Willingness to Pay for Community Health Fund Card in Mtwarra Rural District, Tanzania

January 2003

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Acronyms

BI  Bamako Initiative
CHF  Community Health Fund
CI  Confidence Interval
CO  Clinical Officer
DANIDA  Danish International Development Assistance
DED  District Executive Director
DHMT  District Health Management Team
DHS  Directorate of Hospital Services
DMO  District Medical Officer
DNO  District Nurse Officer
EDP  Essential Drugs Programme
GOT  Government of Tanzania
HC  Health Centre
HF; HFs  Health Facility
HFC  Health Facility Committee
HMIS  Health Management Information System (MTHUA)
IS  Indent System
MoH  Ministry of Health
MRD  Mtwara Rural District
MSD  Medical Stores Department
MSF  Médecins Sans Frontières
MTUHA  Health Management Information Systems (Swahili name)
NHI  National Health Insurance
OPD  Out Patient Department
PHC  Primary Health Care
PSU  Pharmaceutical Supplies Unit
RMO  Regional Medical Officer
Tshs  Tanzanian Shillings
USD  United States Dollar
VHC  Village Health Committee
WHC  Ward Health Committee
WHO  World Health Organisation
WTP  Willingness to Pay

Exchange Rate in January 2003

1,034.3 Tanzanian Shilling = 1.0 Euro

986.3 Tanzanian Shilling = 1.0 USD
Acknowledgments

We want to kindly thank all the individuals who assisted us in carrying out this field study. We want to especially thank the interviewed people in the villages of Mtwara Rural District who graciously welcomed us. Thanks must be also extended to Mrs. Wakari, District Executive Director of Mtwara Rural and Mrs. Kapinga, District Nurse Officer of Mtwara Rural for their support during the survey. Without their participation this study would not have been possible.

We would like to express our gratitude to the following individuals whose assistance was crucial for facilitating our work.

Dr. Kimbau, District Medical Officer of Mtwara, who unfortunately passed away in September 2002
Dr. Mwakipa, acting District Medical Officer, Mtwara
Members of District Health Management Team, Mtwara Rural
Mr. Francis E. Namaumbo, acting District Planning Officer, Mtwara Rural
Mrs. Jennifer Simbua, District Community Development Officer, Mtwara Rural
Mr. Sendoro at Ministry of Health
Dr. Budotela, District Medical Officer, Songea
Dr. Chuwa, District Medical Officer, Kilosa
Dr. Msengi, District Medical Officer, Masasi
Dr. Massay, District Medical Officer, Hanang
Mrs. Gumbo
Ms. Asha Mtupa
Mrs. Hamida Mwarabu
Ms. Annie Hurlstone
All MSF staff, Mtwara
Executive Summary

The Ministry of Health in Tanzania has established a new programme in the primary health care service. CHF is a district-level prepayment scheme targeted at the rural population. CHF starts in 1995 on a pilot basis in one district and in 2003 has to be implemented in all districts. Mtwara Rural District is in the implementation stage.

This study was proposed for assisting the district in pricing the health service and developing recommendations for the process of CHF implementation. It is focused primarily on the willingness of the population to pay for a CHF card. Price is not the only factor related to willingness to join the CHF. Complex human behavior, choices and motivation can also determine it.

The results of the survey have drawn up the demand curve and constructed the chart of expected revenues from CHF card. Next stage was estimating the Health Facility costs in order to find out the amount of funds to be collected. The CHF card rates proposed are based in maximizing the population under the health care system and covering the HF costs.

The questionnaire prepared for the survey includes a section to know the opinion of respondents about the quality of care provided by MoH health facilities. According to the data obtained, the study proposes to establish the Tanzanian national drug programme (Indent System), before CHF. Indent System changes the drug supply system and might improve the health care quality.

Experiences in African countries are also reviewed. This section contents the constraints identified in other studies about different systems of payment. Evidence demonstrates the dangers associated with charging clients at the point of use of health service. Almost invariably payment systems have the effect of dissuading the poor from accessing this service. Exemption mechanisms attempting to mitigate this impact have not tended to work. The experience suggests querying some issues about CHF.

The study is addressed to two audiences, MRD and MSF. This factor made complex drawing up the document. It was prepared with a view to:

- pricing the health care services
- developing recommendations for the CHF implementation in MRD and
- providing qualitative information about the side effects of the payment systems in the health care sector.
1. Willingness to Pay and Policy Decisions

Willingness to pay (WTP) is a concept used increasingly to inform policy decisions in the health sector. The political environment and declining budgetary resources have raised questions about the efficiency and equity of state subsidies for health care. They also have stimulated financing reforms in health sector.

As a result, decision-makers at the government and community levels are faced with the difficult but important policy question of how to price health services. The problem arises up when a price is only based on costs and takes no account of demand, or people’s willingness and ability to pay that price.

People’s WTP is important because consumer responses to prices will influence service utilization levels and patterns, and revenues collected. WTP studies can help to set prices because they provide information about the demand for a service at a given price, and a hypothetical demand curve can be constructed. Prices might be set at a level which the majority of people are willing and able to pay so that utilization does not decrease, but these prices might be too low to cover costs.

If the decision is taken to raise prices because the WTP survey showed that enough people would still use the service, this may be beneficial in terms of revenue and efficiency, but might discourage utilization by poorer sections of the community.

Willingness and ability to pay are not synonymous. Affordability in terms of not incurring financial difficulties should also have an important place in investigation of health reform.
2. Community Health Fund

2.1 CHF Concept

In 1994/95 the Government of Tanzania (GOT) collaborated with the World Bank’s International Development Association and other donors to design a new approach to improve financial sustainability in the health sector. The Community Health Fund (CHF) was identified as a mechanism for providing additional funds for financing health services in rural areas of the country. The CHF in Tanzania is one programme initiated as part of the health sector reform in the early 1990s. The main aims of the health sector reform are to improve financial sustainability and increase access to health services.

The CHF is a type of pre-payment insurance scheme for rural people. It is based on the concept of risk sharing, whereby “those who get sick will benefit from a fund where patients’ contributions are greater than the outflow of funds”\(^1\). Also this scheme is designed to empower communities in health care decisions and promoting cost sharing with strong local participation.

Each household has the opportunity to contribute to the CHF system by purchasing a health card at a flat rate. A household is defined as a nuclear family including father, mother, and children under 18 years. The card entitles the household to a basic package of curative and preventive health services throughout the year. Households unwilling to join will be required to pay a user fee ticket at health facilities each time a family member attends a health facility. For those who cannot afford to join CHF the district decides the exemption criteria and authorizes the community to make exemptions. Also they can decide to make exemptions for other reasons (i.e. disability, citizens over 60 years of age).

The money from the households is pooled at district level. The CHF funds are matched by the central government. The community in conjunction with the district will decide the use of the funds, based on the needs of the health facilities.

The CHF’s primary support has come from the World Bank in the form of matching funds and coordination of the CHF.

2.2 CHF Evolution

In 1996 CHF was launched in Igunga District and in 1998 the MOH decided to expand the CHF to nine additional districts. In 2001 the Community Health Fund Act was passed establishing the CHF as the official health plan at the village level. It is currently established in 23 districts with the goal of implementation in all districts in 2003. Thirteen districts are in various stages of implementation, some of them started preparations in year 2000 but at present time they have not taken-off due to different reasons.

In the original design, the CHF percentage of members was expected to be 60\(^2\) percent of all households in each district. To date enrollment per district ranges between 3-28 percent of total households where CHF is implemented, and the majority of districts are around 4 percent. Moreover the trend to date has been for members to dropout rather the enrollment of new members.

\(^1\) Shirima 1998, p.111
3. Mtwara Rural District

3.1 District Profile

Mtwara Rural District (MRD) is one of the five Districts of Mtwara Region. It is bordered by Lindi District (Lindi Region) to the North, by the Indian Ocean to the East, the Republic of Mozambique to the South and Tandahimba District (Mtwara Region) to the West.

The District has an area of 3,579 km2 of which 72% is arable. The total area which is under cultivation is 48% of the total arable land. Altitude ranges between zero meters along the Indian Ocean coast and 350 metres above sea level in Njengwa, the highest area in the District.


It comprises of 112 Villages, 18 Wards and 6 Divisions. The divisions are Nanyamba, Mpassura, Mayanga, Ziwani, Kitaya and Dihimba.

Mtwara Region is 650 km from Dar es Salaam.

The main tribe in the district is Makonde.

Over 75 percent of the total population is engaged in subsistence agriculture, although in coastal villages fishing is the main economic activity, and some small-scale salt making industries and transportation.

Given the reliance on agriculture, incomes are highly seasonal and the economy is largely dependent on rainfall. The main food crops are cassava, paddy, maize, millet, fruits, sweet potatoes, pulses, and sesame. Cash earning crop include cashew nut, coconut, and groundnut.

The District has a total road network of 1,134 kilometres, of which only about 25km are tarmac road, 220 km gravel and the remaining is earth road. The roads are in bad condition especially the earth roads due to lack of maintenance and rehabilitation. The District has no railway.

Only 23.6 percent of the district population has access to clean water. The rest of the population depends on unreliable and unsafe water sources which makes prone to water borne diseases³.

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3.2 District Health Services Infrastructure

The District has 33 health facilities (HF) in the public health system: 30 dispensaries and 3 health centres and no District Hospital. Patients are referred to the Regional Hospital in Mtwara Town. There is also a mission Health Centre (HC), run by nuns in Nanyamba. Most of the Health Facilities (HFs) were built in the 1960s and 1970s. 33 Health Facilities, including the living quarters, have been rehabilitated by Médecins Sans Frontières (MSF) since July 1997.

85 percent of the population can reach a HF within 2 hours on foot. The economic accessibility is theoretically high, as all services are free of charge at the peripheral level but CHF is to be implemented at the primary health care level.

The most common diseases are malaria, respiratory and gastro-intestinal infections. They account for more than 50 percent of all morbidity causes. In addition TB, leprosy, AIDS, schistosomiasis and filariasis are endemic.

Life expectancy at birth in Tanzania is 51 years and in MRD it is 46 years. Also in MRD, the infant mortality rate is 146 per 1,000 live births, the under 5 mortality rate is 167 per 1000 live births and maternal mortality rate is 340 per 100,000 live births.

3.3 CHF in Mtwara Rural District

For the time being, services at MOH health centres and dispensaries are provided free of charge. Mtwara Rural District is in the implementation phase of the CHF and it is planned to launch it in 2003.

Full Council made the CHF establishment resolution in February 2002. In February 2002 a district sensitisation meeting, about CHF concept, took place with national level facilitators.

At ward and village levels, members of the District Council introduced the CHF scheme: the concept, activities, how to join and become members. In July 2002 a week of sensitisation took place in all 18 wards, attended by ward leaders (around 10 people in each ward).

At village level the sensitisation was from the 25th July to 16th August 2002 in 112 villages. The attendants average was 34% of village population, within 75% males and 25% females.

A CHF Swahili guideline published by MOH was delivered to every village.

CHF card will be for the annual treatment of a household. In MRD the household definition includes father, mother and six children below the age of 18. In polygamous situations, each wife constitutes a separate household. A household deemed unable to pay will be exempted from CHF or user fees payment.

The user fee will be per person and per disease episode of 2 weeks.

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4. Survey Methodology

The survey aimed to provide empirical and qualitative data on:

- Participants’ willingness to pay for the CHF card and user fee
- Use of the MOH dispensaries and health center
- Perceptions of the quality of care provided by the MOH dispensaries and health centers

4.1 Locations and Participants

The survey was held at village level. The district is divided into 18 wards. The survey was conducted in 17 of 18 wards. From each ward, one village was selected. The distribution of participants throughout each ward, as well as the location is illustrated in Table 1.

<table>
<thead>
<tr>
<th>Ward</th>
<th>village</th>
<th>population</th>
<th>participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ndumbwe</td>
<td>Mpapura</td>
<td>2.695</td>
<td>10</td>
</tr>
<tr>
<td>Kitere</td>
<td>Libobe</td>
<td>3.809</td>
<td>20</td>
</tr>
<tr>
<td>Naumbu</td>
<td>Mgao</td>
<td>1.264</td>
<td>11</td>
</tr>
<tr>
<td>Ziwani</td>
<td>Mnawene</td>
<td>2.671</td>
<td>21</td>
</tr>
<tr>
<td>Kiromba</td>
<td>Kiromba juu</td>
<td>1.972</td>
<td>23</td>
</tr>
<tr>
<td>Namtumbuka</td>
<td>Mnongodi</td>
<td>1.876</td>
<td>22</td>
</tr>
<tr>
<td>Nanyamba</td>
<td>Dinyecha</td>
<td>2.063</td>
<td>18</td>
</tr>
<tr>
<td>M廷iko</td>
<td>M廷imbwillmbwi</td>
<td>2.541</td>
<td>30</td>
</tr>
<tr>
<td>NitekeLa</td>
<td>Nyundo</td>
<td>2.168</td>
<td>26</td>
</tr>
<tr>
<td>Ziwani</td>
<td>Msangamkuu</td>
<td>4.349</td>
<td>30</td>
</tr>
<tr>
<td>Kitaya</td>
<td>Kitaya</td>
<td>2.187</td>
<td>31</td>
</tr>
<tr>
<td>Mahurunga</td>
<td>Mahurunga</td>
<td>3.800</td>
<td>32</td>
</tr>
<tr>
<td>Nanguruwe</td>
<td>Nanguruwe</td>
<td>3.127</td>
<td>34</td>
</tr>
<tr>
<td>Mnima</td>
<td>Mnima</td>
<td>4.170</td>
<td>40</td>
</tr>
<tr>
<td>Njingwa</td>
<td>Hinju</td>
<td>1.565</td>
<td>22</td>
</tr>
<tr>
<td>Dihimba</td>
<td>Lyowa</td>
<td>2.368</td>
<td>32</td>
</tr>
<tr>
<td>Madimba</td>
<td>Msimbati</td>
<td>4.630</td>
<td>33</td>
</tr>
</tbody>
</table>

The selection of the villages provided a geographical cross-section of opinions and attitudes. The average time per interview was 20 minutes. The participants were randomly selected by conducting site visits to the villages. This was done to achieve a more geographically dispersed sample. Prospective participants met the following criteria:

- Be a Tanzanian citizen
- Be the head of the household
It was assumed that usually the head of the household are males and they have more influence on household spending decisions. In order to capture meaningful information on willingness to pay for health services, it was important to pose questions to those with the most influence on household spending. A total of 467 questionnaire forms were returned from the 17 villages, of which 435 with complete information were analyzed. Confidence Interval (CI) is 95 percent.

4.2 Survey Structure and Data Analysis

The head of the household was surveyed by questionnaire (Annex A). The questionnaire was written in swahili, and the interview was also done in swahili.

The questionnaire contained the following parts: demographic information, ability to pay, type of user and current user of the health facilities, sensitisation and willingness to pay for CHF card and user fee ticket. Ability to pay was estimated by asking cash and non-cash income for one year.

After an initial workshop, with the main aim of training the interviewers, the fieldwork was executed in 17 days in September-October 2002. The preliminary arrangements to implement the study were made in two-week periods in-between the fieldwork periods. One supervisor and 4 interviewers (three staff from the district and one from MSF) were recruited. The supervisor was responsible for organizing the initial village meetings to explain the study procedures and obtain community consent.

Completed questionnaires were examined and data were entered in Epi-Info 2000. The analysis was undertaken using Epi-Info 2000.
5. Characteristics of Respondents

The decision governing whether or not respondents would join the CHF system will be determined by several factors, including age, marital status, family size, education and household income. This section provides an overview of the demographic and social attributes of the respondents.

5.1 Age

As one of the survey criteria was being the head of the household, therefore most of the participants were males. The average age of male participants was 43 years. Of the respondents, 25 percent were age 36 to 45 years. The age distribution of all respondents is indicated in Figure 1.
5.2 Household Composition

As depicted in Figure 2, 27.9 percent of respondents reside in households of one to three members, 45.4 percent in households of four to six members, 19.1 percent in households of seven to nine members, and 7.6 percent in household of 10 or more.
5.3 Marital Status

As illustrated in Figure 3, approximately 72 percent of respondents were married, 9 percent were single and 19 percent were widowed or separated or divorced.

![Figure 3: Distribution of Respondents by Marital Status](image)

5.4 Education

39.9 percent of respondents have no grade completed, 58 percent have primary school and 1.4 percent has secondary school and 0.7 percent some college.

The results do not include female sector since most of the participants were males.

![Figure 4: Distribution of Respondents by Education](image)
5.5 Occupation

Ninety-five percent of all respondents were farmers. In Mtwara Rural District the main cash crop is cashew nut.

![Figure 5: Distribution of Respondents by Occupation](image)

5.6 Household Income

46.7 percent of respondents reported household incomes of less than 20,000 Tshs over a year. 18.2 percent reported household incomes in the range of 23,000-50,000 Tshs, 5.5 percent in the range of 55,000-70,000 Tshs, 15.6 percent in the range of 80,000-100,000 Tshs, 9.9 percent in the range of 110,000-200,000 Tshs, and 4.1 percent with household incomes in the range of more than 200,000 Tshs.

The majority of respondents have annual incomes of less than 20,000 Tshs.

![Figure 6: Distribution of Households by Annual Income](image)
6. Willingness to Pay

To estimate how many users the CHF system would have at a given price, it is assumed that user volume will decline if prices increase, following the “law of demand”. The “law of demand” states that demand is inversely related to price. As prices increase, use declines, and as prices decline, use increases. Demand curve can be defined as the relationship between price and clients. The following assumptions have been taken in account to calculate the demand curve:

- Respondents’ maximum price is the highest price he/she has explicitly agreed to. For instance: If a respondent answers no to 500 Tshs and yes to 300 Tshs, the maximum price would be 300 Tshs.
- Respondents who are willing to pay a given price for a service are also willing to pay any lower price for that product or service. I.e.: If a respondent answers yes to 500 Tshs are also willing to pay any price lower than 500 Tshs.
- Respondents who are not willing to pay a given price for a service are also unwilling to pay any higher price.

WTP is a survey technique for estimating the use of a service at different prices.

6.1 Willingness to Pay for CHF Card

Participants were asked how much they would be willing to pay for a Community Health Fund card. After responding to two direct pricing questions, all were asked to name the highest price they were willing to pay. The results were expressed in Tanzanian Shillings.

In the Figure 7 is drawn the absolute demand estimation that explains how many users the system would have at a given price.

82 percent were willing to pay the second price asked, 3,000 Tshs and 62 percent were willing to pay the first price asked, 5000 Tshs. Only 30 percent were willing to pay the highest price, 7000 Tshs, and 16 percent were willing to pay more than 7000 Tshs.
6.2 Expected Revenues from CHF Cards

Expected revenues are calculated by multiplying expected number of users by price per unit use. Being able to predict user response to price levels would help to estimate the impact of a proposed price increase on both revenues and use of service.

Figure 8 presents expected revenues for CHF system at different prices. The data are Willingness to Pay for CHF card and its different prices (do not include matching funds).

The lowest price directly asked was 3,000 Tshs. At this price the potential revenue is 126,149,214 Tshs. The percentage of households covered by the system would be 82 percent.

If the price were 5,000 Tshs, the potential revenue would be 158,227,103 Tshs. And the percentage of CHF membership would be 62 percent.

At 2,000 Tshs, the percentage of households under the CHF system is 87 percent and the potential revenue 89,769,103 Tshs.

![Figure 8: Expected Revenue from CHF cards](image)

Tanzanian experience with CHF shows that to date enrollment per district ranges between 3-28 percent\(^5\) of total households. And most of the districts have 4 percent. This level is much lower than the willingness expressed by the respondents.

If MRD follows the 4 percent average, the results would be the following ones:

- At 3,000 Tshs the potential revenue is 6,165,720 Tshs
- At 5,000 Tshs the potential revenue is 10,276,200 Tshs

### 6.3 Willingness to Pay for User Fee Tickets

53.1 percent of 435 respondents answered that if the price of a CHF card were more than their highest price, they will buy a User Fee ticket. After responding to two direct pricing questions, all were asked to name their highest price.

53 percent were willing to pay the second price asked, 300 Tshs and 49 percent were willing to pay the first price asked, 500 Tshs. Only 31 percent were willing to pay the highest price, 700 Tshs, and 16 percent were willing to pay more than 700 Tshs.

![Figure 9: Willingness to Pay for User Fee Ticket](image)
Figure 10 presents expected revenues from user fee tickets at different prices. It is assumed one contact per inhabitant and per year. Calculation is based on the survey findings that 51.3 percent of respondents would buy a user fee ticket if the price of the CHF card were too high. (Under five children 19.4 percent and pregnant women 5.2 percent are excluded in the total population because the national policy exempts them of payment).

The lowest price directly asked was 300 Tshs. At this price the potential revenue is 13,287,553 Tshs. The percentage of users would be 53 percent. If the price were 500 Tshs, the potential revenue would be 18,829,076 Tshs. But the percentage of users would decrease to 49 percent.
6.5 WTP and Household Income

People's WTP is an important factor for decision-makers to consider, because consumer responses to prices will influence service utilization patterns and revenue collected. On the other hand health expenditures may impose considerable costs on household consumption and investment patterns, and may start a process of asset depletion and impoverishment. Household decisions on how to allocate limited resources to health, education and other essential commodities may have serious consequences for the household and individuals within it.

27.8\(^6\) percent of the respondents would go without health service when the price of a CHF card was higher than the price the user wants to pay. And 32.6 percent has the same answer for a User Fee ticket.

Adding both percentages there is 60.4 percent of the respondents who chose this answer. In other words, 60.4 percent of the respondents say that will not to go to the HF if they cannot afford it.

The following example shows some expenses of a household in MRD.

We consider a household with 3 children in school age and an income in cash of 20,000 Tshs. They have to pay

1. children education: they have to buy uniform, shoes and school material for the three children.

   The total cost for education would be:
   
   uniform \(2,000\text{Tshs} \times 3 = 6,000\text{Tshs}\)
   
   shoes \(2,000\text{Tshs} \times 3 = 6,000\text{Tshs}\)
   
   school material \(2,000\text{Tshs} \times 3 = 6,000\text{Tshs}\)

   **Total expenses for education would be 18,000 Tshs**

2. the new Tanzanian health policy ask the households to be a membership of the CHF. The price for a CHF card is 3,000 Tshs.

3. water fees: in the village the price of a 20 liters of water (one bucket) is 20 Tshs and the household consumes 4 buckets per day:

   \(20 \text{Tshs} \times 4 \text{ buckets} = 80 \text{Tshs per day}\)
   
   \(80 \text{Tshs} \times 365 \text{ days} = 29,200 \text{Tshs per year}\)

   **Total expenses for water would be 29,200 Tshs**

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\(^6\) See Annex B
46.7 percent of the households have from 0 to 20,000 Tshs for a year, it means that some of them could not pay the education of the children and neither the CHF card, others they could afford just the CHF card and others they would pay just for the education and not for the CHF card.

Education, health and water sum an amount of 50,200 Tshs per year. 64.9 percent of the households have less than 50,000 Tshs in cash, therefore they cannot afford to pay for education, health and water services.

As a result of income constraint there are households unable to pay for health care. A household which does not consume the health care externally defined as necessary for a given health problem, it could only purchase the health care it needs by cutting expenditure on other goods and services to a sub-minimum level. This situation is where the household is willing to pay for necessary health care, but unable to pay if other costs are taken into account.

Sacrificing consumption of essential commodities to pay for care suggests that the household is facing an affordability problem.
6.6 Willingness and Ability to Pay

The affordability of essential services like health care has become a critical policy issue in many countries because people are increasingly being expected to contribute more from their own pockets, as a result of health sector financing reforms. In countries undergoing stabilization and structural adjustment programmes, the question of affordability is particularly urgent because households often face combined payments burdens from various essential service sectors such as health, education and water, while food prices are rising.

People’s WTP is an important factor for decision-makers to consider, because consumer responses to prices will influence service utilization patterns and revenue collected. On the other hand health expenditures may impose considerable costs on household consumption and investment patterns, and may start a process of asset depletion and impoverishment. Household decisions on how to allocate limited resources to health, education and other essential commodities may have serious consequences for the household and individuals within it.

Income ratios to examine affordability are based on concern that health care expenditure should not impose an “unreasonable burden” on household budgets. This reflects concern about the opportunity cost of health expenditure: if a household spends more than X percent of its budget on health, the ratio approach warns that the household’s command over other commodities will be reduced.

The costs of accessing health care (e.g. transport costs, health charges) can be considered affordable when utilization is not deterred for financial reasons, and when the opportunity costs incurred do not cause levels of consumption and investment to go below minimum needs in the short run. Payment for care may have serious financial consequences for the household when an income-poor household may have to make damaging cutbacks to food consumption and education or may be forced to sell assets.

A shift in perspective is needed to give greater emphasis to equity when assessing the effects of any proposed policy changes on health and social well being of families.
7. Estimating the Cost of Needed Resources

Cost information can be used to estimate resource requirements for the delivery of the basic health service package. The objective is costing the recurrent expenses of a health facility.

There are some steps to be followed in costing:

- identify the resources used to produce the services being costed
- estimate the quantity of each input used
- assign monetary values to each unit of input and calculate the total cost of the input
- allocate the costs to activities in which they are used

The total cost of an item is equal to the quantity consumed multiplied by the price of the item. The costs list in a health facility includes:

- Personnel: individual’s gross earnings (salary + any tax + any insurance)
- Medical supplies: drugs, medical equipment, vaccines... The full financial cost of supplies should include the cost of transportation to point of use.
- Equipment recurrent costs: the main costs are likely to be for operating refrigeration and sterilization equipment (kerosene, gas,...)
- Cleaning material
- In-service training: the daily cost of training should include subsistence allowances paid to participants or the cost of accommodation and meals, as well as materials and other costs.
- Building recurrent costs: the type of input to be included is painting and rehabilitation costs. Materials costs should be included (we do not include the labour costs because the community contributes in labour).

Estimating the recurrent cost is an essential component of planning and budgeting, finding the resources for the budget is the next step. The recurrent costs identified for each HF are: personnel, medical supplies, equipment recurrent costs, cleaning material, in-service training and building maintenance costs.

Currently the MoH, through the district, provides the resources for the delivery of health service in Mtwara Rural District. Although national policy a long term may suggest other sources of financing, so far the government finances the costs in a dispensary and health centre. Nonetheless they are not enough for covering all activities, particularly for building maintenance. CHF will be the main source for financing building maintenance costs of a Health Facility.

In Mtwara Rural District there are 3 Health Centres and 30 Dispensaries. The annual maintenance costs\(^7\) per facility are shown in Table 2.

---

### Table 2: Annual Maintenance Costs per Health Facility

<table>
<thead>
<tr>
<th>Health Centre</th>
<th>Dispensary</th>
</tr>
</thead>
<tbody>
<tr>
<td>584,600 Tshs</td>
<td>350,110 Tshs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Facilities</th>
<th>3 Health Centres</th>
<th>1,753,980 Tshs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensaries</td>
<td>30</td>
<td>10,503,300 Tshs</td>
</tr>
</tbody>
</table>

| Annual maintenance costs for 33 Health Facilities | 12,257,280 Tshs |

In order to finance the maintenance costs of the 33 Health Facilities, the district needs around 12.3 million Tshs per year.

In the CHF scheme the funds collected will be matched by the central government. The total amount collected in a district will be increased in the same amount.

The revenue will include the funds collected in each HF from Community Health Fund memberships, the matching funds and the funds from user fee tickets.

**Example 1: User fee tickets are not included.**

For a 4 percent of coverage rate and 3,000 Tshs per CHF card, the potential revenue is 6,165,720 Tshs

\[
\begin{align*}
6,165,720 \text{ Tshs} & \quad \text{annual CHF collected amount} \\
+6,165,720 \text{ Tshs} & \quad \text{matching fund}
\end{align*}
\]

12,331,440 Tshs total resources for the HF of MRDistrict

More than six million of Tshs collected from the CHF memberships and the same amount matched by the MOH, makes a total amount over twelve million Tshs. for the 33 HF in Mtwara Rural District.

12,331,440 Tshs is an amount that covers the needed resources for the 33 HF in Mtwara Rural District.

In this example we do not include the amount of the user fee tickets. In the districts where the CHF is implemented, the money collected from the user fee ticket is a higher percentage than the one collected from the CHF card.

**Example 2: Including user fee tickets**

At 300 Tshs for a user fee ticket, the potential revenue is 13,287,553 Tshs

\[
\begin{align*}
6,165,720 \text{ Tshs} & \quad \text{annual CHF collected amount} \\
6,165,720 \text{ Tshs} & \quad \text{matching fund} \\
+13,287,553 \text{ Tshs} & \quad \text{amount collected from the user fee ticket}
\end{align*}
\]

25,618,993 Tshs total resources for the HF of MRDistrict

More than six million of Tshs collected from the CHF memberships, the same amount matched by the MOH and the revenue from the user fee ticket makes a total amount over twenty five million Tshs for the 33 HF in Mtwara Rural District.
In example number 2 the total resources for a year are more than double the amount needed. Resources can be used in rehabilitation, stationary for the Health Facilities or other planned activities.

It is important to point out that revenues are calculated for a coverage rate of 4 percent. In the case of 10 percent, revenues would widely increase.
8. CHF and Indent System

The government of Tanzania embarked on a programme of health sector reforms beginning in the early 1990s. The MoH initiates and implements a variety of programmes in this reform and one of them proposes to change the drug supply system.

8.1 Indent System

Health center and dispensaries are provided with a preset, sealed drug kit each month. The preset drug kit is not optimal for all facilities in Tanzania, with its four to five different climatic zones, the kit is wrong by definition. The kit cannot cater for all diseases and will always over-supply a drug which is not used in the highlands and under-supply a drug which is needed in an area with a high malaria prevalence.

The Indent System, the envisaged revision of drug supply at PHC level from a “push system” (see what you receive) to a “pull system” (acquire what you need), is one of the sizeable activities of the Pharmaceutical Supplies Unit (PSU) of the MoH, a unit in the Directorate of Hospital Services (DHS). In 1996 a “Project Proposal” for the “Indent System” was supported by Danida, in which the supply system was outlined. Since the approval of the document, MoH also decided to introduce “cost sharing” at the PHC level.

The IS was developed in the perspective that the MoH will gradually adopt the change from the push system to an order based system. A fundamental change will occur in comparison with previous tasks, the order will be done at the HF level. Ordering according to needs means a quarterly “supply cycle” of defining and processing the order.

The system should promote and support three outspoken health policy and health care goals:

- availability of drugs
- affordability of drugs
- accessibility of the drugs service

The maximum amount allowed to order is equivalent to Essential Drugs Programme (EDP) kits value and a little margin of 7.5% for envisaged price-rises at Medical Stores Department (MSD).

The amount for each facility is:

- Dispensary: \[ 4 \times \text{Tshs} 172,000 + 7.5\% = \text{740,000 Tshs for a quarter} \]
- Health Centre: \[ 4 \times \text{Tshs} 330,000 + 7.5\% = \text{1,440,000 Tshs for a quarter} \]

The HFs where IS is implemented do not expend all available funds and the remainder accumulates for the next order.

---

8.2 Links between Community Health Fund and Indent System

The inadequate drug supply and distribution systems can undermine the population’s willingness to use the public services. One of the purposes of the Community Health Fund is to improve the quality of health services and one component of this objective is the availability of drugs at the HFs.

The survey results show that 94.7\(^9\) percent of households go to a public HF when ill and 51.5 percent proposes to improve the quantity of drugs available at the HFs. This last percent reflects an important lack in public health facilities.

It is expected that when the CHF will be implemented, HF users will request a better service. Concerning drugs, Indent System can be one mechanism for improving health service quality.

Implementing the Indent System six months before CHF, means that each HF will order the needed drugs, the Medical Store Department will provide them and the drugs will be available for the patients at the HFs.

If the availability of drugs is a reality, the population will notice an improvement in the health service and it might reinforce the population’s willingness to use the public HF. Indent System running can help the CHF implementation.

\(^9\) See Annex B
9. Experiences of Payment Systems in Africa

Since the 1980s the number of African countries implementing some form of payment has grown considerably. Governments have come to see fees as a critically important alternative to tax-based financing for government health services in Africa, even in countries such as Kenya and Tanzania, which had previously provided government carefree at the point of use. The most discernible lessons pertain to implementation problems and requisites for surmounting them.

The desire to raise revenue and improve services can presumably be related to a concern to enhance the sustainability of health systems. Financial sustainability can be defined simply as generating sufficient reliable resources to enable continued and improved provision of health care for a growing population.

Generating revenues through some sort of financing mechanism is insufficient by itself to ensure sustainability. Additional measures to redress existing inefficiencies in resource use and to enable any additional revenue to be used effectively over time are vital elements of a sustainable and effective payment system.

9.1 Bamako Initiative Model

The Bamako Initiative model sees community participation in management as the critical mechanism of ensuring that revenues are used in ways that address the persistent quality weaknesses of primary care, and that the health system is accountable to the users of health care. Thus under this model, the community should determine the financing mechanism that is adopted, which might be a user fee system (with or without a community-determined exemption mechanism), prepayment or some form of local taxes.

The BI model is seen as a strategy towards the long-term sustainability of PHC (primary health care). It is intended to raise revenues and ensure effective resource use through the development of community management capacity, and thus permit self-reliance.

The decentralization of control over resource use to regional or district levels, identified as an element of the standard model, can also be seen as a strategy for developing the needed capacities to ensure sustainability, such as developing community management or enabling community participation.
9.2 Impacts on Equity

Payment systems may influence provider behavior, and so have consequences for efficiency, while fee systems may be associated with parallel actions that influence the distribution of benefits and burdens associated with using health care (which is critical for equity). The evidence about these effects is, however, conflicting, because fee systems have been implemented in different ways in different countries, and often not as theory suggests would be best practice. Fees have sometimes had the unintended and undesirable effect of exacerbating existing inequities.

The following points are a summary of impacts with respect to equity from some reviews of experience: Gilson and Mills (1995); Gilson, Russell and Buse (1995); Kutzin (1995); Nolan and Turbat (1995).

1. fees by themselves tend to dissuade the poor from using health services more than the rich and are associated both with delays in accessing care and with increased use of self-medication and informal sources of care (Booth and others 1995)
2. evidence suggests that if fees are associated with quality improvements, as in community financing schemes, this offsets their negative impact on utilization, and the introduction of fees plus quality improvements may even generate utilization increases (Litvack and Bodart 1993)
3. a few studies show that the nature of the payment mechanism has an important influence on its utilization and equity impact. Pure user fee systems are more likely to enhance inequities in access to health care than those that allow for risk sharing and / or prepayment (Diop, Yazbeck, and Bitran 1995), but fees levied for services received (such as drugs) are less likely than general consultation fees to discourage utilization (Collins and others 1996).
4. fees do not appear to generate adequate revenue or to be associated with the resource reallocations necessary to enable substantial and sustained improvements in health care for the poor.
5. the implementation of both formal and informal exemptions that could protect the poor from the full burden of fees is usually ineffective, because they do not in practice protect the poor, and may instead benefit more wealthy groups.
6. the differential implementation of fees between geographical areas within a country can create geographical inequities, particularly if regions whose income levels differ are expected to recover similar proportions of their costs.
7. few investigations have been carried out of poorer households’ ability to pay fees, that is, of the impact of fees on household budgets, on consumption and investment decisions, and therefore on the processes contributing to sustainable livelihoods and the household production of health. Yet the limited available experience hints that in some countries sizable numbers of people who require medical attention and have previously obtained it are staying at home, and in some cases, dying, because they cannot afford to pay.
9.3 Revenue Generation and Sustainability

Experience shows that revenue levels vary over time, sometimes increasing because of improved implementation practices, but sometimes falling as a result of inflation or such problems as war or economic recession. Thus while some countries have achieved higher levels of revenues than others, their sustainability is unclear. Nonetheless, the available information suggests that revenue generation from fee policies in public facilities will likely be inadequate to address the large and growing resource gap that is causing the quality shortfalls that exist in public (as well as in most private) health facilities in many African countries.

A Tanzanian study of decentralization (Mogedal, Steen, and Mpelumbe 1995) suggests that the effective implementation of a payment system would itself require a strong, decentralized management structure.

For access to quality health care for rural populations to be sustained, the contribution system should not only be accompanied by quality improvement measures, but also by cost containment measures, such as drug policies which promote the acquisition of essential generic drugs in competitive markets, and human resource programmes which strengthen management capacities and control drug consumption costs at health facility and district levels.
9.4 Bottlenecks to Effective Implementation

Experience suggests that the following groups of constraints undermine the effective implementation of payment systems.

Poor capacity for local-level financial management and system implementation as shown in:

- lack of financial management skills throughout the health system, but especially at the district or community level
- absence of appropriate financial management information and audit systems that support management rather than simply seeking to prevent misuse of finances
- lack of information with which to target the poorest effectively through exemptions
- limited local authority to take appropriate resource use decisions without reference to higher authorities
- limited effectiveness in collecting money, thereby undermining revenue generation rates and revenue use for quality improvements
- lack of guidance on financial management and control practices, for instance, on how to determine who is eligible for exemptions, on how to account for revenue generated, or on procedures for using revenues
- failure to retain revenues locally, thereby undermining the incentive to collect them and use them for local-level quality improvements
- absence of procedures that would allow monitoring the impact of policy implementation

Weak supporting systems as demonstrated by:

- poor quality public services that undermine the population’s willingness to use them, for instance drug shortage or poor staff attitudes
- inadequate human resource policies that do not promote or sustain staff commitment
- inadequate drug supply and distribution systems
- operational inefficiencies within the health system that contribute to quality failures, for example, drug wastage and abuse, leading to shortages
- limited funding for the supervision and support needed at the primary level
- inadequate management information systems that do not, for example, allow resource use to be related to services provided
- organizational structures that generate weak and conflicting lines of accountability, both downward to the community level or upward to technical supervisors

Contextual constraints such as:

- the population’s lack of experience in paying for public health services, which generates an unwillingness to pay for them, especially when they perceive the services as providing only low quality care
- the weak banking and communication systems, which undermine local-level financial management and the potential for support
- a variety of sociocultural and political constraints at both local and national levels that allow richer groups to be incorrectly exempted and prevent the reallocation of resources to primary health care, which would benefit the poorest members of society the most.
9.5 The Process of Implementation

Recent reviews of health sector reforms point to the importance of a comprehensive process of reform based on careful analysis of problems, leading to the development of appropriate implementation strategies.

The implementation strategy therefore has a critical influence over the development of an effective policy package:

- advocacy before, during, and after implementation is a critical element in garnering the political support that is often required to enable effective implementation
- information strategies undertaken before implementation of a new system can develop community awareness and understanding of such a system, and so offset utilization decreases
- prior improvement of the quality of care provided in government health facilities can enhance community acceptance of the policy
- involvement of a wider range of interested actors or stakeholders in the process of developing and implementing policy can both inform and attract their support for the process. Particularly critical are the service providers, who must implement the policies and the community, which must accept the policies.
9.6 CHF Experience in Tanzania

The Tanzanian CHF was established by the Ministry of Health on a pilot basis in Igunga District in December 1995. The design of the project was based on the assumption that the essence of strong community involvement is for the community to take on the responsibility for generating, using, and controlling financial resources. The principal objectives of the CHF were to increase access and control costs. Currently, the CHF is made up almost exclusively of public sector facilities. However, the intention of the scheme (and the government health reform plan) is to include private sector and mission providers in districts where they exist.

At the time of introduction of the scheme, user fees were implemented in the same districts and an exemption policy introduced for potential CHF members. Fees collected go into the CHF along with premiums paid and matching funds (equal to premiums collected in the district) from the central government. The fund’s primary financial support (matching fund) has come from the World Bank. To ensure access to health services for vulnerable groups, there are national exemption policies (the government recommendations are to exempt not more than the 5 percent of households\(^{10}\)). The exemption policy includes under fives, pregnant mothers, family planning services, tuberculosis, leprosy and other chronic diseases. The districts implementing the CHF are not recognizing all these exemptions.

Although membership has remained very low, the government expanded the CHF to 10 districts in 1998. In 2001, the Community Health Fund was passed establishing the CHF as the official health plan at the local/community level. The CHF is now being rolled out on a national basis. There is a political pressure to expand to all districts in 2003.

At the same time the MOH is promoting and expanding the Community Health Fund, the Tanzania government is moving ahead with the development of a National Health Insurance Scheme (NHIS) for the formal sector. NHIS was introduced in July 2001, covering all civil servants for inpatient and outpatient care. Fees include a deduction from the employee’s salary (3 percent contribution from the employer).

The expectation is that these two plans, CHF and NHIS will be linked at the District level. But policies need to be clarified so that civil servants are not required to participate in both the NHIS and the CHF, thereby double-paying for primary care services.

Problems experienced by the CHF and identified in previous evaluations of the scheme include:

- low enrollment
- inadequate community awareness about the CHF
- lack of accountability to community
- minimal use of exemption programme
- loss of premiums collected
- unclear definition of CHF policy at district level
- lack of capacity of the Health Facilities Committees
- lack of preparedness of the DHMT to implement and supervise the CHF system
- no formal CHF training from the Ministry of Health was provide to some Districts
- lack of commitment on CHF at district and HF level
- minimal use of funds collected

9.7 Community Health Fund Issues

It is essential that districts planning in implementing the system should reflect upon experiences and lessons learnt to date. On the other hand, some questions arise from these lessons.

**Insurance and Pre-Payment Concepts**

The “insurance thinking” is difficult to settle with the public. They are concerned with the problems of today, while those of tomorrow will be solved tomorrow.

A year long of pre-payment just in case some members of the household will feel sick, is a very ambitious scheme for implementing and getting some results in a short term. The “pre-payment concept” requires time and effort for the community to become aware of.

*How to adapt the population from a free service to a payment service?*

**Exemptions**

The primary goals of CHF are to ensure equity and increase access to health services. The exemptions are the tools for achieving these goals.

The community does not know that the exemptions exist, does not have a good understanding about the exemption criteria and exemption procedures. Implementation of a defined and clear exemption policy is required to ensure that nobody is excluded of health care services.

*Does the 5 percent reflect the reality or is just an economic decision for making the system sustainable?*

*Is there any research about the attendance in HFs before and after the CHF?*

**Community Awareness**

In the districts where CHF is implemented, community members have little understanding of, or participation in, the management of the CHF. The community is not informed about decisions made or actions taken by the committee with regard to the CHF. The CHF members do not attend meetings to discuss the programme or use of CHF funds, or voice suggestions or complaints regarding the CHF. Most CHF members do not know whom they should inform of problems concerning their CHF programme.

The community is asked to take financial responsibility without explaining them the system, their rights and responsibilities.

*Is the community strong enough to take on the responsibilities?*
**Budgeting and Planning**

The decentralization process is a national and multisectorial process. Before the CHF system implementation, resources and efforts invested in trainings about planning and budgeting have been not enough. Financial management tools and information systems must be developed at district level and facility level in order to improve the management capacity. Increasing the human and financial resources can help for managing, supervising and monitoring the system.

**Health Facility Level**

*Are the relevant stakeholders at community level capable enough to manage the collected funds and planning and budgeting the activities of the HFCs?*

*Is it appropriate for the clinical staff at HF to assume responsibility of money collection and record-keepings?*

**District Level**

*Has the government considered all the necessary resources for improving the capacity of all stakeholders, especially at District level?*

*Is the staff at district level sufficient and enough trained for facing the implementation and supervision of the new system?*

**Payment at Once**

The MRD population is engaged in a subsistence economy predominantly, most households have limited access to a cash incomes earned by selling crops both staple or cash. This income is seasonal and dependent on external forces: weather patterns and international markets.

The CHF system is designed for collecting money in cash and at one payment. It does not offer the possibility of payment in kinds, installments or some sort of credit. This condition is favorable for traditional healers and private pharmacies who accept different types of payment.

*Is nowadays this system compatible with a subsistence economy?*
10. Conclusions and Recommendations

This study is focused in the willingness to pay for the CHF card and not specifically to evaluate CHF success. Taking advantage of all the information gathered during the study, this work proposes some keys for an effective implementation of the system.

10.1 Conclusions

The results of the survey may have several important implications for the CHF in Mtwara Rural District. The results also provide valuable insights on the public’s perception of the quality of MoH services.

Household size, education, annual income, occupation show the portrait of the population of MRD. 45.4 percent of the households have from 4 to 6 members, 39.9 of the heads of the households have no grade completed, 95.7 percent are farmers and the 46.7 percent of the households have an annual income in cash from 0 to 20.000 Tshs. In MRD the population is engaged in a subsistence economy where cash is non existent.

The limited financial resources of the potential membership is a major problem. These results mean that the MRD will need to carefully design and implement the exemption policy, (even if the recommendation of the MoH are to exempt of payment not more than the 5 percent of households).

The challenge for social programmes is to set prices low enough to be affordable for the population and yet high enough to be sustainable. In order to make rational pricing decisions two values have to be compared, demand curve and recurrent costs. In other words, estimating how many users the programme would have at a given price and how much financial resources the HF will need.

After considering the results of the survey, analyzing HF's costs and CHF system design, the findings are going no further than the following rates:

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF Card</td>
<td>3.000 Tshs</td>
</tr>
<tr>
<td>User Fee at Dispensary</td>
<td>300 Tshs</td>
</tr>
<tr>
<td>User Fee at Health Centre</td>
<td>500 Tshs</td>
</tr>
</tbody>
</table>

There are several cultural issues that require attention before launching a new payment system. The CHF system is to be voluntary, therefore the sensitisation is an important activity before starting the system. The concept of insurance is poorly understood and a barrier to people’s willingness to pay premiums when they are not sick.

Regarding population awareness, sensitisation should be a continuous process before, during and after the implementation of the CHF.

The results are also rich in feedback to the MRD on various aspects of the quality of services delivered by MoH facilities. The quality of MoH services should be improved before the district introduces the CHF system.

94.7 percent of households go to a public HF when ill. And 51.5 percent will improve the quantity of drugs available that reflects an important lack in public health facilities.
It is important to point out the percentage of respondents who would go without health service when the price of a CHF card or a User Fee will be higher than the price they want to pay. 60.4 percent of the respondents say that they would not go to the HF if they cannot afford it.

Achieving equity, efficiency, and, in particular, sustainability requires implementing a broader policy package to develop the skills, systems, and mechanism of accountability critical to ensure effective implementation. Some local control of revenues at primary level is an element of this package, but equally important are supporting systems, such as those associated with drugs and human resources. In addition, the process of policy development and implementation is itself an important aspect of this package, as it enables the development of the full range of capacities necessary to ensure sustainability.

Policy analysis is a useful tool for strategic management in the health sector and for developing processes that help the effective implementation of any health care financing reform. A simple analytical model identifies the four key factors that governments should consider when developing the CHF system: the context of implementation, the actors influenced by implementation, the content of the policy package, and the process of its implementation.

Increasing community participation, implementing the exemption policy and improving health services are the most important areas in the CHF implementation.

### 10.2 Recommendations

Mtwara Rural District has the opportunity to implement the CHF system incorporating the lessons learned from other districts.

These recommendations are developed by gathering information from other districts, other countries and analyzing their problems in order to avoid the difficulties faced.

**Rates for the CHF card and User Fee Tickets**

- 3.000 for the CHF card
- 500 for User Fee at Health Centre
- 300 for User Fee at Dispensary

**Before the CHF Implementation**

**District Level**

*Exemptions*
- Defining a clear exemption policy to exempt the population not able to pay the health care service.
- Implementing the national and district exemption policy.
- Reporting the community about the exemption procedure.
**Sensitisation**
- Advertising the CHF system by Radio Tanzania before the CHF implementation.
- Advertising the CHF system at schools.
- Publishing the membership rights in the CHF system, right to participate with their opinion and the right to decide the use of the money belonging to the community and to be spend in the HF.
- Explaining the population the economical advantages of being a CHF membership rather than paying for user fee ticket.
- Designing a guideline with the CHF policy at district level: exemptions, rights of a membership, health services covered for the memberships (can a membership be attended in the entire district or not?, can a membership be attended at the hospital or not?)
- Delivering the swahili guidelines for each HF with the previous contents.

**Policy Design**
- Extending the types of payment like the possibility of paying half of the total amount of the CHF card and being a membership for 6 months. The user gets the service for the period paid.
- Offering the option to students to have one CHF card for 10 students.
- Signing an agreement with the Regional Hospital to attend the CHF memberships.

**Management**
- Designing tools for record-keepings at HF level and District level.
- Designing a checklist for CHF supervision.
- Appointing a CHF accountant full time for management of CHF system.
- Appointing a CHF coordinator.
- Planning a supervision of the CHF system in each HF.

**Capacity**
- Training the DHMT in CHF management, planning and budgeting.
- Reinforcing HFC with training in planning and budgeting.
- Training in CHF record-keepings for clinical staff in charge of collecting money at HFs.

**Health Care Quality**
- Implementing the Indent System before the CHF in order to improve the availability of drugs at HFs.

**Health Facility Committee**
- Holding a meeting with the community for planning and budgeting the activities to be done in the HF.
- Drawing up the annual plan and the annual budget every year.
- Holding CHF meetings twice a year with all the community, memberships and not memberships.
- Taking in account the opinion of the community and carry out the planned activities.

**Health Facility Level**
- Appointing one person in charge of collecting money.
- Preparing a fixed a safe box in the HF.
- Encouraging the commitment of the HF staff.
After CHF implementation

District Level

- Supervising the correct implementation of the exemption policy.
- Analyzing the coverage of the exemption for the community not able to pay.
- Controlling the revenues reported and patients registered at each HF.
- Analyzing the CHF data for MRD and deciding some activities to maximize participation.
- Analyzing the covering costs for the HF.
- Respecting the decisions taken by the HFC.
- Explaining the evolution of the CHF system in MRD by Radio Tanzania.

Health Facility Level

- Filling the record keeping daily and monthly.
- Keeping the money collected in fixed safe boxes.
- Transferring the money monthly to the bank account.
- Encouraging the commitment of the HF staff.

Health Facility Committee

- Involving the community in the HFC meetings held twice a year about planning and budgeting activities in each HF.
- Reporting the amount of money collected for the CHF.
- Reporting the activities done with the CHF funds collected.
- Reporting the community the amount of money available.
- Analyzing the expenses and revenues in the HF and budgeting according these results.
- Transparency in CHF accountancy.
Annex A: Questionnaire

CHF

Willingness to Pay
Model Questionnaire

MODEL FOR CURRENT AND POTENTIAL USERS OF CLINICAL SERVICES

[SPEAK TO RESPONDENT] Can I have a minute of your time, please? The Government wants to continue providing you with convenient, high quality services. In order to do this, it will be necessary for the Government to raise the prices of the health care services at health facilities. We want to know how you will be affected by these price changes.

In this questionnaire there are no right or wrong answers, so please be honest and tell us what is true for you.

The information being collected is for statistical purposes only. I do not need to know your name and address. Everything that you say will be completely confidential. No one, including the staff of the health facilities, will be told what you personally have told us and no one will be given your name.

The interview takes about fifteen minutes. You can terminate the interview whenever you want. Would you like to participate, or do you have any questions?

1. Participation YES (proceed to interview)
   NO (thank respondent and wish him/her a nice day)

2. Questionnaire Number: [ ] [ ] [ ] [ ]

3. Village name: ________________________

4. Interviewer Name: _____________________

5. Interview Date: Month ___ Day___ Year ___

6. Time Interview Began:

7. Time Interview Completed:

A. Demographic Questions

<table>
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<tr>
<th>Q.</th>
<th>QUESTION</th>
<th>RESPONSE CODE</th>
<th>SKIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>How old are you?</td>
<td>Years</td>
<td>__</td>
</tr>
<tr>
<td>101</td>
<td>What is your marital status?</td>
<td>Married/ In-union</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Widowed, Separated, Divorced</td>
<td>02</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single</td>
<td>03</td>
</tr>
<tr>
<td>102</td>
<td>How many wives do you have?</td>
<td>One</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two</td>
<td>02</td>
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<tr>
<td></td>
<td></td>
<td>More</td>
<td>99</td>
</tr>
<tr>
<td>103</td>
<td>How many living children do you have?</td>
<td>None</td>
<td>00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>__</td>
</tr>
<tr>
<td>Q.</td>
<td>QUESTION</td>
<td>RESPONSE CODE</td>
<td>SKIP</td>
</tr>
<tr>
<td>----</td>
<td>----------</td>
<td>---------------</td>
<td>------</td>
</tr>
<tr>
<td>200</td>
<td>How many rooms does your household have?</td>
<td>1 room..................01</td>
<td>GO TO 205</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 room..................02</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 room..................03</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 room..................04</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 room..................05</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 room..................06</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 or more..................07</td>
<td></td>
</tr>
<tr>
<td>201</td>
<td>Does your household have Radio</td>
<td>YES 01</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>Water Well</td>
<td>NO 02</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Latrine</td>
<td>01 02</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bicycle</td>
<td>01 02</td>
<td></td>
</tr>
<tr>
<td>202</td>
<td>Do you work as a farmer?</td>
<td>Yes 01</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>No 02</td>
<td></td>
<td>02</td>
</tr>
<tr>
<td>203</td>
<td>What type of job do you have?</td>
<td>Job__________</td>
<td>03</td>
</tr>
<tr>
<td>204</td>
<td>How much do you make per year in cash?</td>
<td>Amount__________</td>
<td>03</td>
</tr>
<tr>
<td>205</td>
<td>How many hens do you have?</td>
<td>Amount__________</td>
<td>03</td>
</tr>
<tr>
<td>206</td>
<td>How many goats do you have?</td>
<td>Amount__________</td>
<td>03</td>
</tr>
<tr>
<td>207</td>
<td>How many hectares of land do you have?</td>
<td>Amount__________</td>
<td>03</td>
</tr>
<tr>
<td>208</td>
<td>How many korosho hectares do you have?</td>
<td>Amount__________</td>
<td>03</td>
</tr>
<tr>
<td>209</td>
<td>What type of job does your wife(s)/partner have?</td>
<td>Do not have partner 01</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>Job__________ 02</td>
<td>GO TO 211</td>
<td>02</td>
</tr>
<tr>
<td></td>
<td>Does not work 03</td>
<td>GO TO 211</td>
<td>03</td>
</tr>
<tr>
<td>210</td>
<td>How much does your wife(s)/partner(s) make per year in cash?</td>
<td>Amount__________</td>
<td>03</td>
</tr>
<tr>
<td>211</td>
<td>Who provides monetary support for your family?</td>
<td>Interviewed 01</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>Wife/ Partner 02</td>
<td>02</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children 03</td>
<td>03</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other 04</td>
<td>04</td>
<td></td>
</tr>
</tbody>
</table>
### C. Type of user

<table>
<thead>
<tr>
<th>Q.</th>
<th>QUESTION</th>
<th>RESPONSE CODE</th>
<th>SKIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>300</td>
<td>Where do you go first when you are ill?</td>
<td>Public dispensary or health centre 01 Private centre 02 amount paid__________</td>
<td>GO TO 303</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Traditional healer 03 amount paid__________</td>
<td>GO TO 303</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private pharmacy 04</td>
<td>GO TO 303</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private consultation 05 and amount paid__________</td>
<td>GO TO 303</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others ________________ 88</td>
<td></td>
</tr>
<tr>
<td>301</td>
<td>Are you satisfied with the quality of the health care provided?</td>
<td>Yes 01 No 02</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>What would you improve in the public dispensaries and health centres?</td>
<td>Quantity of drugs available 01 Quality of the health care 02 Politeness of clinical staff 03 Cleanliness 04 Faster service 05 Others ________________ 88</td>
<td>GO TO 400</td>
</tr>
<tr>
<td>303</td>
<td>Why are you not using the public dispensaries or health centres?</td>
<td>No drugs available 01 Poor quality of health care 02 Impoliteness of clinical staff 03 Poor cleanliness 04 Slow service 05 Others ________________ 88</td>
<td>GO TO 400</td>
</tr>
</tbody>
</table>

### D. Current Users

<table>
<thead>
<tr>
<th>Q.</th>
<th>QUESTION</th>
<th>RESPONSE CODE</th>
<th>SKIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>400</td>
<td>Have you ever paid for the consultation in a public dispensary or health centre?</td>
<td>Yes 01</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 02</td>
<td>GO TO 402</td>
</tr>
<tr>
<td>401</td>
<td>How much did you pay?</td>
<td>Amount ________________</td>
<td></td>
</tr>
<tr>
<td>402</td>
<td>Have you ever paid for the drugs in a public dispensary or health centre?</td>
<td>Yes 01</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 02</td>
<td>GO TO 404</td>
</tr>
<tr>
<td>403</td>
<td>How much did you pay?</td>
<td>Amount _________________</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>--------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 404 | Have you ever found out of stock drugs in a public dispensary or health centre? | YES 01  
NO 02 | GO TO 407 |
| 405 | What have you done when you found out of stock drugs? | Buy drugs in the private pharmacy 01  
Buy drugs in another public facility 02  
Others _________________ 88  
None 99 | GO TO 407 |
| 406 | How much did you pay the last time? | Amount _________________ |
| 407 | What is the TOTAL price of your health care for one case of illness (consultation and drugs)? | Amount _________________ |
| 408 | How many times were you ill since last new year? | Amount _________________ |

**E. Sensitisation Questions**

<table>
<thead>
<tr>
<th>Q.</th>
<th>QUESTION</th>
<th>RESPONSE CODE</th>
<th>SKIP</th>
</tr>
</thead>
</table>
| 500 | Have you heard about the Community Health Fund system? | Yes 01  
No 02 | GO TO 600 |
| 501 | Have you attended to a Community Health Fund sensitisation performance? | Yes 01  
No 02 | GO TO 503 |
| 502 | Did you understand the sensitisation? | Yes 01  
No 02 | GO TO 600 |
| 503 | Could you explain how the CHF works? | Correct 01  
No Correct 02  
He/She cannot 03 |

**F. Willingness to Pay Questions**

<table>
<thead>
<tr>
<th>Q.</th>
<th>QUESTION</th>
<th>RESPONSE CODE</th>
<th>SKIP</th>
</tr>
</thead>
</table>
| 600 | READ TO RESPONDENT:  
The Community Health Fund policy says that you will pay the money in advance for your annual treatment per household (the father, the mother and six children), in the dispensaries and health centres.  
This money will be used for drugs, cleanness, rehabilitation...of the health facility.  
If you are not a CHF membership you can buy the user fee ticket that will be valid for one treatment for one person, for 14 days in a dispensary and health centre. | | |
| 601 | Suppose that the price of the CHF card for your household will be fixed at 5,000 Ts. Will you buy a CHF card? | Yes 01  
No 02 | GO TO 603 |
| 602 | Suppose that the price of the CHF card for your household will be fixed at 7,000 Ts. Will you buy a CHF card? | Yes 01  
No 02 | GO TO 604 |
| 603 | Suppose that the price of the CHF was less than the previous amount, it will be fixed at 3,000 Ts. Will you buy CHF card? | Yes 01  
No 02 | |
<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
<th>Next Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the highest price you would pay for a CHF card?</td>
<td>Amount ____________________</td>
<td></td>
</tr>
<tr>
<td>If the CHF card were fixed a price beyond your highest price (previous amount), what would you do?</td>
<td>- Buy user fee ticket 01</td>
<td>GO TO 607</td>
</tr>
<tr>
<td>- Go without service 02</td>
<td>GO TO 700</td>
<td></td>
</tr>
<tr>
<td>- Go somewhere else 03</td>
<td>GO TO 606</td>
<td></td>
</tr>
<tr>
<td>- I don’t know 99</td>
<td>GO TO 700</td>
<td></td>
</tr>
<tr>
<td>- Other: specify_________ 88</td>
<td>GO TO 700</td>
<td></td>
</tr>
<tr>
<td>Where would you go?</td>
<td>Private centre 01</td>
<td>GO TO 700</td>
</tr>
<tr>
<td>DO NOT READ CHOICES CODE ALL MENTIONED</td>
<td>Private Pharmacy 02</td>
<td>GO TO 700</td>
</tr>
<tr>
<td>- Traditional healer 03</td>
<td>GO TO 700</td>
<td></td>
</tr>
<tr>
<td>- I don’t know 99</td>
<td>GO TO 700</td>
<td></td>
</tr>
<tr>
<td>- Other: specify_________ 88</td>
<td>GO TO 700</td>
<td></td>
</tr>
<tr>
<td>Suppose that the price of the user fee ticket will be fixed at 500 Ts. Will you buy a ticket?</td>
<td>Yes 01</td>
<td></td>
</tr>
<tr>
<td>- No 02</td>
<td>GO TO 609</td>
<td></td>
</tr>
<tr>
<td>Suppose that the price of the user fee ticket will be fixed at 700 Ts. Will you buy a ticket?</td>
<td>Yes 01</td>
<td></td>
</tr>
<tr>
<td>- No 02</td>
<td>GO TO 610</td>
<td></td>
</tr>
<tr>
<td>Suppose that the price of the user fee ticket was less than the previous amount, it will be fixed at 300 Ts. Will you buy a ticket?</td>
<td>Yes 01</td>
<td></td>
</tr>
<tr>
<td>- No 02</td>
<td>GO TO 610</td>
<td></td>
</tr>
<tr>
<td>What is the highest price you would pay for a user fee ticket?</td>
<td>Amount ____________________</td>
<td></td>
</tr>
<tr>
<td>If the User Fee Ticket were fixed a price beyond your highest price (previous amount), what would you do?</td>
<td>- Go without service 01</td>
<td>GO TO 700</td>
</tr>
<tr>
<td>- Go somewhere else 02</td>
<td>GO TO 612</td>
<td></td>
</tr>
<tr>
<td>- I don’t know 99</td>
<td>GO TO 700</td>
<td></td>
</tr>
<tr>
<td>- Other: specify_________ 88</td>
<td>GO TO 700</td>
<td></td>
</tr>
<tr>
<td>Where would you go?</td>
<td>Private centre 01</td>
<td></td>
</tr>
<tr>
<td>DO NOT READ CHOICES CODE ALL MENTIONED</td>
<td>Private Pharmacy 02</td>
<td></td>
</tr>
<tr>
<td>- Traditional healer 03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- I don’t know 99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other: specify_________ 88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>END THE INTERVIEW AND THANK VERY POLITELY THE RESPONDENT FOR HIS/HER COLLABORATION. LOOK AND WRITE DOWN THE TIME.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Annex B: Survey Results

**Characteristics of Respondents, General Social and Economic Status**

No. household heads surveyed  435

<table>
<thead>
<tr>
<th></th>
<th>18-25</th>
<th>26-35</th>
<th>36-45</th>
<th>46-60</th>
<th>61-80</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>average age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.3%</td>
<td>24.5%</td>
<td>25.0%</td>
<td>24.1%</td>
<td>16.1%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>married/in-union</th>
<th>widowed/separated/divorced</th>
<th>single</th>
</tr>
</thead>
<tbody>
<tr>
<td>72.6%</td>
<td>18.6%</td>
<td>8.7%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
<th>10 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.9%</td>
<td>45.4%</td>
<td>19.1%</td>
<td>7.6%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>no grade completed</th>
<th>primary school</th>
<th>secondary school</th>
<th>some college</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.9%</td>
<td>58.0%</td>
<td>1.4%</td>
<td>0.7%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>farmer</th>
<th>fishermen</th>
<th>businessmen</th>
<th>others</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.7%</td>
<td>2.0%</td>
<td>1.0%</td>
<td>1.3%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>farmer</th>
<th>other</th>
<th>does not work</th>
</tr>
</thead>
<tbody>
<tr>
<td>70.2%</td>
<td>1.1%</td>
<td>1.6%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5%</td>
<td>44.4%</td>
<td>49.1%</td>
<td>3.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>radio</td>
<td>32.4%</td>
<td>67.6%</td>
</tr>
<tr>
<td>water well</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>latrine</td>
<td>89.5%</td>
<td>10.5%</td>
</tr>
<tr>
<td>bicycle</td>
<td>38.8%</td>
<td>61.2%</td>
</tr>
<tr>
<td>Livestock</td>
<td>0</td>
<td>1-3</td>
</tr>
<tr>
<td>---------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>hens</td>
<td>68%</td>
<td>14.7%</td>
</tr>
<tr>
<td>goats</td>
<td>80.2%</td>
<td>9.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hectares of land</th>
<th>0-20.000</th>
<th>23.000-50.000</th>
<th>55.000-70.000</th>
<th>80.000-100.000</th>
<th>110.000-200.000</th>
<th>more than 200.000</th>
</tr>
</thead>
<tbody>
<tr>
<td>cashew nut</td>
<td>36.8%</td>
<td>22.1%</td>
<td>17.0%</td>
<td>14.0%</td>
<td>10.1%</td>
<td></td>
</tr>
<tr>
<td>other cash crop</td>
<td>26.7%</td>
<td>32.0%</td>
<td>27.6%</td>
<td>12.2%</td>
<td>1.6%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual income in cash</th>
<th>0-20.000</th>
<th>23.000-50.000</th>
<th>55.000-70.000</th>
<th>80.000-100.000</th>
<th>110.000-200.000</th>
<th>more than 200.000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46.7%</td>
<td>18.2%</td>
<td>5.5%</td>
<td>15.6%</td>
<td>9.9%</td>
<td>4.1%</td>
</tr>
</tbody>
</table>
### Type of User

**where do you go when you are ill?**

<table>
<thead>
<tr>
<th>Type of User</th>
<th>public dispensary of health centre</th>
<th>private centre</th>
<th>private pharmacy</th>
<th>traditional healer</th>
<th>private consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>94.7%</td>
<td>4.4%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.2%</td>
<td></td>
</tr>
</tbody>
</table>

**what would you improve in the public dispensaries and health centres?**

<table>
<thead>
<tr>
<th>Improvement</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>quantity of drugs available</td>
<td>51.5%</td>
<td>48.5%</td>
</tr>
<tr>
<td>quality of health care</td>
<td>36.1%</td>
<td>63.9%</td>
</tr>
<tr>
<td>faster service</td>
<td>22.8%</td>
<td>77.2%</td>
</tr>
<tr>
<td>politeness of clinical staff</td>
<td>15.2%</td>
<td>84.8%</td>
</tr>
<tr>
<td>cleanliness</td>
<td>3.2%</td>
<td>96.8%</td>
</tr>
</tbody>
</table>

**how many times were you ill since last new year?**

<table>
<thead>
<tr>
<th>Times</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>33%</td>
<td>24.2%</td>
<td>24.0%</td>
<td>12.7%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

**have you ever paid for the consultation in a public dispensary or health centre?**

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>33.3%</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

**have you ever paid for the drugs in a public dispensary or health centre?**

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22.3%</td>
<td>77.7%</td>
</tr>
</tbody>
</table>

**have you ever found out of stock drugs in a public dispensary or health centre?**

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>53.2%</td>
<td>46.8%</td>
</tr>
</tbody>
</table>

**what have you done when you found out of stock?**

<table>
<thead>
<tr>
<th></th>
<th>go to private pharmacy</th>
<th>none</th>
<th>go to another public facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>82.4%</td>
<td>10.0%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>
Sensitisation

<table>
<thead>
<tr>
<th>have you heard about the Community Health Fund?</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>54.9%</td>
<td>45.1%</td>
</tr>
</tbody>
</table>

out of 54.9%

<table>
<thead>
<tr>
<th>have you attended a Community Health Fund sensitisation performance?</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27.8%</td>
<td>27.1*%</td>
</tr>
</tbody>
</table>

out of 27.8%

<table>
<thead>
<tr>
<th>did you understand the sensitisation?</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22.9%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

out of 22.9% and 27.1*%

<table>
<thead>
<tr>
<th>could you explain how the CHF works?</th>
<th>correct</th>
<th>she/he cannot explain</th>
<th>no correct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31.2%</td>
<td>14.4%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>
Willingness to Pay for CHF Card

<table>
<thead>
<tr>
<th>will you buy a CHF card at 5.000 Tshs?</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>62.5%</td>
<td>37.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>what is the highest price you would pay for a CHF card? (complement of the cumulative percentage)</th>
<th>100-3.000</th>
<th>3.100-5.000</th>
<th>5.100-7.000</th>
<th>7.100-10.000</th>
<th>more than 10.000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97.9%</td>
<td>62.5%</td>
<td>33.1%</td>
<td>15.6%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>if the CHF card were fixed a price beyond your highest price, what would you do?</th>
<th>buy user fee ticket</th>
<th>go without service</th>
<th>do not know</th>
<th>go somewhere else</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>53.1%</td>
<td>27.8%</td>
<td>12.6%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>
Willingness to Pay for User Fee (out of 53.1%)

Will you buy a user fee ticket at 500 Tshs?
- Yes: 49.2%
- No: 3.9%

What is the highest price you would pay for a user fee ticket? (complement of the cumulative percentage)
- 100-300: 52.9%
- 400-500: 49.2%
- 600-700: 33.1%
- 800-1.000: 16.3%
- More than 1.000: 2.1%

If the user fee were fixed a price beyond your highest price, what would you do?
- Go without service: 32.6%
- Go somewhere else: 13.4%
- Do not know: 7.2%

Where would you go?
- Private pharmacy: 5.5%
- Private centre: 4.1%
- Traditional healer: 2.5%
- Do not know: 0.7%
References


Lucy Gilson. 1995. The Lessons of User Fee Experience in Africa. University of Witwatersrand, South Africa and London School of Hygiene and Tropical Medicine, United Kingdom.


