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DISSEMINATION WORKSHOP REPORT

Assessment findings of the functionality of Community Health Funds in Misenyi, Musoma Rural, and Sengerema districts



SEPTEMBER 2014

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DISCLAIMER

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Acronyms

ACT	Artemisinin combination therapy
CBHF	Community-based health financing
CHMT	Council Health Management Team
CHSB	Council Health Services Board
CM	Case management
DMO	District Medical Officer
GIZ	German International Development Agency
HFGC	Health Facility Governing Committee
HMTC	Hospital Medicines and Therapeutic Committee
IHI	Ifakara Health Institute
MoHSW	Ministry of Health and Social Welfare
mRDT	Malaria rapid diagnostic test
MSD	Medical Stores Department
MSH	Management Sciences for Health
NHIF	National Health Insurance Fund
PHCMTC	Primary Health Care Medicines and Therapeutic Committee
PQIT	Pediatric quality improvement teams
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
R&R	Report and request forms
SCM	Supply chain management
SDC	Swiss Development Cooperation
THP	Tibu Homa Program
TZS	Tanzanian Shilling
URC	University Research Co., LLC
USAID	United States Agency for International Development

ABSTRACT

Over the past three years, the Tibu Homa Program (THP) has been working to improve case management of children under five with fever in the Lake Zone (Kagera, Mara, Mwanza, Geita, Shinyanga, and Simiyu regions) of Tanzania through system strengthening interventions. The Lake Zone was identified by the Ministry of Health and Social Welfare (MoHSW) and the United States Agency for International Development (USAID) because of its high under-five mortality rate, above the national average, and a high prevalence of malaria.

To help achieve universal access and make health care affordable, the Ministry of Health and Social Welfare supports the implementation of the Community Health Funds (CHFs). The CHF scheme is a form of pre-payment insurance designed as a mechanism for improving access to basic health care services to populations in the rural areas and the informal sector in the country. It is based on the concept of risk pooling and sharing whereby members pay a small contribution on a regular basis to offset the risk of needing to pay a much larger amount in health care costs through user fees if they fall sick.

The Tibu Homa Program is supporting health managers to mobilize additional resources from sources that will compliment limited funds from the government budgeted for child health, all this aimed at ensuring long term improved and sustained child health services. The CHF scheme is emerging as a valuable alternative source of funding for child health services. Before embarking on a community financing intervention, Tibu Homa conducted an assessment of the functionality of CHFs in three selected districts in the Lake Zone (Misenyi, Musoma, and Sengerema) to determine: 1) The status of implementation of the funds, and 2) the functionality of the health governance structures, such as the Council Health Services Boards and Health Facility Governing Committees.

The study was conducted in the three districts (on the above parameters) and used primary data from key informants at the district level. Secondary data were drawn from a variety of sources which included the MoHSW and organizations that support the implementation of CHFs in various districts, such as the Ifakara Health Institute, German International Development Agency, German Ministry for Economic Cooperation, and Swiss Development Cooperation.

In assessing the performance of the CHF in the sampled districts, various performance parameters were used. These included enrollment rates, management and use of CHF, application for matching grants, benefit package, portability (ability to use CHF member card in accessing services in other primary health care facilities), mechanisms for enrolling the poor, and governance and administration (including community sensitization).

Study findings show that CHF enrollment is still below the national target of 30% enrolled households before 2015 (Mtei & Mulligan 2007) – the highest enrollment of households was found in Sengerema District at 12.3%, followed by Musoma Rural District at 1.4%, and Misenyi District at 1.2%. Other findings showed poor CHF management in terms of reporting and book keeping, lack of standardized data collection formats, lack of awareness among Council Health Service Boards and Health Facility Governing Committees of their roles and functions, and lack of guidelines on how sensitization should be conducted.

The study recommends various CHF strengthening interventions which focus on strengthening the capacity of health governance structures for managing the funds, sensitization at all levels using a mix of communication channels, and proper record keeping.

I. INTRODUCTION

The goal of the USAID-funded Tibu Homa Program (THP) is to reduce morbidity and mortality of children under five years of age in the Lake Zone of Tanzania (Mwanza, Mara, Kagera, Shinyanga, Simiyu, and Geita regions) by improving proper diagnosis and treatment of severe febrile illness in children under five years of age, focusing on improving case management at the facility level (both public and private). Tibu Homa is implemented by University Research Co., LLC (URC) in collaboration with Management Sciences for Health (MSH) and Amref Health Africa.

To ensure sustained, long-term improvements in case management, Tibu Homa is supporting health managers from 27 districts in the Lake Zone to mobilize resources from sources other than the government. These efforts aim to complement limited funds from the government budgeted for child health services and thereby contribute to financial sustainability in management of childhood illnesses in the Lake Zone.

One of the alternative sources of funding being implemented is community-based health financing (CBHF). According to Carrin (2003), CBHF has emerged as one of the responses to the existing challenges in health financing in developing countries with low economic growth, constraints in the public sector, and low organizational capacity. CBHF schemes can be seen as a step towards universal health coverage following the widely acknowledged difficulties in tax financing and social health insurance, especially in less developed countries. CBHF is an option for extending insurance coverage in low-income countries, particularly among rural and informal sectors. Rwanda has implemented CBHF on a national scale, and health insurance coverage has increased dramatically with CBHF services to about 85% of the population (mostly rural and poor) (Shimeles 2010).

Just like Rwanda and other sub-Saharan countries, Tanzania has a small health budget which makes it hard to improve access to health services. To date, the country has not been able to meet the Abuja Declaration 2001 target of allocating at least 15% of the national budget to health. The allocation to health and a proportion of the national budget has fluctuated between 10% and 13% (United Republic of Tanzania 2012).

To help make health care affordable, the Ministry of Health and Social Welfare (MoHSW) supports the implementation of the Community Health Funds (CHFs). This paper provides a snapshot of the functionality of the CHFs in three selected districts in the Lake Zone (Missenyi, Musoma, and Sengerema) in terms of the status of implementation; the roles and responsibilities of the health governance structures such as the Council Health Services Boards and Health Facility Governing Committees, which are supposed to oversee the implementation of the scheme; and the challenges in implementing community-based health financing. Based on these findings, interventions to strengthen the CHFs in the three districts are proposed.

II. METHODOLOGY

The assessment of the functionality of the CHFs in the three districts used both primary and secondary data. Primary data was collected from selected key informants in the three districts. These included the District Medical Officers (DMOs), district CHF coordinators, members of the Council Health Services Boards (CHSB), members of Health Facility Governing Committees (HFGCs), and some CHF beneficiaries. Secondary information was obtained mainly from publications by the MoHSW and organizations supporting the implementation of CHF in various districts, such as the Ifakara Health Institute, German International Development Agency, German Ministry for Economic Cooperation, and Swiss Development Cooperation.

III. FINDINGS

This study found that CHF have been established in all the three districts, the oldest fund being that in Sengerema (established in 2004), followed by that in Musoma Rural (established in 2007), and the most recent fund in Misenyi (2012). All three districts have a CHF focal person who oversees the day-to-day operations of the fund. Enrollment procedures are the same, though there are currently no facility membership cards in Musoma Rural and Misenyi. In Sengerema, however, upon joining the CHF, the household receives only one membership card, with the photo of the household head and the names of all the beneficiaries on the back of the card.

The membership fee/annual premium per household is TZS 10,000 (approximately US\$6.25) across the three districts, but the average number of beneficiaries (household members) is 6 in Misenyi and Musoma Rural and 10 in Sengerema District. The CHF coverage rate in the three districts is below the national 2015 target of 30%. Sengerema has coverage of 12.3%, followed by Musoma Rural at 1.4% and Misenyi at 1.2%. In the three districts, the user fee for non-CHF members is very low (TZS 1,000.00 in Musoma at all levels of health care); TZS 1,000.00 and TZS 1,500.00 at dispensary and health centre levels, respectively, in Sengerema; and TZS 2,000.00 in Misenyi. This makes the prepayment scheme less attractive because community members can get the services at lower costs.

Table 1: CHF Membership by District

CHF Parameters	Musoma Rural	Sengerema	Misenyi
Subscription fee per year (TZS)	10,000	10,000	10,000
Number of beneficiaries per household	6	10	6
Active CHF members (early 2013)	624	4,716	256
Total beneficiaries/household members	3,744	47,160	1,536
Total district population	446,516	639,096	210,783
CHF coverage rate (total population)	0.70%	7.40%	0.70%
60% target population	267,910	383,458	126,470
CHF coverage rate (60% of the total population)	1.4%	12.3%	1.2%

According to MoHSW Policy, the government is required to match the amount collected by CHF when the collection reaches TZS 500,000.00. Musoma District has applied for a total of TZS 9 million from National Health Insurance Fund (NHIF), but these funds have not been received. Sengerema District applied for matching funds for the period from 2004 to 2006 and received a total of TZS 6,020,000. The district has further applied for another batch amounting to TZS 14 million but has not yet received the sum because they have not complied with the requirements, including producing the district CHF policy document. Misenyi District has not applied for matching funds because they have only TZS 2.5 million in the CHF account, less than the TZS 5 million minimum required to qualify for matching funds.

The CHF membership covers health care benefits mainly at primary public facilities, although Musoma District has expanded the benefit package to include the district hospital. In terms of CHF data management and reporting, most of the health facility in-charges did not have the basic knowledge of book-keeping. Furthermore, no standardized data collection format was available for reporting CHF data at both levels (facility and district) in Musoma

Rural. For Sengerema, a standardized reporting format was only available for the purpose of matching fund application. In Misenyi, there was a standardized record keeping format but the district just printed membership forms, receipt, and claim forms using the NHIF format. However, the CHF guidelines in Misenyi do not show how to use the claim forms.

Musoma District has been able to utilize the funds to procure medicines. Each health facility has a bank account, and CHF funds and any matching funds from the district level are deposited into those accounts. In the year 2012, the CHSB transferred a maximum of TZS 500,000 to each health facility. In this way, the HFGC can plan and use the funds to improve health services in their facility. In Sengerema, facilities did not have bank accounts, and sometimes the decision to use the money was made at the district level without the involvement of the HFGC. In Misenyi, the funds have not been utilized.

The study found out the CHSBs and HFGCs have been unable to articulate their roles and responsibilities, which makes it difficult to realize their objectives and ultimately achieve improved health outcomes. The findings also show that apart from regular participation in quarterly meetings, the boards did not have action plans to guide them in their activities. Also, there were no budgets to facilitate the CHSBs to execute their activities and ensure proper health service delivery in the districts. There was a general lack of commitment among members due to the fact that they are not paid, except during the statutory board meetings when they are paid allowances (they are expected to work on a voluntary basis).

On community sensitization, efforts have been made to sensitize community members to join the CHF in Musoma Rural. Nevertheless, there were no guidelines on how sensitization should be conducted and possible collaborators. Also, in the three districts, the level of understanding of the structure of the CHFs among communities and sensitization skills among HFGCs were low. The district has conducted advocacy meetings with political leaders as champions in their locality to sensitize community members on the benefit of the CHF scheme.

IV. DISCUSSION

Challenges facing proper implementation of CHFs range from design to management issues. While the Health Financing Strategy of the MoHSW, whose preparation is underway, is expected to address the design-related issues, various stakeholders can contribute to addressing the management-related challenges. CHFs, if properly managed, can make a significant contribution to improving quality of care (also measured by reliable supply of medicines). This will happen only when a critical mass of households has been enrolled into the CHF to enable collection of sufficient funds to make substantial change and when such funds are properly utilized by managers.

Strengthening the capacity of health governance structures through properly designed capacity-building seminars and coaching through supportive supervision is critically important. Coaching is done on preparing action plans, preparing budgets, applying for funds from the district (CHF accounts are located at the district level), and data management at health facility level. Sensitization of political and technical leaders, including the service providers and community members, can significantly increase achievements. Hamlet and village authorities who are closest to the people can be effective in sensitizing communities. Sensitization of political leaders, such as District Commissioner and Councilors, is also imperative. Political and technical leaders can be sensitized to include CHF as an agenda item in all meetings. Various forums can also be used as sensitization platforms. For example, during the indoor residual spraying activities in Musoma District, the same platforms were used to sensitize community members to join CHF.

Collaboration with various stakeholders is imperative. The first actor is the District Council through the health, education, community development, and communications departments. These departments should be at the forefront in ensuring positive collaboration in service delivery. Other partners at the ward level, such as Ward Development Committees and

Village Councils, are also important. Another major actor is the National Health Insurance Fund (NHIF), which has the national mandate to manage the funds. NHIF also provides support for transport and public address systems for community sensitization. Other stakeholders include national and international organizations working on CHF in the respective districts. These include Amref Health Africa and Plan International, among others. Thus, there is a need to map all actors in the CHF scheme and tap into their synergies.

V. CONCLUSION AND RECOMMENDATIONS

Based on the lessons learnt and best practices on the availability and access to key medicines and supplies and overall quality health care delivery from the well-performing districts, such as the Iramba District in Singida Region (Stoermer et al. 2012), we recommend strengthening the capacity of health governance structures for managing the CHFs and sensitization at all levels using a mix of communication channels. Proper record keeping will greatly strengthen the management of the CHFs in the Tibu Homa Program intervention districts.

After completion of the study, Tibu Homa conducted a stakeholder's workshop to discuss the link between CHF strengthening and improved management of severe febrile illness. The workshop participants concluded that, though the CHF has not traditionally focused on under-fives, it can be refocused to address key interventions that will improve services to children under five years of age. Recommendations include: procurement and establishment of patient files for under-five records instead of exercise books currently in use; purchase of supplementary medicines and supplies for under-fives; and strengthening of health facility and council service boards to address child health issues.

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