above shows whether the personnel morale of health workers is high, 88 percent of health workers are not working with morale at health service delivery while 12 percent working morale is high. Further discussion with health workers pointed out that, the reasons for them to work at low morale includes low salary, lack of motivation i.e. no extra duty payment and they live in poor environment and house in villages. Also, they do not get chance to attend short or long term courses for updating their knowledge.

However, majority among 12 percent observed that are those health workers who work at high morale live in town and they have top positions at health service delivery.

### 4.8.5 Poor health service at public health service

Table 13 shows that, 36 percent of respondents said that poor health service at public health service are due to complicated procedure at hospitals. Further

discussion revealed that, a person may be serious sick but a very long process will be taken before treating him/her. Also 33 percent indicated that, nowadays at any public service there is a passive resistance by workers. Moreover, findings discovered that, government is not considering its workers in terms of paying them satisfied salaries in relation to their demand, also lack of motivation in paying extra duty for health workers who work in village and those who have low position.

### 4.8.5 Poor health service at public health service

Table 13 shows that, 36 percent of respondents said that poor health service at public health service are due to complicated procedure at hospitals. Further discussion revealed that, a person may be serious sick but a very long process will be taken before treating him/her. Also 33 percent indicated that, nowadays at any public service there is a passive resistance by workers. Moreover, findings discovered that, government is not considering its workers in terms of paying them satisfied salaries in relation to their demand, also lack of motivation in paying extra duty for health workers who work in village and those who have low position.

**Table 13: Reasons for unsatisfactory/poor public health services (N=96)**

| **Reasons for unsatisfactory public h/services** | **Head of households** | | **Health workers** | |
|---|---|---|---|---|
| | **Frequency** | **Percentage** | **Frequency** | **Percentage** |
| Passive resistance | 24 | 33 | 1 | 4 |
| Salary is not enough | 1 | 1 | 5 | 21 |
| Complicated procedures | 26 | 36 | 1 | 4 |
| **Total** | **51** | **71** | **7** | **29** |

### 4.8.6 People willingness to pay cost sharing for health service

**Table 14: Willingness to pay cost sharing for health service (N = 96)**

| Willing to pay cost sharing for health service | Head of households | | Health workers | |
|---|---|---|---|---|
| | **Frequency** | **Percentage** | **Frequency** | **Percentage** |
| Yes | 38 | 53 | 10 | 42 |
| No | 34 | 47 | 14 | 58 |
| | **72** | **100** | **24** | **100** |

During the study respondents were also asked whether they like and are willing to pay cost sharing for health service. Results in Table 14 above show that, 53 percent of head of households are willing to pay cost sharing for health service while 47 percent indicate that they do not willing to pay cost sharing for health service. But 58 percent of health workers respondents do not like to pay cost sharing for health service through National Health Insurance Fund (NHIF) which is automatic contribution for any government employee while 42 percent they like to pay cost sharing for health service. Further discussion by respondents, findings revealed that community contributed a lot for health service but improvement of health service is very low compared to objectives of cost sharing policy.

## 4.9 Determinants of Health Service Accessibility and Affordability

### 4.9.1 Determination of cost sharing participation

Linear regression analysis and T-test were conducted to ascertain factors that influenced significantly health service accessibility and affordability by health user under cost sharing (see Table 15). Access and affordability of health service under cost sharing was regressed and tested against age, education level, income status,

belief, availability of medicine, enough health workers, motivated health workers, and occupation.

### 4.9.2 Age

The results indicate no significant relationship between cost sharing and age, probability was 0.204 which is greater than 0.05. Beta was -0.04, this implies that as age increases ability of people to access and afford health service decreases (Table 15). This finding implies that older people have poor chances to afford cost sharing on health service. This is because older people are always risks averse they can not work and be paid as they used before in case of retired.

However, rural older people can not work effectively for income generation. Therefore cost sharing for the old people is not in position. Hence, the older people should be excluded from cost sharing for their health service without any restrictions.

### 4.9.3 Occupation for income generation

Occupation activity was thought to be significant because farming which was the main occupation of the majority respondents could influence a person to run income generation. However, the results show that there was no significant relationship between occupation and accessibility of health service, since probability was 0.41 which is greater than 0.05. Beta statistic was -0.09, this implies that, those who have good employment anywhere can always be treated at private hospital and not at

public hospital. They always fear to waste their time while they have money to choose whether to be treated at public or private hospital (Table 15).

**Table 15: Linear regression factors influence accessibility and affordability of health service under cost sharing (N = 96)**

| Variables | B statistic | T statistic | Probability |
|---|---|---|---|
| Age | -0.04 | -1.08 | 0.20 |
| Availability of health workers | 0.37 | 3.59 | 0.00 |
| Education | -0.03 | -0.2 | 0.84 |
| Peoples' perception on cost sharing | 0.22 | 2.22 | 0.03 |
| Employment | -0.09 | -0.82 | 0.41 |
| Belief on traditional healers | -0.12 | 1.28 | 0.04 |
| Availability of medicine | 0.35 | 3.23 | 0.00 |
| R square = 0.508 | | | |
| Significance P<=0.05 | | | |

### 4.9.4 Education

Education was found to be not significant variable that determines ones to attend and afford public health service under coast sharing, since probability was 0.84. Beta statistic was -0.03 (Table 15). These meant that increased level of education does not make people attend public health service under cost sharing, as educated people have increased awareness on privation to various diseases and they know that at public hospital, health service provision is poor compared to private hospital. Therefore highly educated people are not likely to get diseases and if they become sick they prefer private health service while people with or without education are at risk of becoming sick and if they become sick they prefer public health service if not traditional healers.

### 4.9.5 Availability of medicine

Availability of medicine was found to be a significant variable that determines accessibility and affordability of health service under cost sharing, probability was 0.003, Beta statistic was 0.35 (Table 15). Moreover, when medicines are available the attendance of patients at public health service increased also, the vice verse is also true.

### 4.9.6 Health workers at public health service

Health service delivery is determined by personnel. Results in Table 15 show the most significant relationship between health workers and accessibility/affordability of health service under cost sharing, probability was 0.001 and Beta statistic was 0.37. This meant that, at any health service if there is enough, motivated and qualified health workers, health service users or customers will be increased also.

### 4.9.7 Belief on witchcrafts/traditional healers

The results indicate a significant relationship between access and beliefs on witchcrafts, probability was 0.04 while Beta statistic was -0.12 (Table 15). This finding revealed that as the number of believers in witchcrafts increases, the number of people to attend at health service decreases. Therefore most people choose for witchcrafts service provision rather than health service. This is due to the number of reasons include cheap treatment; use of natural trees and some diseases can not be treated at hospital.

### 4.9.8 Perception of people on health service under cost sharing

The results indicate a significant relationship between access/affordability and perception of people on health service under cost sharing, probability was 0.03 while Beta statistic was 0.221 (Table 15). This finding revealed that as the number of people perceives that cost sharing is for everybody and is therefore the purpose of improving public health service increases, the number of people to attend and afford health service under cost sharing increases also.

### 4.9.9 Testing the hypothesis

Null hypothesis stated that, there is no significant relationship between associated factors/variables of cost sharing (age, education level, income status, occupation, availability of medicine, enough health workers, and belief) and accessibility/affordability of health service. More variables tested above show there is a significant relationship between associated factors/variables of cost sharing and accessibility affordability of health services. Therefore, from these evident results by linear regression model, alternative hypothesis is true, which states that there is significant relationship between associated factors of cost sharing and accessibility/affordability of health services.

# CHAPTER FIVE

## 5.0 CONCLUSION AND RECOMMENDATIONS

### 5.1 Introduction

The main objective of this study was to assess the impact of cost sharing on access to health care services in Geita District. The rationale for this study was to determine whether cost sharing managed to impose its positive impact on health service delivery as it aimed. This was accomplished by assessing health service improvement under cost sharing programme, whether availability of health delivery facilities i.e. medicine, buildings, enough and motivated health workers. However, ability of people to pay cost sharing for health service was determined. Also, assessment of peoples' attitude and perception of cost sharing on health service was done. Nevertheless, identification of preferential group for health service under cost sharing was in line with this study.

## 5.2 Conclusions

The following are aspects of the conclusion made from the findings.

1. Information on cost sharing policy does not reach well the health service users especially rural people. Therefore lack of good procedure for sensitizing any policy before starting implementation is a big problem in the study area.
2. Majority of people do not have an ability to pay cost sharing for health service. This is due to an adverse poverty situation which is dominating the majority of Tanzanians.
3. Many people have negative attitude on cost sharing for health service. This is because they do not see an expected highly positive improvement of health service delivery.
4. People have started to deny health service provision under cost sharing. This is due to unavailability of medicine most of the time and low health workers with low education level and low morale to work.
5. Both heads of household and health workers appreciates traditional healers since they use traditional medicines services by natural trees and at low cost compared to cost sharing in health services.
6. Exemption policy treatment for preferential group i.e. the old and disabled people is not well known to some health workers and the community.

## 5.3 Recommendations

From the conclusions of this study, the following recommendations are made.

1. Government especially health policy makers should aim at making extensive sensitization of any new programme to all stakeholders before implementation takes place.
2. There should be a survey to determine people who are very poor in order to exclude them from paying cost sharing for their health service. Nevertheless, a big loss of people may happen because of failing to pay for their treatments at hospital.
3. Health workers especially leaders in collaboration with government should make sure that money obtained through cost sharing must reflect the objectives of improving health service delivery and not otherwise.
4. There should be simple procedure used to identify the old and disabled people in order to exclude them from cost sharing in health services. Findings revealed that majority of the old and disabled people are not simply excluded because of complex procedure existing at public health service facilities, but the policy for exempting them from cost sharing in health service is clear defined and stated by the government. It seemed that the policy actors such as health workers management are the source of problem. Therefore, the government should work on this in order to serve its people.

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## APPENDICES

**Appendix 1: Questionnaire Heads of household questionnaire (Rural and urban respondents)**

Date of interview……..

Questionnaire number…….

Location/mtaa…….

Ward……

Division……

Health facility……

| **1. DEMOGRAPHIC INFORMATION**<br><br>Please put tick in the provided box | | |
|---|---|---|
| 1.1 Sex | Male | |
| | Female | |
| | | |
| 1.2 Age | 10-18 | |
| | 19-27 | |
| | 28-36 | |
| | 37-45 | |
| | 46-54 | |
| | 55-63 | |
| | 64 above | |
| | | |
| 1.3 Occupation | Peasant | |

| | | | |
|---|---|---|---|
| | Teacher | | |
| | Businessperson | | |
| | Officer | | |
| | Manner | | |
| | Others (specify) | | |
| | | | |
| 1.4 Education level | None | | |
| | Primary | | |
| | Secondary | | |
| | College | | |
| | University | | |
| 1.5 Marital status | Single | | |
| | Married | | |
| | Divorced | | |
| | Widowed | | |
| **2.0 SOCIO ECONOMIC FACTORS** | | | |
| 2.1 Income (Money earned per year Tsh) | Below 100,000 | | |
| | 110,000-200,000 | | |
| | 210,000- 300,000 | | |
| | 310,000- 400,000 | | |
| | 410,000- 500,000 | | |
| | 510,000- 600,000 | | |
| | 610,000- 700,000 | | |
| | Above 710,000 | | |
| | | | |
| **3.0 SOCIAL CULTURAL FACTORS** | | | |
| a) Are disabled people being treated free at hospital? | | YES | NO |
| | | | |
| c) If the answer above is NO, why? | | | |
| d) Are the old people being treated free at hospital? | | YES | NO |
| e) If the answer above is NO, why? | | | |
| f) Are children being treated free at hospital? | | YES | YES |
| g) If the answer above is NO, why? | | | |
| h) Are the pregnant women being treated free at hospital? | | YES | NO |
| i) Do you go to hospital when you become sick? | | YES | NO |

| | | |
|---|---|---|
| j) If the answer above is NO, why? | | |
| k) Do you believe in witch craft? | YES | NO |
| l) If the answer above is YES, why? | | |

**Likert Scale**

Please pick number for the scale to show how you agree or disagree with each of the following statements, “1” = strong agree, “2” = agree, “3” = undecided, “4” = disagree, “5” = strong disagree

| NO | ITEMS | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | Fee for health service is affordable | | | | | |
| 2 | Fee for health service is not affordable | | | | | |
| 3 | Health facility in my village is good due to cost sharing on health service | | | | | |
| 4 | Medicine are available throughout the time at my health facility | | | | | |
| 5 | Building of my health facility is good | | | | | |
| 6 | There are enough doctors and nurses at my health facility | | | | | |
| 7 | Doctors and nurses are very kind when I’m sick | | | | | |
| 8 | I like to pay cost sharing when I become sick | | | | | |
| 9 | Cost sharing on health service excludes disabled people like old, children, and pregnancy women | | | | | |
| 10 | Cost sharing on health services is for rich people | | | | | |

**B. Health service workers questionnaire (Rural and urban respondents)**

Date of interview……..

Questionnaire number…….

Location/mtaa…….

Ward……

Division……

Health facility…….

| | | |
|---|---|---|
| **1.0 DEMOGRAPHIC INFORMATION**<br>Please put tick in the provided box | | |
| 1.1 Sex | Male | |
| | Female | |
| | | |
| 1.2 Age | 10-18 | |
| | 19-27 | |
| | 28-36 | |
| | | |
| | | |
| | 37-45 | |
| | 46-54 | |
| | 55-63 | |
| | 64 above | |
| | | |
| 1.3 Occupation | Nurse | |
| | Doctor | |
| | Pharmacist | |
| | Others (specify) | |
| | | |
| 1.4 Education level | None | |
| | Primary | |
| | Secondary | |
| | College | |
| | University | |
| | | |
| 1.5 Marital status | Single | |
| | Married | |
| | Divorced | |
| | Widowed | |
| | | |
| 1.6 House hold size | 1-3 | |
| | 4-6 | |
| | 7-9 | |
| **2.0 SOCIO ECONOMIC FACTORS** | | |
| 2.1 Income (Money earned per month Tsh) | Below 100,000 | |
| | 110,000-200,000 | |
| | 210,000- 300,000 | |
| | 310,000- 400,000 | |
| | 410,000- 500,000 | |
| | 510,000- 600,000 | |
| | 610,000- 700,000 | |
| | Above 710,000 | |

| | | |
|---|---|---|
| **3.0 SOCIAL FACTORS IN RELATION TO COST SHARING PROGRAMME** | | |
| a) Are disabled people being treated free at hospital? | YES | NO |
| | | |
| c) If the answer above is NO, why? | | |
| d) Are the old people being treated free at hospital? | YES | NO |
| e) If the answer above is NO, why? | | |
| f) Are children being treated free at hospital? | YES | YES |
| g) If the answer above is NO, why? | | |
| h) Are the pregnant women being treated free at hospital? | YES | NO |
| i) Do you go to hospital when you become sick? | YES | NO |
| j) If the answer above is NO, why? | | |
| k) Do you believe in witch craft? | YES | NO |
| l) If the answer above is YES, why? | | |
| m) Is there any kind of corruption at health service? | YES | NO |
| n) If the answer above is YES, how? | | |

**Likert Scale (checklist)**

Please pick number for the scale to show how you agree or disagree with each of the following statements, “1” = strong agree, “2” = agree, “3” = undecided, “4” = disagree, “5” = strong disagree

| NO | **ITEMS** | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | Fee for health service is affordable | | | | | |
| 2 | Health facility in my village is good due to cost sharing on health service | | | | | |

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|---|---|---|---|---|---|---|
| 3 | Medicine are available throughout the time at my health facility | | | | | |
| 4 | Buildings of my health facility are good because of cost sharing introduction | | | | | |
| 5 | There are enough doctors and nurses at my health facility | | | | | |
| 6 | Doctors and nurses are very kind when I'm sick | | | | | |
| 7 | I like to pay cost sharing when I become sick | | | | | |
| 8 | Cost sharing on health service excludes disabled people like old, children, and pregnancy women | | | | | |
| 9 | Cost sharing on health services is for rich people | | | | | |
| 10 | I'm self motivated because of cost sharing, thus, I can be paid extra duty and I can attend for short courses | | | | | |