# PERCEPTIONS TOWARDS THE ROLE OF EXEMPTION SCHEME IN UTILIZATION OF HEALTH SERVICES AMONG MOST VULNERABLE CHILDREN IN TANGA

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**Master of Public Health Dissertation**

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**By**

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**A Dissertation Submitted in Partial Fulfilment of the Requirement for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences**

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## CERTIFICATION

The undersigned certify that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled: ***Perceptions towards the role of exemption scheme in utilization of health services among most vulnerable children in Tanga*** in partial fulfilment of the requirement for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

Signature_____

**Mangi J. Ezekiel**
**(Supervisor)**

**Date_____**

## DECLARATION AND COPYRIGHT

I, Adam Eliapenda, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature.....Date.....

**ACKNOWLEDGEMENT**

At this juncture, I feel highly indebted to express my sincere gratitude for the support and cooperation given to me in the course of accomplishing this study.

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## DEDICATION

This work is dedicated to my beloved wife, Joyce Hongoa Kanza and our beloved daughter Nataniella Adam Kanza. Without Joyce's brave, courage and motherhood, it would have been very challenging for me to complete my studies and the dissertation especially when our daughter got sick several times. I thank you very much.

**ABSTRACT**

**Background**

Tanzania is experiencing rapid increase in number of Most Vulnerable Children (MVC). Currently the total number of most vulnerable children is 10% of all child population. These children are facing serious challenges in utilizing health care due to various reasons including poverty, distance to health facility and ability to pay for health care. Health is an expensive commodity which MVC households fails to foot its costs. Given the existence of health exemption scheme for MVCs, why does utilization remain low was the fundamental question of this study.

**Materials and Methods**

The study aimed at exploring peoples' perceptions on the role of exemption scheme in utilization of health services among most vulnerable children. A qualitative study was conducted in Tanga City Council. Using a purposive sampling technique, a tota of 36 key informants were recruited for participation in in-depth interviews. Thematic analysis was followed.

**Results**

The study revealed that, majority of the people perceived a poor coordination in the operationalization of health exemption scheme. It was further found that, the scheme covered only one MVC per MVC household. The scheme package of services was selective to cover less costly diseases only. Also the issue of running out of stock of drugs, entailed poor quality of health care was perceived as a challenge in utilization of health care. However, majority of the people perceived a scheme as a useful intervention that would meant a lot if it would cover all health services at the point of need.

**Conclusions and recommendations**

It is recommended that, key stakeholders for this intervention should be sensitized on exemption scheme implementation protocol. In addition, the health benefit package must be comprehensive to accommodate all health needs of MVCs. Finally, Tanga City Council

should take necessary budgetary steps to avail medical supplies in all health facilities, giving special attention to MVCs who have been financially constrained to foot medical costs in health facilities, short of which morbidity and mortality rates among MVCs may increases due to resortment to folk healers, spiritual leaders and self medication.

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| CDC | Centers for Disease Control and Prevention |
| CHF | Community Health Fund |
| CHF | Community Health Fund |
| DSW | Department of Social Welfare |
| DSWO | District/Municipal Social Welfare Officer |
| HIV/AIDS | Human immunodeficiency Virus/ Acquired Immuno Deficiency Syndrome |
| HMIS | HIV/AIDS and Malaria Indicator Survey |
| IDI | In-depth Interview |
| MUHAS | Muhimbili University of Health and Allied Sciences |
| MVC | Most Vulnerable Child |
| MVCC | Most Vulnerable Child Committee |
| NCPA | National Costed Plan of Action |
| NGOs | Non Government Organizations |
| NHIF | National Health Insurance Fund |
| OVC | Orphans and Vulnerable Children |
| PASSADIT | Pastoral Activities and Services for HIV/AIDS, in Dioces of Tanga. |
| PI | Principal Investigator |
| REPOA | Research on Poverty Alleviation |
| SPHSS | School of Public Health and Social Science |
| UNAIDS | United Nations AIDS |

# CHAPTER ONE

## 1.0 INTRODUCTION

### 1.1 Background Information

Globally, the United Nations estimates that, there are between 143-163 million orphans and vulnerable children who are in need of immediate care and support in order to survive (1). Nearly 80% of most vulnerable children are found in Africa south of the Sahara.

In East Africa the burden of MVCs is alarming. In Kenya, the magnitude of most vulnerable children is said to have reached 60% of the population of children and in 2006 there were estimates of 1.1 million children who were orphaned due to HIV/AIDS (1,2). Moreover, the 2002 statistics from mainland Tanzania indicates that, there were a total of 836,032 identified most vulnerable children, but increased to about 930,000 in 2006. With increased vulnerability this number increased to 969,045 MVCs by 2008. In 2009 there were 1,007,044 MVCs and in 2010 there were 1,044,096 MVCs (3). These statistics show that MVC problem is escalating at the alarming rate in the country. Currently, Tanzania is estimated to have 2,000,000 children identified as most vulnerable who are approximately 10% of children less than 18 years of age. These children face a multitude of challenges ranging from nutrition, education, psychosocial support, shelter and health.

On the other hand, evidence confirms that utilization of health care in developing countries is a major problem. Each year more than 11 million children die from preventable diseases as a result of inequalities in health and development, and the problems are worse where resources are least available; those who need more care (particularly children) have the least utilization (4).

There is a growing movement, globally and in the Africa region, to reduce financial barriers to health care generally, but with particular emphasis on high priority services and vulnerable groups (5). Across Africa studies have shown that, financial insecurity accounts for a greater contribution of limited utilization of health services compared to other factors. Public health care services are increasingly delivered through a cost- sharing approach. This is due to the global health policies which were introduced across Africa by the name of Health sector reform programs. Primarily these reforms introduced user charges, which are claimed to have

posed serious barriers to utilization of health care. Budget cut-off and introduction of user financing in social services provision and health in particular has been reported to result in a severely limited utilization particularly among the poor. In Zambia for example the increasing user fees are culminating into massive decline in utilization of health facilities (6). Similarly, in Kenya it is documented that there has been a very large decline in health service utilization as a result of an absolute increase in fees (7,8).

In Tanzania, studies have revealed that upon introduction of user charges, utilization of health services declined to 53% (9). In efforts to establish a comprehensive strategy to address the problem of utilization of health services among most vulnerable children, the Government of Tanzania through the Ministry of Health and Social Welfare came up with a standard classification of Vulnerable Children which incorporates demographic characteristics and indicators of poor living conditions which includes those children; living in a child headed households, those living in elderly-headed households with no adult from 20-59 years old present, with one or both parents deceased, those with disability, those in rural areas; children with one surviving parent living in a house with poor quality roofing (grasses and/or mud) and those with a disability living in similar poor conditions, those in urban areas: children with one surviving parent living in a house with poor quality roofing (grass and /or mud) or with poor wall materials or without toilet facilities and those with a disability living in a similar conditions (3).

However, this framework provided by the Government recognizes that, a child may be staying with both parents and still be most vulnerable. On the same token a child may be an orphan and still not vulnerable due to availability of working social safety nets which may be available at a given context. Consequently, this study will employ the Government defition of an MVC as stipulated in the National Costed Plan of Action for MVCs (NCPA) as operational defition but to include only MVCs living in households as opposed to those institutionalized in orphanage centers or living on the streets.

Country's response to the problem is vivid through the multi-sectoral approaches that involve public and private sectors. The revised Child Development Policy of 2008 and subsequent

Law of the Child Act 2009 have captured the MVC issues, Development of early Childhood Development Programs for children 0-8 years with an emphasis on vulnerable children (10)**.** Furthermore, National guidelines for institutional care and support of MVCs aim at providing standards for care and support of MVCs living in Institutions and development of National Costed Plan of Action for MVCs are some of initiatives at the policy level to address the problem. On top of that, at the grass root level there has been some ongoing MVC programs like Global Funded OVC and "let's bring up children together," (Pamoja Tuwalee) program, attempting to eliminate among others, the problem of limited utilization to health care among MVCs.

In efforts to team up with stakeholders in accordance with national strategies, Tanga City Council has been implementing a health fee exemption scheme for MVCs since October 2012. The scheme targets MVC whose age ranges between 5 to 17 years. It was established to facilitate MVCs to cross the financial barriers and utilize health care at the time of need. Unlike the existing health financing mechanisms like out-of-pocket, NHIF and CHF which relies on members contributions, the health fee exemption scheme enroll all identified MVCs as eligible beneficiaries whose health care costs are incurred by the City Council. MVCs are neither contributing seed nor registration money. The estimated total beneficiaries of the scheme are 5,474 MVCs. Currently the program beneficiaries are 2,114 MVCs. The remaining numbers (3360 MVCs) are yet to benefit because the program is implemented in 5 out of 24 wards of Tanga City Council.

## 1.2 Problem Statement

Utilization of health services is an important public health and policy issue in developing countries. However, the level of health care services in many countries of the world is not satisfactory. In Tanzania, utilization to health services is a great challenge especially among most vulnerable children who constitutes more than 10% of population under 18 years of age.

In efforts to tackle a problem of vulnerability, the Government of Tanzania in collaboration with development partners and civil societies has collaborated to address the problem. At the policy level, the Ministry of Community Development, Gender and Children released a revised National Policy on the Development of a Child in 2008 with the aim of ensuring provision of child rights, survival, child development and child protection. Moreover, the department of social welfare of the Ministry of Health has released a National Costed Plan of Action for MVCs which guides MVCs-centered interventions in Tanzania in thematic areas of health, education, psyschosocial support, protection and economic empowerment (3). At the community level, "let's bring up children together," (Pamoja Tuwalee) MVC program and other local community initiatives are some of existing collaborative actions to address the question of vulnerability through establishment of small scale income generating projects runned by MVC households, reunion of broken families, revival of community social safety nets and mutual support groups as well as provision of free health services through Local Governemnt Initiatives.

Literature identifies various factors associated with limited utilization of health care among vulnerable groups. Dimensions of utilization to clarify barriers to health care have been well studied which includes geographical accessibility, availability, affordability as well as acceptability of health services (11). The above initiatives aim at enhancing among other things, MVCs utilization of health care which is reported to have been a problem

Given the wide-spread poverty in Tanzania, costs for health services impose a significant barrier for most Tanzanians and have been shown to decrease utilization of health services. Furthermore, when user fees were introduced in Tanzania, utilization of outpatient services in public hospitals declined by 53 % (9). Previous studies have shown that the most common

barriers stem from people's inability to afford direct cost of purchasing health care, including limited income and the lack of health care insurance; therefore a step towards improved utilization of health services rests on removing financial barrier (12).The review of National Costed Plan of Action for MVCs (2013) shows that majority of MVCs are under the custodian of care takers who are relatively poor to afford paying for child health. Furthermore, an assessment of the health financing system in Tanzania revels that the level of out-of-pocket payments is high compared to other sources of health care financing (13).

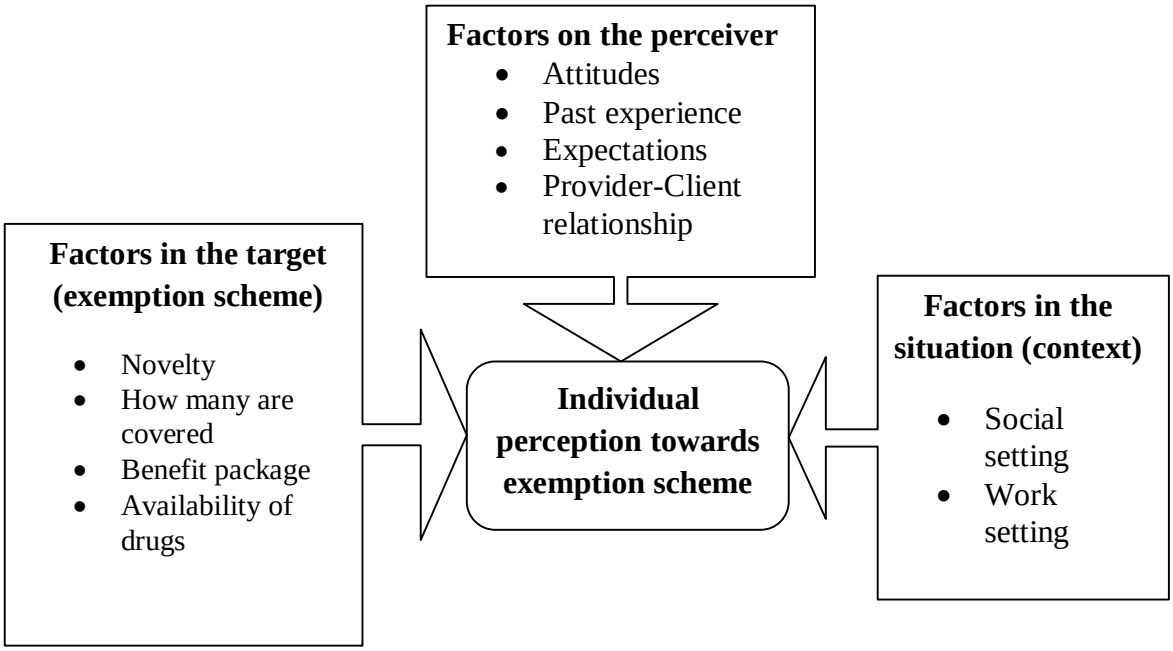
A wide range of study findings across Tanzania shows that, in a general population, utilization of health services declined by more than 53% when user fees and cost sharing were introduced in public health facilities. Tanga City Council in collaboration with PASSADIT, introduced exemption scheme whose primary goal was among others, to eliminate financial insecurity and thereby increase utilization of health services among MVCs. The 2011 PASSADIT annual report shows that, inspite of introduction of exemption mechanism, utilization of health services remain as low as 43%. The study is therefore seeking to explore the peoples' perceptions on reasons for low utilization of health services given existence of exemption coverage among MVCs in Tanga.

### 1.3 Rationale

This study was conducted to explore perceptions and attitudes of the people on the role of exemption scheme in utilization of health services. It addresses peoples' opinion on barriers to utilization of health services given the fact that, a perceived financial barrier was eliminated through health exemption scheme. Based on the findings, the study has given light to the following:

- Majority of health facility staff were of the opinion that, exemption alone has not fully uplifted barriers to utilization of health services among MVCs because; the intervention didn't communicate these changes to the health facilities. It was a hurried program which wasn't introduced systematically to key stakeholders and the communities where beneficiaries were coming from. It therefore has improved understanding on the fact that, whenever new changes are introduced, there should be timely and appropriate communication between parties involved so that changes can pave their way smoothly.
- The study findings will help NGOs, health facilities and City Council in strengthening coordination of the intervention in order to increase utilization of health services among MVCs using the scheme.
- This study has further added more in a body of knowledge by showing the fact that, eliminating financial barrier alone through exemption scheme can not guarantee utilization of health services among MVCs. Other factors plays crucial role; adequate coordination, availability of medical supplies, number of beneficiaries per household, client-provider relationship, comprehensive coverage of the scheme to all MVCS in the household, appropriate sensitization to the communities are significant components of this intervention.

**Figure 1: Conceptual framework for Individual perceptions towards exemption scheme in utilization of health services**




**Source: Adopted from (Sa-u et al. 2003)** (14)

This study was based on assumption that, the role of exemption scheme in facilitating utilization of health services among MVCs rely heavily on peoples' attitudes and perceptions towards the scheme, their experience in utilization of health services before and after introduction of the scheme, expectations towards the scheme, quality of health services through the scheme, the extent to which people are informed about the scheme and the perceived client-provider relationship. These factors were found to be relevant in explaining why the uptake of health services was low given the existence of exemption scheme.

## 1.4 Research Questions

### 1.4.1 Broad Research Question

What are perceptions on the role of exemption scheme in utilization of health services?

### 1.4.2 Specific Research Questions

1. What is the attitude of caregivers on the effect of exemption scheme in utilization of health services among MVCs?
2. What are perceptions of MVCC members on the contribution of exemption scheme in utilization of health services?
3. What are client experiences in utilization of health services before and after introduction of exemption scheme among MVCs?

## 1.5 Study Objectives.

### 1.5.1 Broad Objective

To explore perceived role of exemption scheme in utilization of health services among MVCs.

### 1.5.2 Specific Objectives

1. To assess the attitude of caregivers on the effect of exemption scheme on utilization of health services among MVCs.
2. To explore perceptions of MVCC members on the contribution of exemption scheme in utilization of health services.
3. To evaluate client experiences in utilization of health services before and after introduction of exemption scheme among MVCs.

## CHAPTER TWO: LITERATURE REVIEW

### 2.1. Overview of the situation of Most Vulnerable Children in Tanzania

HIV/AIDS pandemic is the major cause of increased number of orphans and vulnerable children in Tanzania, coupled with other factors such as poverty and family disintegration (MoHSW,2009). It is estimated that, there are more than 2.6 million children in the Country who are orphaned by HIV/AIDS and other factors(1). The 2002 Population census shows that the commonest orphanhood is paternal which accounts for 7.4% while 3.4% have lost a mother (16).

The 2011/2012 THMIS shows that 9% of children under age 18 are orphans (i.e., they have lost one or both biological parents. It is doubtless that these trends show that, the problem of orphans and vulnerable children is critical.

### 2.2. Definition of a child in Tanzanian context

The 1989 United Nations Convention of the Rights of the Child, Part One, Article One, states that 'For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.' World Bank retains a definition that regards a Child as a person between 0-14 years. As per Tanzania 1977 Constitution, a child is a person under the age of 18. This is also reflected in the 2009 Law of the Child Act where a person under the age of 18 is identified as a child. However, the Law of the Child Act definition which subscribes to the Constitution contradicts that stipulated in the law of the Marriage Act 1978, which allows a 14 years old girl to get married prior to approval by her parents. This debate on definition of a child has a lot of implications in the process of identifying and helping the need during the Interventions that targets children.

### 2.3. Most vulnerable children

The National Costed Plan of Action for MVCs provides an inclusive frameworks that provides a standard categorization of most vulnerable children that includes demographic characteristics and indicators of poor living conditions namely; living in a child headed households, those living in elderly-headed households with no adult from 20-59 years old present, with one or both parents deceased, those with disability, those in rural areas; children

with one surviving parent living in a house with poor quality roofing(grasses and/or mud) and those with a disability living in similar poor conditions, those in urban areas: children with one surviving parent living in a house with poor quality roofing (grass and /or mud) or with poor wall materials or without toilet facilities and those with a disability living in a similar conditions. However, this framework recognizes that, a child may be staying with both parents and still be most vulnerable. On the same token a child may be an orphan and still not vulnerable due to availability of working social safety nets which may be available at a given context (3).

**2.4. Drivers of child vulnerability**

In Tanzania, HIV/AIDS is recognized as a principal driver of child vulnerability. Orphanhood increases child vulnerability on two fronts: it makes it more likely that a child is denied schooling and more likely that a child is exposed to child labor (17). Becoming an orphan reduces of probability of attending school and increases the probability of work. The loss of only one parent has a smaller but still significant effect on school attendance and work. Other factors include nutrition, access to primary education, shelter, access to basic needs and services. It is evident that, child characteristics ( low birth weight, disability, chronic illness) parents and their parenting style (single parent, rejection, young maternal age, Drug and alcohol abuse), Family factors and life events (divorce, large family size) and Community factors (poor housing condition) can eventually produce a most vulnerable child (42). Although HIV/AIDS is widely documented as a prime driver of child vulnerability, still other factors retain significant contributions into the problem of increasing number of Most Vulnerable Children in the Country. However, it is pointed out that, the running strategies to mitigate the impacts of HIV/AIDS may help to reduce the increasing burden of growing number of MVCs.

**2.5 MVCs utilization of health care.**

Utilization of health care has been widely studied. However it is acknowledged that there is no universally accepted definition of utilization of health services (18). However, for this study it is appealing to equate word utilization to ‘timely use of services according to the need’. Furthermore it is argued that, geography, availability; affordability as well as

acceptability are key determinants of utilization of health services (19). However, poor customer care on the part of health workers and lack of self esteem among the poor can also contribute towards limited utilization of health services (20). However, it is strongly argued on the same line that, utilization of health services rests heavily on how people perceive health care being delivered, the context within which they find themselves receiving those services and the characteristics of those services offered to them (21).

People's inability to pay is a prime barrier to utilization of health services. This is true of most MVC households whose income sources are quite constrained by vulnerability of a child or weak community solidarity (22). Peoples inability to pay is vivid through a study by Households, especially poor households which try to cover the financial costs of illness by selling assets such as livestock, land, grain, etc., taking loan, and the like. This idea is further accentuated by studies which shows that in order to remove barriers to increase utilization, policy makers may do good to target their attention to improve financial accessibility of modern health services and improve drugs availability (23). Therefore it may be implied that, income factor is most persistent in decisions of ill people to stay with home-based care and/or traditional medicine, or go to consult modern health services.

Studies have revealed that, despite financial challenge that hampers utilization of health services, Public health facilities are the most used by majority poor to seek health care (18,24,25). The 1990s introduction of user fees payments in these facilities has an adverse effect to the poor (13). Health care charges have placed an impossible financial burden on the poorest households; many fail to utilise primary care when they need it most and many more fail to obtain the necessary referral for more skilled care. These arguments on financial barriers were strongly rejected by those who argued that, the perceived quality of health services is a strong determinant of health care utilisation and it has a differential impact on utilisation of health services (26).

In efforts to mobilize resources, pooling risks, the Government of Tanzania introduced the Community Health Fund (CHF) as a locally managed health financing mechanism to help the

poor utilize health services. However evidence shows that, CHF enrollment in most District Councils is just 2%. Income is amongst the most important factors determining household participation in the schemes, besides quality of care and insurance package. This means the poorest of the poor within the society are not reached as they cannot afford to pay regular insurance premiums (27). The Community Health Fund may have improved the quality and range of services in those places where the CHF is in place. However, the scheme is not necessarily benefiting the very poor in a more equitable way. Many report they are not able to afford the joining fees and therefore pay for treatment on a case-by-case basis, which can ultimately be more expensive.

Most of the MVCs, by virtual of their socio-economic characteristics they cannot afford to pay for these schemes and consequently they are eliminated in the health care system. Eventually, their health seeking behaviors are dictated by caregivers. Studies have shown that a significant proportion of caregivers (65%) are taking action regarding the child illness. Caregivers perceptions on utilization of health services depends on their level of education, motivation for the job, perceived severity of a child and health facility factors (28).

Although a wide scope of knowledge indicates that financial barrier poses a fatal challenge for the poor to utilize health services, other factors are significant to explain the challenge of health services utilization among the poor especially the Most Vulnerable Children. Quality of care, distance and transport and Governance and accountability are serious barriers to utilization of health services (22).

Studies have been conducted in Tanzania to explore poor people's attitudes and perceptions on utilization of health services with regard to condom use, PMTCT uptake, and reproductive and family planning issue. These studies have targeted youths, pregnant women and elders in both rural and urban settings leaving MVCs perceptions on utilization of health services unstudied. This study will seek to explore why utilization of health services remains low, given the existence of exemption scheme. It will further explore perceptions of the people towards the role of exemption scheme in utilization of health services among MVCs.

## CHAPTER THREE: METHODOLOGY

### 3.1 Study Area

The study was conducted in Tanga Region. It is located in the northeastern side of Tanzania Mainland. Tanga City Council has a total area of 536 square kilometers, with a population of 261,613 (29). It is administratively divided into 4 divisions, 24 wards and 60 streets. It is one among six other councils of Tanga Region namely; Kilindi, Nkinga, Handeni, Pangani, Korogwe and Lushoto. The Council's ethnic composition includes; Digo, Sambaa, Bondei, Zigua and Segeju. The Muslims composes a lion share of majority followed by Christians. Tanga City Council has a total of 5474 identified MVCs (3).

Tanga City Council was selected purposefully from a list of six councils because literature review shows that, it is the only council implementing a health exemption scheme in the Region since October 2012 and therefore it suited being a site for this study.

More importantly, the researcher was familiar with health exemption scheme and the place. As Marshall suggested that, investigator should avoid cases/places which are difficult to access or those which the possibility of getting willing respondents is bleak (30).

### 3.2 Study design

Descriptive Cross sectional study design was employed. Considering the fact that the aim was to explore perceptions of MVCs with regard to utilization of health services through their health exemption scheme in Tanga City Council, a qualitative approach seemed relevant because the scheme is a phenomenon in the contenxt in which it was operating. This type of study is used to describe an intervention or phenomenon and the real-life context in which it occurs (31). A similar study design to explore factors influencing utilization of health services was used in Uganda (32).

### 3.3. Study Population

The study population included the following groups of respondents; the City Council's social welfare officers, caregivers, health facility staff, NGO staff and the most vulnerable children committee members. The study's main questions and objectives required involvement of these

respondents because of their roles and attachment to MVCs activities in the Council as follows:

**City Council's social welfare officers:** According to the Law of the Child Act 2009, these officers are obliged to coordinate all MVCs responses and activities by all collaborators in the district, including access to health care.

**NGO implementing MVC programs:** This is a non-governmental, not for profit, international or local, faith or community based institution that implements MVC programs in the City Council in collaboration with the local Government..

**Care Givers (Parents/guardians):** This is a prime group at the household level which is responsible for offering parental care to MVC on daily basis and ensuring that child welfare is enshrined and free from jeorpady.

**Health Facility Staffs:** These are medical and non medical personnels employed to avail health services to the people who come into contact with health facilities.

**Most Vulnearble Children Committee members:** These committees have been established as per NCPA for MVCs 2007 elected by the community members in order to cooperate with caregivers to ensure maximum protection and access to all services needed by MVCs like any other non MVC in the community.

### 3.4 Sample size and Sampling Process

A total of 36 respondents were recruited for the study using purposive sampling technique. It is documented that, a research that uses qualitative methods can be based on quite small samples (33). A list of MVC households who experienced the use of health services through exemption scheme was prepared and a simple random sampling. Names of MVC households were written in different pieces of paper and shuffled in a wide bottle. Then one piece of paper bearing a name of a household was picked up with replacement until a saturated sample was obtained. This technique was robust because it gave an equal probability of each household to be selected. In-depth interview method was used to collect data from key informants who were

judged being rich with information that suits study objectives. The selected respondents for this study were; 3 social welfare officers, 4 NGO staffs implementing MVC program and health exemption scheme, 5 health facility staffs, 6 MVCC members and 18 caregivers. These were the most representative and productive units of the study which were chosen based on their roles and responsibilities in connection to MVC welfare in the Council.

### 3.5. Sources of data

The study used both primary and secondary data to gather information about people's perceptions towards the role of exemption scheme in utilization of health services among MVCs. Primary data was collected from social welfare officers, NGO staffs implementing MVC and exemption scheme, health facility staffs, MVCC members and caregivers. Information about the primary objective of the scheme, the number of MVC targeted per household and the package of services per each visit at the health facility, were secondary data obtained from NGO quarterly reports.

### 3.6 Research Instruments

In-depth Interview discussion guides were developed and used for different groups of respondents. These guides covered topics that correctly answered main and minor research questions and objectives. All discussion guides were composed in English, translated and administered in Kiswahili which was the respondents' common medium of communication.

### 3.7 Pre-Testing

Pre testing was conducted to members of MVCC, caregivers and NGO representatives. A sample of 2 MVCC members, 2 caregivers and 1 NGO representative was selected to take part in the pilot study. Pre-testing was done in one of the wards benefiting exemption scheme services because the scheme is implemented in 11 out of 24 wards of Tanga City Council alone and not in other districts of Tanga Region. However, these respondents were not involved during the main study data collection activities.The exercise revealed that the questions were clear to majority of respondents and themes were coming out from the transcripts to the satisfactory level of the investigator.

### 3.8 Recruitment and Training

Two research assistants were recruited and trained on data collection. These were individuals with background in qualitative study. A Two days training was conducted to equip them with more skills and comprehend very clearly about the study protocol so that study objectives are met. They were primarily involved in interviewing caregivers and transcribe audio data into transcripts.

### 3.9. Data collection Procedures

Data collection and transcription were simultaneoulsy conducted in the field. For 12 days, from Thursday 13th June- Monday 24th June 2013 data were collected from recruited respondents. Before interviews, respondents were screened for eligibility and only eligible participants were enrolled for discussions. In order to get rid of recall bias, we interviewed caregivers from MVC households which had contacted health facility for management of illness episodes, using exemption scheme, over the past two weeks prior to the date of discussion/data collection. A written informed consent was sought having read study objectives to the respondents. In fewer occasions appointments were to be made especially discussion arrangements with City social welfare officers and the NGO staff, but health facility staff and caregivers were willing to be interviewed without setting appointments.

#### 3.9.1 In-depth Interviews

These are flexible, continuous and face-to-face discussions between an interviewer and respondent. It is a data collection technique that involved conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program or situation, in this case the idea about health exemption scheme in relation to utilization of health services. One-to-one interviews were recorded after the researcher had built rapport and asked for a written informed consent from respondents. Kiswahili discussion guides were used to administere in-depth interviews. On average, the discussions lasted for up to 32 minutes while the shortest and longest discussions lasted for 20 and 43 minutes respectively. Researcher used communication skills namely, nodding, gesturing, repeating respondents words and eye contact to extract more information until themes were saturated (ie no further information emerging from interviewee). At the end of each discussion, researcher thanked the participant for the time and participation before filling in Interview Summary Form. Data were checked for correctiness and quality of recording, answered and unanswered questions were carefully tracked and identify gaps that would lead to improvement in subsequent discussions.

### 3.9.2 Document review

This is a data source from which information related to exemption scheme was solicited. The principal investigator reviewed NGOs quarterly and annual reports which were availed to him. On top of that, National Costed Plan of Action for MVCs was also reviewed. These documents were reviewed to give an overview of the health exemption scheme, how it operates, who are beneficiaries, what package of health services does beneficiaries enjoy, the number of beneficiaries it targeted per household and the policy statements regarding operations of child welfare programs. More information was obtained from NGO's quarterly reports. These documents provided an opportunity to substantiate the information obtained from other data collection methods employed in this study.

### 3.10 Data Management and Quality Control

Audio data generated from in-depth interviews were checked for quality and consistency. Then they were transcribed in verbatim using InqScribe and stored in a computer in the format of MS word transcripts for analysis. Each complete transcript beared unique identification features. Names were not written on any study materials because of ethical considerations and compliance to a rule of thumb of confidentiality in researches.

### 3.11 Coding and Analysis

Data collected were coded manually and were based on pre determined themes as per conceptual framework**.** Data analysis employed thematic approach which involved reading through the transcribed texts of all interviews, identifying responses which matched prepared themes based on research questions asked by the study. Then indexing codes into small categories which were eventually grouped together to form a category. Main themes were extracted from these categories, based on research questions. Finally, interpretation was done to make sense of these themes.

### 3.12 Ethical Considerations

Ethical clearance was obtained from Research and Publication Committee of Muhimbili University of Health and Allied Sciences. Approval to carry out the study was obtained from Tanga City Council Executive Director through Social welfare Department. Written informed consent was obtained from all eligible voluntary interviewees for both recording discussions

and photographing. Interviews were conducted in safe locations and free from interference. In order to secure confidentiality names were not recorded anywhere during the study period.

### 3.13 Limitations during data collection

The NGO implementing MVC program in Tanga City Council declined to allow the researcher to photocopy relevant documents for the study. However, permission was given to read and summarise issues of interest to the study during working hours and that helped to obtain relevant information to meet this study objectives.

# CHAPTER FOUR: RESULTS

## 4.0 Characteristics of Respondents

A total of 36 respondents were recruited in the study. All of them participated during in-depth interviews in Tanga City Council. These respondents were obtained in the following distribution: 3 social welfare officers, 4 NGO staffs implementing MVC and health exemption scheme, 5 health facility staffs, 6 MVCC members and 18 caregivers. A table below shows the demographic characteristics of respondents.

**Table 1: Demographic details of respondents by age, sex, educational level and occupation**

| Variable | | Number of respondents | Percentage (%) |
|---|---|---|---|
| Sex | Male | 12 | 33.3% |
| | Female | 24 | 66.7% |
| Total | | 36 | 100% |
| Age in years: | 30- 39 | 7 | 19.4% |
| | 40-49 | 11 | 30.6% |
| | 50-59 | 14 | 38.9% |
| | 60+ | 4 | 11.1% |
| Total | | 36 | 100% |
| Education Level: Graduates | | 1 | 2.8% |
| Advanced Diploma/diploma | | 6 | 16.7% |
| Secondary Education | | 4 | 11.1% |
| Primary Education | | 22 | 61.11% |
| No education | | 3 | 8.3% |
| Total | | 36 | 100% |
| Occupation : Employed | | 12 | 33.3% |
| :Gardening and petty trading | | 24 | 66.7% |
| Total | | 36 | 100% |

The study had 36 participants and the majorities (66%) were females because it was found that majority of MVC households enrolled into the study were headed by women. The table above shows that 91.7% of all respondents had education above primary school level along with 8.3% who reported not to have been to formal schooling. Majority of respondents (66.7%) reported to have been involved in urban agriculture (gardening of green vegetables, fruits) and petty trading to earn their living, while the remaining few were employed in both local government and the NGO. The study found out that, utilization of health services among MVCs was low inspite of existence of exemption scheme. Limited utilization was due to lack of appropriate communication that led to low awareness of exemption scheme. Moreover, inadequate healthcare package and minimal coverage of exemption scheme per household were found to be significantly contributing to limited uptake of health services among MVCs using exemption scheme. Moreover, there were mixed perceptions on people's experience in utilization of health services before and after the scheme. People's expectations towards the scheme were reported to be high. Finally, there was poor quality of health services and poor client-provider relationship in health seeking process.

**4.1. Lack of appropriate communication that led to low awareness of exemption scheme**

The importance of communication when introducing change has been widely documented. Most programs fail because of poor communication between and among stakeholders. Lack of communication was found to be a salient feature in the implementation of exemption scheme for MVCs to utilize health services. Some respondents reported that:

> *"We have been receiving children, accompanied by parents and guardians holding these cards [exemption cards] but we are not aware of their use, the DMO office has not communicated to us of its use, in fact it bears a city council stamp, but it is not enough, they should have told us that there are changes in health care delivery for these children"* [health worker, Mabokweni Dispensary]

Moreover, majority of caregivers in MVC households reported that, the NGO distributed exemption cards without clearely introducing them as to what the card was all about. This entails that, there were very little involvement of direct beneficiaries, right from the beginning, as one respondent was quoted reporting:

> *"……..they came here and gave us a card which we didn't know what to do with it. Second time they said, we should take a card with us when visiting health facilities, but we didn't receive much information about it"* [caregiver, Duga dispensary]

Another respondent reported that, poor communication during introduction of exemption scheme has resulted into low utilization of health services because people have a feeling that, the program didn't involve them and hence it lacks the people's sense of ownership:

> *" they came here quickly, taking photos and they went away, ……., but on the last visit they took photos and names and later they brough us these cards, ……..after sometimes they came back saying we can use health services without paying money, we were all happy, but initially we were not aware how the card would work, that is why I just kept that card waiting, but it came to my attention later that, we can use cards to get exemption for health care costs.…."*[caregiver,Mwambani]

Communication was further capitalized as a barrier to utilization of health services among MVCs using their exemption scheme. An NGO staff said that:

> *".....infact we are negotiating with DMO's office to solve this problem, because we agreed that having signed memorandum of understanding, MVCs should receive health services for free without constrains, but we are aware that there are reported problems especially when MVCs attend health facilities, majority have not been enjoying their right as it was anticipated……"* [NGO staff, Tanga City Council]

### 4.2 Majority had a positive attitude towards exemption scheme

Respondents were asked about their attitudes towards the role of exemption scheme in utilization of health services among MVCs. Majority of respondents strongly approved the idea of introducing exemption scheme to carter for health services among MVCs. Respondent were quoted saying:

> *"This is a helpful initiative, we thank very much our government, Kikwete (President) has a good intention to us, we thank him.……."* [Caregiver, Duga]

Moreover, people's positive attitude towards the role of exemption scheme was vivid when they reported that, the scheme has enabled them to visit and receive healthcare and thereby reduced a financial burden at least by eliminating consulation fee. One among many respondents reported that:

> *"You see … many of them[MVC shouseholds] do not have money they are doing these petty trade activities which earn them just little money to buy daily needs, but the card [exemption scheme] is a good idea to help these children and their families to go to the hospital, get free consulation and receive some drugs if any……."* [MVCC member, Mikanjuni]

These findings imply that, introduction of exemption scheme has helped MVC households to partially foot healthcare costs, unlike the past, when they had to pay for consultation, examination and laboratory as well as medication costs.

### 4.3 Limited health services package offered by exemption scheme

Literature and field experience based on data collected shows that, health insurance schemes tend to be selective in terms of coverage of services in order to discourage expensive patients and accommodate less expensive ones.When respondents were asked about the minimum package of health services, they repeatedly report that the package was very small. This condition disallows MVCs to utilize certain health services. One respondent was quoted saying:

*" ……..…for example it covers consultation, tablets for these common diseases like malaria, abdomenal pain and just small diseases, but if you want to undergo laboratory test, minor operations.……..…my child is suffering from hernia, he is just at standard six, I am told to pay 46,000/- TShs. How can I afford that, they would rather cover these larger costs and leave us the minor ones.……..…"* [Caretaker, Tongoni]

On the same token, it was further reported that, exemption scheme didn't completely take care of financial insecurity of MVCs when they visited health facilities, because the scheme was selectively cartering for less expensive health costs and abandon expensive one:

*"This is just like a game of children ….you give some one an assistance which can not help to eradicate a big problem, let me take a card for you, [respondent, goes inside the house, she collects a card] look at the card, it covers just fewer services…."* [MVCC member, Mabawa]

This implies that, benefit package has not been comprehensive enough to cover all health services that would benefit MVCs who come into contact with health facilities. Nature of the scheme has failed to stimulate utilization of health services among MVCs at the point of need and therefore the scheme didn't play a bigger role in enabling MVCs to use health services.

**4.4 Limited number of MVCs covered by exemption scheme per household**

The study found out that exemption scheme covered neither all household members nor all MVCs identified in one household. From the respondents' perspective, there is ambiguity on the number of people per household who are covered by the scheme. Some respondents reported that:

*"……you are my son, I am telling you that, your sisters have brought me six children and they are all identified as MVC, ask my local leader, he will tell you that….they are staying with me……this card covers only one child, the rest are not covered, even me, I am not covered…."* [Caregiver, Tongoni ward,]

It was further reported that, in majority of MVC households there were more than one MVC. One respondent was quoted saying:

*"….they offer services to only one child, may be they would take care of all children and the non-MVCs because all these are children, they are angels, they are the blessings Allah [God] has given us, why do we discriminate them,…..you have walked in some houses here you see yourself, there is no house with just one child, there are many children in each house…." [Caregiver, Mikanjuni]*

The agony of restricted number of household members taken care by the scheme was a thorn in a flesh, which continued to raise majority of the respoondents' concerns. This was due to the fact that, majority's expectations towards the scheme was too high. Many people who were interviewed had expectations that, the scheme would cover all household members. As some people were quoted saying:

*"…..they give relief to only one [MVC], so if you have three chidlrens [MVCs] like these ones, it is a challenge. We expected that, we would all be covered by the scheme because it is assistance, how can you assist by half, just give a full assistance to the poor, these children are poor and we are also poor. It is impossible because they have put a photo there at the card, not three photos, and if you take a child whose photo doesn't appear on the card, they reject the card"[caregiver, Mikanjuni]*

This implied that health exemption scheme has not been able to maximize utilization of health services among MVCs. For being segregative it might have done more psychological harm rather than benefit because in the same household one MVC is insured while others are not.

### 4.5 Mixed people's perceptions on experience in utilization of health services pre and post exemption scheme

Respondents were asked about their experience in utilization of health services before and after introduction of exemption scheme. There were mixed opinions from different respondents. It appeared that program implementers had similar responses towards questions that asked about the scheme because it is an intervention jointly implemented between NGO and the City Council as one of the NGO staff reported that:

*"Unlike the past [before exemption scheme] now children [MVCs] can easily go to the health facility without contributing any money… for me this is an achievement in bringing health services into human face"* [NGO staff, Tanga]

Majority of caregivers suggested that, exemption scheme had brought significant improvement in utilization of health services but needs some improvements in order for MVCs to enjoy health services like their non MVC fellows. As this respondent capitalized that:

*"We are grateful for the cards……we can manage diseases of these children. Taking care of these children is really challenging and we don't have money to buy our own food, we use cards and they give relief…."*[caregiver, Mikanjuni]

It was further claimed that, there was a very big difference between previous and current experience in utlization of health services, and therefore for some respondents it was claimed that, exemption scheme had played a greater role in enabling MVCs to access and use health services, unlike tha past when they didn't had even some money to pay for consulation. One respondent was quoted saying:

*"……for me there is a greater difference now instead of contributing registration fee at the reception desk[consultation fee], I use that money to buy drugs because several times we are told that drugs are out of stock, so it help indeed……but just that, they need to improve so that we receive many services for these children. There is no way we can deny that we have benefited despite some weaknesses of the scheme"* [Caregiver, Duga]

**4.6 Poor quality of health services**

The aim of exemption scheme as it was found in NGO quarterly reports was to guarantee medical care to MVCs at all times. However, for majority of respondents, it was repeatedly claimed that, there had been problems with availability of drugs in most of health facilities at different times. One respondent was quoted reporting that:

*"……we don't see drugs at the dispensary. We often receive panadol. The drugs may be available for few weeks if you are lucky you may receive miscellaneous drugs for your medication, but after one or two weeks there are no drugs, and for us with*

*these children we are really suffering. No drugs there ……..…..so why do they prescribe us drugs while they know that we can't get them [drugs] there……..."[Caregiver, Mabokweni]*.

This finding entail that, exemption scheme alone is not a solution to avail health services among MVCs, other factors must consistenly cooperate fully to enable the scheme avail expected quality of health services among MVCs who are benefiting from the scheme. One respondent was quoted saying:

*"No drugs there, generally no drugs at the health facility. Even if you have a card, you may get free consultation but without drugs it is nonsense……" [Caregiver, Tongoni]*.

From the health worker perspective, it was revealed that, the scheme is a helpful initiative that would help MVCs use health services at the point of need. However, they claimed that, drugs shortage is inherently a challenge beyond their management. They argued that:

*"Our catchment area is so large, we serve clients from all these surrounding areas bordering Mabokweni, we receive drugs but most of the time they are not in large quantities as we request. We are using the ILS [intergrated logistic system], we send them our projections based on the type of illnesses and the number of clients per quarter, but we don't receive stocks as we order" [health worker, Mabokweni]*.

**4.7 Poor client-provider relationship in health seeking process**

It was found out in this study, people have fear and whenever they want to consult a health facility they recall their previous visits and get discouraged to visit again for medical care. Majority of respondents interviewed reported that, health care workers have been unfriendly when healthcare is being sought. The languages and instructions given by health workers are in a way that, they threaten clients from even asking questions about the type of illnesses they are suffering from, their examination results and how to take medicines. On top of that, there has been poor customer care experience among clients who take MVCs to the hospital. One respondent was quoted bitterly saying:

*"The health workers treat us badly like we are animals,….., she was moody and I said, ……she would rather treat me badly but not this innocent angel,……..angels, she didn't take a child for a laboratory tests,…[Moderator interrupts]……she asked the illness of a child and finally she asked us to go and collect drugs, we got Alu and off we went….no room for questions, they say they are experts;we obey"*. [Caregiver, Mwambani].

On the same line, another respondent was quoted capitalizing this finding. It was said that, the languages spoken by healthworkers are so rude and discourages clients from seeking health care with confidence:

*"Me I don't understand, we used to have one health worker who was really rude and her languages were really bad. I remember in a general meeting we agreed to sack her off. ……are they trained to treat us like this? I go to different places and they are all the same, they threaten us thorugh languages and practices which are deterring"[MVCC member, Tongoni]*

# CHAPTER FIVE: DISCUSSION

## 5.0 DISCUSSION OF FINDINGS

This section provides discussion based on findings obtained from document reviews of NGO quarterly reports and in-depth interviews with 36 respondents. This study aimed at exploring perceptions of the people towards the role of exemption scheme in utilization of health services among most vulnerable children in Tanga.

### 5.1. Lack of appropriate communication that led to low awareness of exemption scheme

Awareness as a sense of informedness is an output of people's participation in development initiatives which stimulates self esteem and a sense of belonging (34). Hence the role of participation in community development interventions is very important withoutwhich development can not take place. The study found that, majority of health facility staffs interviewed claimed not to have adequate information about the scheme and how it operates. It can further be argued on the same token that, awareness at the workplace increases efficiency and customer expectations and reduces efforts needed to coordinate task and resources (35). Although the objective of health exemption scheme was to eliminate financial barriers and increase utilization of health servces among most vulnerable children in Tanga, the findings have revealed that the situation on the ground was contrary. The absence of sensitization component among stakeholders and community members had severely affected the program from attaining its primary objectives and thereby failing to eliminate financial constraints for MVC households from utilizing health services. These findings are consistent with those of Timmis who found that majority of the people including health workers had a very little information about CBHI in Kongwa such that enrollment was low and there happened low uptake of health services due to poor communication between players of the scheme (36). In one published paper, it was argued that, poor planning, poor coordination and poor communication are salient features of most failed exemption schemes across Africa (37). There is sufficient evidence showing that excellent communication strategies must be employed to communicate changes through dialogue, meetings and training in order to clarify the reasons why new changes are introduced (38,39). Community mobilization and sensitization plays a vital role in managing changes in health programs contrary to that changes are prone to resistance and poor cooperation from the people to whom changes are

directed. It is known that health insurance in China collapsed when community mobilization and sensitization were not effectively organized to introduce and sustain changes in provision of health services (40). This is consistent with the body of knowledge which shares the fact that, in places where good planning and coordination is lacking there is a likelihoodness of a failure to realize the goal of exemption scheme (37). This entails that, communication and prior planning are necessary elements to smoothen availability of services such as drugs and other medical consumables. Findings from this study show that, since introduction of exemption scheme there was'nt organized communication strategy that would involve both health facility staffs and community members. There is a vacuum on the part of health facility staff about how does the exemption scheme operate and also caregivers community has been unaware about the exact number of beneficiaries the scheme targets per household and more importantanly a community sense of ownership is lacking in this intervention.

**5.2 Majority had a positive attitude towards exemption scheme**

Study findings also showed that people had a very positive attitude towards exemption scheme because they had very huge exepectations from the scheme. Majority believed that, exemption scheme was their redeemer for all health related matters particularly utilization of health services in the areas of consultation, diagnosis and drugs. These findings are consistent with studies on health insurance funds which were conducted recently across Tanzania. It was found out that, majority's expectations were faded out by poor quality of services which were reflected through a very small health benefit package and shortage of drugs (13,41). It was further argued that, majority of the people who had huge exepectations towards community health fund in Tanzania didn't enjoy the prepayment scheme because the quality of health services was significantly poor. This suggests that health exemption scheme has not been able to fully break the financial barrier for MVCs to utilize fully health services because MVC households continue to seek medical care from nearest drug shops and other health care options available in the community includingfolk healers and self medication.

**5.3. Limited health services package offered by exemption scheme**

Both literature and field experience based on data collected shows that, health insurance schemes tend to be selective in terms of coverage of services in order to discourage expensive

patients and accommodate less expensive one. When respondents were asked about the benefit package of health exemption scheme they repeatedly report that the package was very narrow. This condition disallows MVCs to utilize certain health services. Earlier studies revealed that, majority of health care insurance schemes tend to welcome enrollment of patients with diseases that are less costly and discourage expensive clients to enroll in the schemes so that a business environment is created for profit maximization (42). Given the case in Tanga City it is quite obvious that health care cost for most vulnerable children is a burden that the council can not bear. The MVC households therefore find it worthlessness consulting health facilities to get panadol alone. They therefore continue making use of alternative medical health care options available in their homesteads.

### 5.4 Limited number of MVCs covered by exemption scheme per household

The study found out that, exemption scheme covered only one MVC per household. Respondents reported complain about the ambiguity on the number of people covered by exemption scheme per household. Majority of the households believed that, exemption scheme benefits all household members. They were referring to the community health fund (CHF) experience. However the council's exemption scheme covers only one MVC and segregates other household members. The people interviewed argued that, this is a serious discrimination that has caused lots of complains and psychological trauma to most MVC households particularly MVC who are not covered by the scheme. The scheme is lacking moral credibility which is widely regarded as ethically grave mistake in community health interventions (47).

Furthermore, it has been argued on the same line that, differing interests can occur between program interventionist and the beneficiaries , even when both groups believe that they represent the best interests of vulnerable (43). In this study it was revealed that, the intervention was implemented with clear characteristics which are judged by the beneficiaries as immoral and unethical because the scheme didn't cover all members of MVC households.

### 5.5 Mixed people's perceptions on experience in utilization of health services before and after introduction of exemption scheme

The study has found that there has been no significant difference in utilization of health services before and after introduction of health exemption scheme. Despite the fact that

majority of MVCs have exemption, access to health services have been hampered by absence of drugs and the fact that, exemption package is not comprehensive to cover holistic health services. Similar observations were made by a study which examined the effects of exemption policies in health system (44). It was found out that, lack of information about free services provided and their reimbursement,unavailability of drugs and delays in the distribution of consumables are factors that fails to uplift the financial barriers in facilitating utilization of health services especially among exempted categories of population.

### 5.6 Poor quality of health services through exemption scheme

This study has found that, there are perceptions that public health facilities were perceived to offer low quality care with chronic gaps such as shortages of essential medical supplies and medicines. This is caused by poor logistical systems for ordering and distribution of drugs as well as a very low financial base to accommodate the scheme which exempts MVCs from paying health costs. Similar study findings have been documented in various studies across Africa. It was revealed that, abolition of user fees and introduction of waiver and exemption mechanism to assit the marginalized social groups like pregnant women, children under five and elders posed serious burden and reduced health system revenues to support health services delivery. Studies have further found that introduction of similar exemption mechanism in Uganda, Kenya, South Africa, Madagascar and Ghana in late 1990s and early 2000 led to a loss of revenues for health facilities that had to be compensated (45). Supplementary funding was necessary to implement the abolition policy and particularly to buy medicines. For Tanga City, a financial base to uphold the exemption scheme is weak to sustain the intervention and avail medical supplies in health facilities.

### 5.7 Poor client-provider relationship in health seeking process

The study had found out that, MVC households were not satisfied with the way health workers treated them. The poor customer care has negative weight to the MVC households who needs health care. These findings are consistent with those obtained in a study which shows that, people developed fear and skepticism in using services at health facilities in Uganda, due to unfriendly customer-provider relationship (32). Similarly, poor customer care was a prominent complains in health seeking process which left majority of clients without clear information about the type of illnesses they were suffering from and the direction of next department of services within health facility (46).

### 5.8 Limitations of the study

One of the challenge in this study was, a laborious activity to obtain a list of all MVCs who had experience using exemption scheme in seeking health care. However, the researcher organized all assistants to work hand in glove with chairpersons of MVCC and health workers in relevant health facilities to find out and document a list of all MVCs who had visited and received health services through exemption scheme in health facilities. This list was necessary for the study because, before recruitment of respondents, it was mandatory to run a simple random sampling to select respondents from a list obtained, in order to give an equal chance of eavery household to participate in the study.

It is likely that, some respondents answered questions in a manner that reflected their personal or social desirability. In order to get rid of this bias, we employed research techniques of rephrasing questions and more probes along with assurance of maximum confidentiality in order to minimize the effect of social desirability in this study.

Finally, the study findings contained in this report may not necessarily be generalized to entire Tanga Region population because for qualitative inquiry methodology, the sample size is small and may not necessarily be representative. However, the study findings may be useful for exemption scheme implementing stakeholders, in order to improve and avail quality health services to MVCs using exemption scheme, and therefore achieve the primary goal of the initiative.

## CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

### 6.1Conclusion

The aim of this study was to explore the people's perception towards the role of exemption scheme in eliminating financial barrier and thereby stimulate utilization of health services among most vulnerable children with experience from Tanga. The study findings suggest that, the health exemption scheme has not been able to eliminate financial barriers among MVC in utilization of health services in the event of sickness. The following are the reported reasons which people consider to be determinants of utilization of health services, using the exemption scheme that targeted MVC households in the study area.

Although the objectives of exemption scheme were to eliminate financial barriers and increase utilization of health servces among most vulnerable children in Tanga City Council, the findings from this study have revealed that targeted beneficiaries and other implementing stakeholders were poorly informed about the scheme. This information gap has caused unnecessary incoviniences that exert negative weight to MVCs who fails to foot medical costs. It is lack of information that has rendered people perceiving a scheme as an initiative that has failed to eliminate financial barrier in utilization of health services.Awareness creation through community meetings and training to program implementers is mandatory for a program to achieve increased utilization of health services among most vulnerable children bearing in mind that, customer care, availability of drugs and client-provider relationship must be addressed before it is ruled out that, the scheme has promoted utilization of health services.

Moreover, study findings revealed that people had a very positive attitude towards exemption initiative, but the package of services through exemption was reported to have been burdensome because the package only included consultation and treatment of common illnesses such as malaria and headache. This package constrained efforts to avail quality health services that would see most vulnerable children overcoming health challenges through full protection under exemption scheme. It could have been better if the City Council in collaboration with the NGO and other stakeholders strengthen the scheme by widening a scope of services that MVC could benefit.

The results further suggest that utilization of health services was constrained by limitations of the structure of the scheme in terms of number of people covered per household. The study revealed that, only one MVC was covered by the scheme disregarding the actual number of MVCs per households. There were many circumstances that saw, only one covered in a household of six MVCs who equally need healthcare. On human rights perspective this is an example of human rights violation which imposes serious psychological problems, discrimination and stigma among MVCs. It is more harm than good contrary to ethics of community health interventions.

### 6.2 Recommendations

The following are recommendations based on the findings of this study:

First, there must be some deliberate actions to raise awareness about exemption scheme among community members who are primary beneficiaries, followed by other collaborating partners at the Council level. These are key implementers of an intervention whose achievement relies heavily on people's acceptance and collaboration at all levels. If involved and informed, the community supportive strucutures may be revived in taking care of MVCs.

Secondly, the health exemption scheme should have a comprehensive coverage of benefits so that it fully benefits the most vulnerable children. Access to healthcare is a necessary human right which most vulnerable children need to enjoy in order to reduce morbidity and mortality rates in the country. The exemption scheme must be an insurance mechanism that carter for all health needs of MVCs so that children can realize their full potential.

Moreover, exemption scheme should cover all MVCs in the household as opposed to current situation whereby only one MVC is targeted per household. Such discriminatory interventions may pose serious psychological and social stratifications which may unnecessarily weaken the existing social bonds.

Third, the city council health care system should make maximum efforts to avail medical supplies and equipments. Ideally, these supplies will benefit all patients attending health facilities, but special attention may be put to most vulnearable children who are economically poor to support themselves in efforts to foot health care costs. This will increase utilization of health services particularily among most vulnerable children. Consequentially, caregivers (parents/guardians) will take their children to the hospital much earlier and hence promote health seeking behavior which may contribute to early diagnosis, treatment and management of diseases and thereby reduce child morbity and mortality rates.

Moreover, sustainability of the scheme is unlikely due to lack of strong financial resources at the city council to support this initiative. The study revealed that, this is a challenge that needs collaboration and involvement of community members in order to promote community ownership, and make the scheme a sustainable intervention.

Finally, the City council should solicit supplimentary financial resources to strengthen the scheme through expansion of healthcare coverage per household and scope of services that will include costs for all medical problems. More importantly there should be an improved drug ordering and management actions in order to ensure availability of drugs at all times in the health facilities. Regular supportive visits at health facilities are necessary to coach healthworkers with customer care skills in order to create favourite working relationships between health workers and clients.

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## Appendices

### Appendix: I. Informed Consent Form, English Version

**MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES**

**DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS.**
**INFORMED CONSENT FORM**

ID-NO: | | | | | | | | | | |

Greetings,

My name is ....., a student from School of Public Health and Social Sciences at Muhimbili University of Health and Allied Sciences in Dar es Salaam. I am working on a study which seeks to explore 'perceptions towards utilization of health services among most vulnerable children in Tanga City Council'.

**Purpose of the Study**

Dear respondent I would like to inform you that this study seeks to explore perceptions towards utilization of health services among most vulnerable children in Tanga City council with focus on a Health Fee Exemption Scheme. I further would like to understand what barriers do MVCs encounter in the course of seeking health care, how they overcome these barriers. More importantly I would like to understand whether the scheme has helped MVCs to utilize health services by comparing the previous and current experience among covered MVCs. The findings will help to strengthen and scale up this approach as the best local initiative that may help MVCs utilize health services not only in Tanga but also across all District Councils in Tanzania and thereby reduce donor dependency programs whose sustainability is documented to have been weak. Last but not least, this study is conducted as a partial fulfilment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied sciences.

**Confidentiality**

We will protect and treat the information you will be providing with high confidentiality to the best of our knowledge. We will not write your name on the questionnaire or in any report/documents that might let someone identifies you. Your name will not be linked with the research information in any way. The investigators will take care of the data. And information collected. However, the final results after the analysis will be shared with local and national stakeholders and I will submit the manuscript for publication in scientific journals.

Right and withdrawal alternatives

Your participation is voluntary. You may decline from participation to the study at anytime during interview even if you have consented to participate. Your decision to participate or not will not be associated with your right to work in the facility. There is no penalty for refusing to participate on the study. You will not experience any loss if you refuse to participate in this study.

**Benefits**

The information you provide will help to increase our understanding and give a clear picture on the attitudes of MVCs, caregivers/guardians and stakeholders with regards to utilization of health services using health fee exemption scheme in Tanga City Council. This can therefore help in providing useful information and contribute to future health care policy formulation and strategic planning at the local and national levels.

If any damage will occur

It is not expected that there will be any damage for your participation as the respondent to this study.

**Risks**

There is no harm for participating in the study. However, you are free to stop participation at any time during this discussion in the event you feel uncomfortable.

**Who to Contact**

If you ever have questions about this study, you should contact the Study Supervisor, **Dr. Ezekiel Mangi (+255 (0)713 788 811)** of Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam.

If you ever have questions about your rights as a participant, you may call **Prof. Mainen J, Moshi, Chairman of the Senate Research and Publications Committee, MUHAS. P.O. Box 65001, Dar es Salaam – Tanzania, Tel: 2152489**

**Signature:**

Do you agree?

Participant agrees …….. Participant does NOT agree …….....……

I ……. have read or being read for by researcher and understood the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of participant ……

Signature of Research Assistant ……..

Date of signed consent ……

**DECLARATION**

The above document describing the benefits, risks, and procedures for the research titled "Perceptions towards utilization of health services among Most Vulnerable Children in Tanga City Council**"** has been read and explained to me and I have agreed to participate. I certify that the nature and purpose, the potential benefits and possible risks associated with participating in this study have been explained to me.

Signature or Right Thumb stamp of the respondent.....DATE.....

Signature of Research Assistant.....…….DATE.....

**Appendix: II. Informed Consent Form, Kiswahili Version**

**CHUO KIKUU CHA SAYANSI ZA AFYA MUHIMBILI**

**KURUGENZI YA TAFITI NA UCHAPISHAJI**

**FOMU YA RIDHAA**

Namba ya utambulisho | | | | | | | | | | |

**Ridhaa ya kushiriki kwenye utafiti**

Hujambo! Ninaitwa ……., nashughulika kwenye utafiti huu wenye lengo la kutathmini mtazamo wa watoto waishio katika mazingira hatarishi juu ya upatikanaji wa huduma za afya jijini Tanga.

**Madhumuni ya Utafiti**

Utafiti unalenga kuchunguza mtazamo wa watu juu ya upatikanaji wa huduma za afya kwa kutumia kadi ya bima ya afya ya Jiji la Tanga, kadi hizi huwalenga watoto waishio katika mzingira hatarishi. Unaombwa kushiriki katika utafiti huu kutokana na upeo na ufahamu ulio nao ambavyo ni muhimu kwa utafiti huu. Tafadhali kuwa mkweli na muwazi kwa vile matokeo ya utafiti huu yanaweza yakatoa maamuzi na mapendekezo ya baadaye kwa maslahi ya watoto. Pia, Utafiti huu unafanyika katika kutimiza sehemu ya matakwa ya shahada ya uzamili ya Afya ya Jamii ya Chuo Kikuu cha Afya na Sayansi ya Tiba Muhimbili.

**Nini kinahitajika ili kushiriki**

Ukikubali kushiriki katika utafiti huu, utasailiwa ili kuweza kujibu maswali toka kwenye dodoso lililoandaliwa kwa ajili ya utafiti huu.

**Usiri**

Taarifa zote zitakazokusanywa kupitia dodoso zitaingizwa kwenye kompyuta kwa kutumia namba za utambulisho.Kutakuwa na usiri na hakuna mtu yeyote asiyehusika atakayepata taarifa zilizokusanywa.

**Hatari**

Hatutegemei madhara yoyote kukutokea kwa kushiriki kwako kwenye kwenye utafiti huu.

Haki ya kujitoa au vinginevyo

Ushiriki katika utafiti huu ni wa hiari. Unaweza kuacha kushiriki katika utafiti huu muda wowote hata kama ulikwishatoa idhini yako. Kukataa kushiriki au kujitoa kutoka kwenye utafiti hakutahusisha adhabu yoyote.

**Faida**

Kama utakubali kushiriki kwenye utafiti huu taarifa utakazotoa zitatuwezesha kutupa mwanga zaidi juu ya mtazamo za watoto waishio katika mazingira hatarishin pamoja na walezi wao juu ya upatikanaji wa huduma za afya kwa kutumia kadi ya bima ya fya ya halmashauri ya jiji la Tanga. Matokeo ya utafiti huu yanaweza kutoa taarifa ambazo zinaweza kusaidia katika kuboresha sera ya huduma ya afya na mipango ndani ya jiji la Tanga na hata katika halmashauri zingine nchi nzima.

**Endapo utapata madhara**

Hutegemewi kupata madhara yoyote kutokana na ushiriki wako katika utafiti huu.

**Nani wa kuwasiliana naye**

Kama una maswali kuhusiana na utafiti huu, wasiliana na Msimamizi mkuu wa utafiti, Dokta Ezekiel Mangi (+255 (0)713 788 811) wa Chuo Kikuu cha Afya na Sayansi ya Tiba Muhimbili, S. L. P. 65001, Dar es Salaam.

Kama una swali kuhusu stahili zako kama mshiriki unaweza kupiga simu kwa Prof. Mainen J, Moshi, Mwenyekiti wa baraza la Utafiti na machapisho S.L.P. 65001, Dar –es Salaam. (Simu: 2152489)

Sahihi: .....

Je umekubali?

Mshiriki amekubali ……..... Mshiriki hajakubali …….....

Mimi ..... nimesoma maelezo ya fomu hii.

Maswali yangu yamejibiwa.Nakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki……

Sahihi ya mtafiti msaidizi……

Tarehe ya kutia sahihi ya idhini ya kushiriki……..

## Appendix III. In-Depth Interview Guide (IDI) with Caregivers/MVCC Members: English Version

### Part I: Particulars of a caregiver/MVCC member

Sex…….. Street……..Age……..Education……
Relationship with a child.....
For how long have you been with this child.....……

**Part II. General Health problems and utilization issues**

**a)** What are common health problems that you know in this area?
b) Among those mentioned, which ones affect your child most?
c) Has your child ever fall sick in the last 3 weeks?
d) Where did you go to seek medical care?
e) Why? Why not elsewhere?

**Part III: utilization of health services**

a) Did you get services?
b) How did you manage to afford direct health care costs?
c) What about indirect costs (transport, bribe)
d) What are barriers to utilization of health services which you have experienced?
e) Do you think that, other non MVC can utilize health services easily than a child like yours?

**Part IV: Perceptions on Health Exemption Scheme.**

a) Are you aware of a health fee exemption scheme?
b) Is your child covered? If not why?
c) Have your child ever fall sick and use a scheme?
d) What is your opinion on usefulness of the scheme?
e) Which barriers does it remove in utilization of health services?
f) Is there any difference before and after the scheme in terms of utilization of health services?
    a. Ask about quality, package, customer care,
g) What are some weaknesses of the scheme?
h) What would you recommend about a scheme reaching other children? Why?

***Thank you for your participation and Time.***

**Appendix: IV. Mwongozo wa Majadiliano ya Kina Na Walezi/Wanakamati Wa MVCs: Kiswahili Version**

## Part I: Taarifa za mlezi/ mwanakamati wa MVCs

Jinsi…….. Mtaa……..Umri……..Elimu……...
Mahusiano na mtoto.....
Kwa muda gani umekuwa na huyu mtoto.....……

**Part II. Matatizo ya jumla ya afya na upatikanaji wa huduma za afya.**

a) Ni matatizo gani ya kawaida ya kiafya unayoyafahamu katika eneo hili?
b) Kati ya hayo uliyoorodhesha, yepi humuathiri mtoto wako zaidi?
c) Je, mtoto wako amewahi kuugua katika kipindi cha wiki tatu zilizopita?
d) Mlikwenda wapi kupata huduma?
e) Kwanini? Kwanini isiwe sehemu nyingine?

**Part III: Upatikanaji wa huduma za afya**

a) Mlipata huduma?
b) Ni kwa jinsi gani mliweza kumudu gharama za matibabu?
c) Ni vikwazo gani katika upatikanaji wa huduma za afya mmekumbana navyo?
d) Unadhani kwamba, watoto wengine ambao si MVCs wanaweza kupata huduma za matibabu kirahisi kuliko mtoto kama wako?

**Part IV: Mtazamo juu ya mfuko wa ruzuku ya afya.**

a) Je, unaujua mfuko wa bima ya afya wa jiji?
b) Je mwanao anafaidi mfuko? Kama hapana kwanini?
c) Je, mwanao amewahi kuugua na kutumia huo mfuko?
d) Je, kwa mawazo yako unasaidia?
e) Je, ni vikwazo vipi ambavyo inaviondoa katika upatikanaji wa huduma za afya?
f) Kuna tofauti zozote za upatikanaji wa huduma za matibabu kabla na baada ya kuanzishwa mfuko? Uliza kuhusu ubora wa huduma, hudma zipi zimo nfdani ya mfuko na huduma kwa wateja.
g) Nini mapungufu ya mfuko?
h) Ungependekeza nini kuhusu mfuko kuwafikia watoto wengine? Kwanini?

***Asante kwa muda wako Pamoja na ushiriki***

**Appendix: V. In-Depth Interview Discussion Guide (IDI) With Key Informants (NGO Staffs) English Version**

**Introduction**

My name is……..a student from Muhimbili University of Health and Allied Sciences. I am conducting a study on perceptions towards utilization of health services among MVCs covered by health fee exemption scheme, which is a Municipal Initiative to ensure that MVCs utilizes health services.

I would like to hear from you:

**Part I. Identification particulars of an Interviewee and socio demographic data.**

Which Institution are you working for…… Department…..……
Job title…….Position
Sex……How long have you been in a position?.....

1. **Background Information about the NGO**
   a) What is the name of your NGO?
   b) When was it established?
   c) What are the running programs?
   d) Who are your program beneficiaries?

2. **Back ground information to Health exemption scheme**
   a) How did the health fee exemption scheme come in your program?
   b) When did it start
   c) Who are covered by the scheme?
   d) How do they benefit?
   e) What is the benefit package?
   f) Is there member's contributions? How much? Is it annually?
   g) What is your opinion on sustainability?

3. **What are barriers to utilization of health services among most vulnerable children?**

a) In your experience what are barriers?
b) What are most sticking barriers? Why do you rank them on top
c) What can happen when an MVC fails to breakthrough these barriers?

4. **How do you perceive a role of the scheme towards utilization of health services?**
   a) Do you consider the scheme as a good or bad thing?
   b) Is the scheme effective in facilitating utilization of health services

c) How has it been able to facilitate utilization of health services?
d) Any other relevant information you wish I may know?

**5. Before and after the scheme**

a) In your views, do you think utilization was limited before the scheme?
b) Are you sure that after scheme utilization now is higher?
c) Do you approve that it is helpful in increasing utilization of health services?
d) What do you consider to be the scheme weaknesses?
e) What can be done to improve its efficiency?

**6. Scheme Coverage**

a) How many MVCs are covered?
b) What are their characteristics?
c) What is the feeling of those not covered?
d) What are the plans for full coverage?
e) From which sources shall you be able to raise more funds?

**7. Any other relevant information worth sharing.**

***Thank you for your time and participation***

**Appendix: VI. In-Depth Interview Discussion Guide (IDI) With Key Informants (City Council Officials-Social Welfare, DMO, Community Development) English Version**

**Introduction**

My name is……..a student from Muhimbili University of Health and Allied Sciences. I am conducting a study on perceptions towards utilization of health services among MVCs covered by health fee exemption scheme, which is a Municipal Initiative to ensure that MVCs utilizes health services. I would like to hear from you:

**Part I. Identification particulars of an Interviewee and socio demographic data.**

a) Which Institution are you working for…… Department…..……
b) Job title…….Position
c) Sex……How long have you been in a position?.....

1. **Back ground information to Health exemption scheme**
    a) Are you aware of health fee exemption scheme?
    b) What is it?
    c) Where the idea did came from?
    d) When did it start
    e) Who benefits? How?
    f) What is the benefit package?
    g) What is the contribution for each MVC household?
    h) What is your opinion on sustainability?
    i) What is the financial incentive for providers through the scheme?
    j) Has the Council ever had a similar intervention in the past?
    k) Which group did it target?
    l) Did it work? How?
2. **How does the scheme operate?**
    a) What are sources of funds?
    b) To what extent is it guaranteed?
    c) Any other relevant information you wish I should know?
3. **What are barriers to utilization of health services among most vulnerable children?**
    a) Mention them
    b) What are most sticking barriers? Why do you rank them on top
    c) What can happen when an MVC fails to breakthrough these barriers?
4. **Before and after the scheme**
    a) In your views, do you think utilization was limited before the scheme?
    b) Are you sure that after scheme utilization now is higher?
    c) What is your opinion on the usefulness of the scheme in utilization of health services?
    d) What do you consider to be the scheme weaknesses?
    e) What can be done to improve its efficiency?

## Appendix: VII. Mwongozo wa Majadiliano ya Kina (IDI) Na Watoa Taarifa Muhimu (Wafanyakazi Wa Halmashauri Jiji Tanga) Kiswahili Version

**Utangulizi**

Naitwa……..ni mwanafunzi kutoka Chuo Kikuu cha Afya na Sayansi shiriki cha Muhimbili. Ninafanya utafiti kuhusu mitazamo ya watoto na wadau kuhusu upatikanaji wa huduma za afya miongoni mwa watoto waishio katika mazingira hatarishi ambao wana hudumiwa na mfuko wabima wa Jiji la Tanga, mfuko ambao ni ubunifu wa halmashauri katika kuhakikisha kwamba watoto waishio katika mazingira hatarishi wanazifikia huduma za afya.

**Sehemu ya Kwanza. Taarifa za utambuzi na demografia za mhojiwa.**

a) Unafanya kazi katika taasisi gani…… Idara……..……
b) Wadhifa……Nafasi……..
c) Jinsia……Kwa muda gani upo katika wadhifa huo?.....

1. **Taarifa za awali za mfuko wa jiji wa bima ya afya**
    a) Je unaujua mfuko wa bima ya afya wa jiji?
    b) Ni nini?
    c) Je wazo la mfuko lilitoka wapi?
    d) Ulianza lini?
    e) Nani anafaidi? Kwa jinsi gani?
    f) Je mfuko unajumuisha huduma gani?
    g) Nini mchango wa kila kaya?
    h) Nini maoni yako katika uendelevu?
    i) Je ni motisha gani huipata mtoa huduma kupitia mfuko?
    j) Je, halmashauri imeshawahi kuwa na mfuko kama huo siku za nyuma?
    k) Uliwalenga kundi gani?
    l) Je ulifanikiwa? Kivipi?
2. **Mfuko unafanyaje kazi?**
    a) Vyanzo vya mapato ni vipi?
    b) Je una dhamana kiasi gani?
    c) Taarifa zingine zozote unazodhani ni vema nijue?
3. **Watoto waishio katika mazingira hatarishi wanakumbana na vikwazo gani katika upatikanaji wa huduma za afya?**
    a) Orodhesha vikwazo
    b) Vikwazo gani ni vikali zaidi? Kwanini unaona ni vikwazo vya juu?
    c) Nini kitatokea endapo mtoto atashindwa kuvuka hivyo vikwazo?
4. **Kabla na baada ya mfuko**
    a) Kwa maoni yako, unadhani kwamba upatikanaji wa huduma za afya ulikuwa mgumu kabla ya mfuko?
    b) Unahakika kwamba baada ya mfuko, upatikanaji wa huduma umekuwa ni zaidi?
    c) Nini maoni yako kuhusu faida za mfuko katika kuongeza upatikanaji wa huduma za afya?
    d) Nini udhaifu wa mfuko?
    e) Nini kifanyike kuongeza ufanisi wake?
5. **Taarifa zozote ambazo unadhani zafaa nizijue.**