USER FEE INCREASE IN IMPROVED COMMUNITY HEALTH FUND: *COMMUNITY PARTICIPATION AND COPING MECHANISMS IN KONDOA DISTRICT COUNCIL.*

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By

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A Dissertation Submitted in Partial fulfillment of the Requirements for the Degree of Master of Public Health

Muhimbili University of Health and Allied Sciences
October, 2017

CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance by Muhimbili Muhimbili University of Health and Allied Science as dissertation entitled ***User fee increase in improved Community Health Fund: community participation and coping mechanisms in Kondoa district Council,*** in (partial) fulfillment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

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Dr. Amani Anaeli

(Supervisor)

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DEDICATION

This research work is dedicated to the loving memory of my parents, the late Rashid Hajj Kaku and Tatu Athuman Ngairi for their inspiration and a lovely upbringing that shaped me into a good citizen. May Almighty God have mercy on them.

ABSTRACT

Background: Evidence shows that introduction or user fee increase not coupled with improvements in quality of services triggers diverse coping strategies that result in substantial decline in services utilization. Previous studies focused on the impacts of user fees mainly on utilization of health services and the illnesses-related coping strategies. Little is known on how user fees increase would trigger full range of coping mechanisms in the Tanzanian context. This study explored community participation in decision to increase user fees and the mechanisms to cope with the user fee increase.

Objectives: To explore community participation and coping mechanisms in respect to user fees increase in the improved CHF.

Materials and Methods: A descriptive cross-sectional study using qualitative approach was conducted in Kondoa district Council. Study population was community members, health managers, local community leaders, in-charges of health facilities and relatives of admitted patients. FGDs, IDI and document reviews were employed to foster triangulation of the findings. A total of 33 participants were recruited (23 participants from FGDs, 10 from IDI). FGDs and IDI guides were used to collect data. Special designed forms were used to collect OPD attendance data for document reviews. Qualitative data were analyzed using thematic analysis approach. Inductive approach was used to identify themes as they emerge from the data. The data were analyzed manually through reading and re-reading the transcripts until the content was clear.

Results: This study found that the community was not involved in decision to increase user fees; the decision lacked community ownership, and it was a ‘’top-down’’ order. Regarding strategies to cope with increased user fees; poor people embarked on cost prevention strategies, which in its extreme were marked with complete neglect of treatment, leaving everything to God’s mercy, signifying hopelessness. Others resorted to self-treatment consuming herbals yet others delayed treatment, waiting for spontaneous recovery. Cost management strategies took the form of

borrowing, selling assets, some of which with survival value to households like farms/lands and cereals signaling catastrophic health spending and deepening poverty. The study also found a reduction in health services utilization following user fees increase. Waivers as a protection for the poor against social exclusion were virtually inaccessible especially by the poor. There was a modest increase in enrolments in iCHF following user fees increase.

Conclusion: Community did not participate in the decision to increase user fees and this was linked to poor enrolments in iCHF. Generally, raising user fees as a standalone strategy to accelerate enrolments in improved CHF (iCHF) did not adequately work and came with a heavy price tag of reduction in utilization of health services that offsets any potential benefits. Manipulation of user fees to accelerate enrolments in CHF has to be balanced with strategies that improve accessibility to waivers to protect the poor and vulnerable people.

Recommendation: Kondoa district council should give community participation a due priority in activities targeting the community for the realization of envisaged goals. Further, it should identify the poor and give subsidized CHF ID cards similar to those of the paying counterparts. Kondoa district Council should consider going back to usual user fees for the sake of safeguarding the accessibility of the poor to health services. The Government of the United Republic of Tanzania through the MoHCDGEC and PO-RALG should consider making CHF mandatory using the iCHF model to attain UHC. More studies are needed to establish whether the observed decline in services utilization was due to user fees increase.

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LIST OF ABBREVIATION

AIDS	Acquired Immunodeficiency Syndrome
CBHI	Community Based Health Insurance
CHF	Community Health Fund
FBOs.	Faith Based Organizations
FGDs	Focused Group Discussions
IDI	In-depth interviews
IMIS	Insurance Management Information System
HIV	Human Immunodeficiency Virus
HPSS	Health Promotion And System Strengthening
iCHF	Improved CHF
IMF	International Monetary Fund
KII	Key Informant Interviews
LGAs	Local Government Authorities
LICs	Lower Income Countries
LMICs	Lower And Middle Income Countries
MHI	Micro Health Insurance
NHIF	National Health Insurance Fund
OOP	Out-of-Pocket
OPD	Outpatient Department
SES	Socio-Economic Status
SSA	sub-Saharan Africa
TB	Tuberculosis
UHC	Universal Health Coverage
WB	World Bank
WHO	World Health Organization

DEFINITION OF TERMS

Exemption: An exemption is a statutory entitlement to free health care services, granted to individuals who automatically fall under the categories specified in the cost sharing operationalization manual; MCH services, including immunization of children in all Grade III services; children of 5 years of age and below; patients suffering from TB, leprosy, paralysis, typhoid, cancer and HIV/AIDS; cholera, meningitis, plague, and long term mental disorders (from CHF design manual)

Waiver: A waiver is granted to those patients who do not automatically qualify for statutory exemptions but are in need of the same, and classified as ‘unable to pay, in the operationalization manual (from CHF design manual).

CHAPTER ONE

INTRODUCTION

1.1. Background

Following the economic crisis of 1980s and its impacts in financing of free health systems in developing countries [1] coupled with overwhelming persuasions and conditions orchestrated by the International Monetary Fund (IMF) and the World Bank (WB) [3,4,5], many low income countries (LICs), sub-Saharan Africa (SSA) included, ultimately surrendered to proposed economic reforms that introduced user fees [2,5].

Tanzania introduced cost sharing policy in health services in the form of user fees in 1993 [6]. Subsequently, Community Health Fund (CHF) and the National Health Insurance Fund (NHIF) were introduced in 1996 and 2001 respectively [6,7].

Miserably, the IMF and WB anticipated revenue generation capacity of user charges and its spillover effects into efficiency, quality and improved utilization of health services by the poor did not work due to poor revenue generation capacity [8, 9]. Further, out-of-pocket (OOP) collections were challenged by poor managerial abilities in SSA [27].

Globally, user charges fell out of support as a viable financing mechanism [9, 10]. User fees are a regressive form of health financing that perpetuates the social inequality in accessibility to health care services [11, 17]. World Health Organization estimates that 100 million people are pushed into poverty each year by paying for services while excluding millions others from health services they are deadly in need [23]. Across developing countries, introduction or increase of user fees has been shown in many studies to cause, among others, remarkable decline in health services utilization and widen the existing inequality [12-16].

In Tanzania, OOP spending on health services as a fraction of total health spending accounted for 31.8% in 2012[21], well exceeding the set limit of 20% proposed by World Health Report

below which catastrophic spending is unlikely [31]. In Tanzania, nearly half –a-million people are pushed into poverty each year owing to user charges spending for health [17].

There has been an increasing recognition of the role of CBHIs in reducing OOP spending in health and accelerating the progress toward UHC [33]. However low enrolments in these Micro Health Insurances (MHI) remains the biggest challenge undermining effectiveness and sustainability of MHIs [28, 29].

In Tanzania, people residing in the rural settings and engaged in informal sector makes over 80% of the country's population [18], to them the insurance of choice is CHF. In Tanzania CHF coverage remains painfully low at 10% [20] while in some council it is absurdly less than 2% [21]. Dropout is also very high due to lack of motivation to renew membership. Lower user fees have been associated with low CHF enrolments and dropouts [21,25]. Further, it has been advocated that, higher user charges would enthusiastically push community to enroll into CHF [21] in the same manner the effect of increasing price of coffee would have on the demand for tea. To that end, Kondoa district increased user fees in all primary health facilities effective from 1st of August 2014 to accelerate enrolments in improved CHF (iCHF). However, the approach is likely to hinder accessibility to health services by the poorest and financially vulnerable people [30].

User fee increase is one of the wider proactive approaches employed by Health Promotion and System Strengthening (HPSS) operating in Dodoma since 2011 as iCHF model known in Swahili as ''*CHF iliyoboreshwa"* to accelerate enrolments in iCHF [30]. Evidence shows that user fees increase causes reduction in health services utilization and wider marginalization of the poor [12-16]. Further it triggers series of coping strategies some with detrimental effects.

Previous studies had focused on the impacts of user fees mainly on utilization of health services and the illnesses-related coping strategies. Little is known on how user fees increase in health facilities would trigger full range of coping mechanisms in the Tanzanian context. This study explores the coping mechanisms in reaction to user fees increase and community participation in decision to increase user fees.

1.2 PROBLEM STATEMENT

Evidence shows that introduction or user fee increase not coupled with improvements in quality of services triggers diverse coping strategies with consequent decline in health services utilization [12-16]. Whereas decreasing levels of out-of-pocket (OOP) spending signals good progress toward UHC, nearly half (47%) of the households pay for health services out of their pocket in Tanzania [7].

Community Based Health Insurances (CBHIs) have gained an increasing role in reducing OOP spending and accelerating the progress toward UHC in LMICs [33]. However, low enrolments and dropouts in these CBHIs remain the biggest challenge behind effective and sustainable progress toward UHC in LMICs [28, 29]. In Tanzania CHF coverage remains painfully low at 10% [20] and in some Council it is absurdly less than 2% [7].

Low CHF enrolment has attracted multiple strategies to accelerate enrolments, some with potential for consequences. Fuelled by studies which suggests that lower user fees causes low CHF enrolments [21, 25], Kondoa district council as part of the wider approaches of the iCHF operating in Dodoma Region, raised user fees across the district effective from 1st of August 2014 to shift demand from CHF to CHF in the same manner increasing price of coffee would have effect on the demand for tea.

Previous studies had focused on the impacts of user fees mainly on utilization of health services and the illnesses-related coping strategies. Little is known on how user fees increase in health facilities would trigger full range of coping mechanisms in the Tanzanian context. This study intended to explore community participation in decision to increase user fees and the mechanisms to cope with the user fee increase.

It tries to answer the question of how do households cope with user fee increase? (More enrolments in iCHF? reduction in utilization of health services?, more demand for waivers?, or more impoverishments of the poor households?).

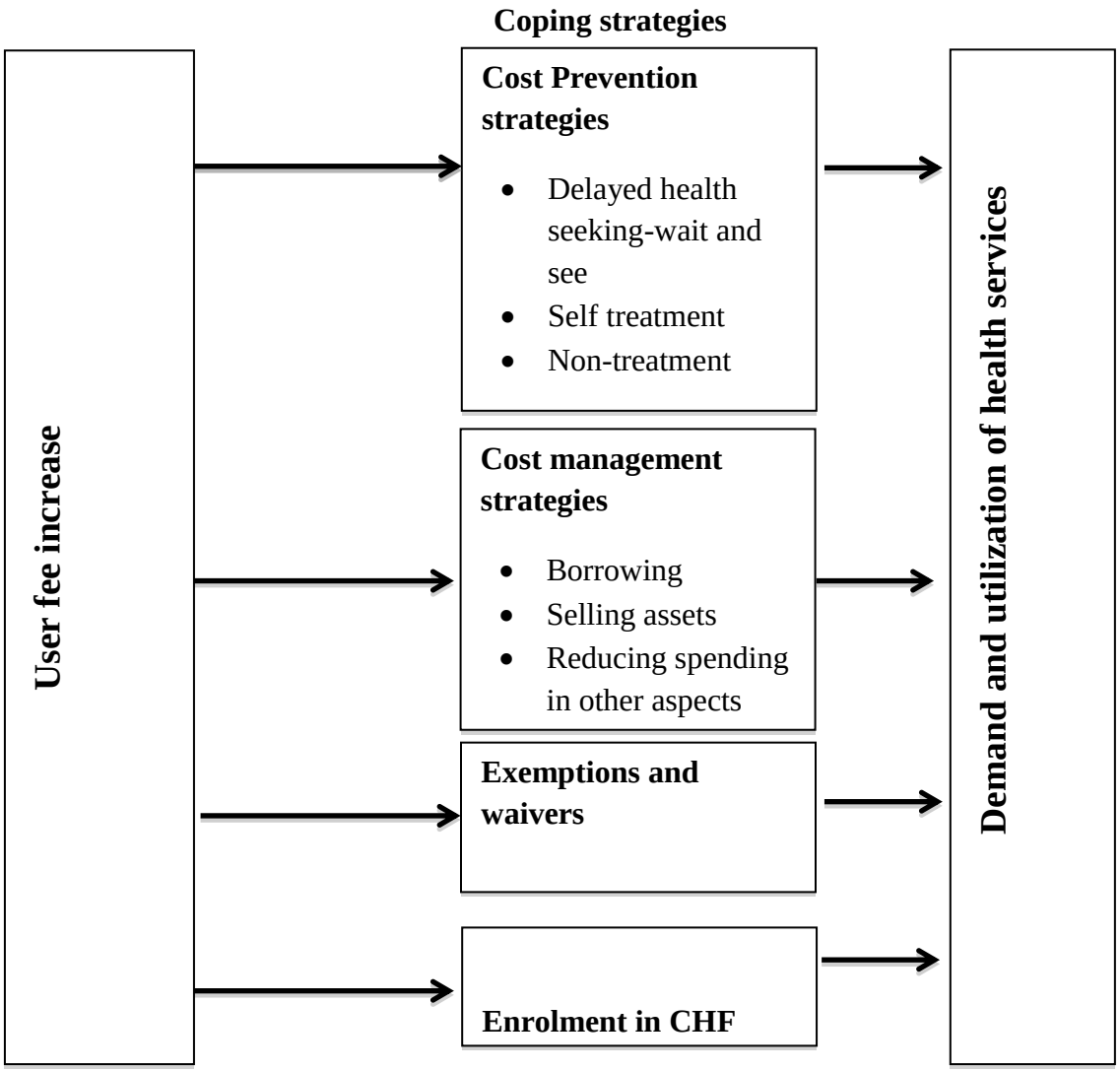
1.3 CONCEPTUAL FRAMEWORK

The figure below illustrates various strategies employed by the community to cope with the burden of out-of-pocket payment for health services. Increase in user fees triggers series of coping strategies. Generally community in the extreme cases copes by; cost avoidance/prevention strategies where people delay seeking healthcare until they realize its threat to the sick with potential for consequences, neglecting treatment at all, self-medication with modern medicine and reaching out for traditional medicine/healers.

Cost management strategies entail ways in which families raise funds to meet medical expenses after they have decided to send the patient for health care. It takes the form of; borrowing, selling assets, and reducing spending in other aspects.

Enrollments in CHF, exemptions and waivers are another strategies that poor families can exploit to cope with higher burden of user charges payments. However, the usefulness of exemption and waivers as a protection against social exclusion by the poorest is subject to how easy is it to access. These coping strategies generally affect demand and utilization of health services.

Factors related to user fees increase, coping strategies and demand and utilization of services.



Source: Researcher's own construct

1.4 RATIONALE OF THE STUDY

This study will generate information on to what extent-raising user fees affect the demand and utilization of health services especially by the poor and therefore will enable decision makers to embrace or ban the approach.

Further, the accessibility to exemptions and waivers, as a major protection of the poor and destitute against social exclusion in health services will be unearthed; this will enable decision makers at local and possibly national level to take actions to make waivers accessible to the poor.

In the wake of Universal Health Coverage (UHC) and the Tanzania's strive to conceive the mandatory Community Health Fund (CHF) scheme for the rural population engaged in informal sector, this study will provide an insight on how best future interventions should protect the poor against inequity, financial catastrophe and impoverishment especially the issue of waivers and exemptions.

Findings of this study is critical for evidence-based policy decision/revision at Kondoa district council, Ministry of Health, Community development, Gender, Elderly and children (MoHCDGEC) in conjunction with President's Office, Regional Administration and Local Government Authorities (PO-RALG) to approve or to ban the approach of increasing user fees as a way of accelerating enrollments in CHF in other LGAs.

1.5 RESEARCH QUESTIONS.

1.5.1 Main research question

What are the community participation and strategies to cope with user fee increase in the improved CHF in Kondoa district council?

1.5.2. Sub-questions.

1. How did the community participate in decision to increase user fee in Kondoa district council?
2. What are the coping mechanisms of the community members after user fee increase?
3. What are the relationships between user fee increase and the utilization of health services?
4. What are the challenges in accessibility to waivers and exemptions?
5. What are the relationships between user fee increase and enrolment in improved CHF?

1.6 OBJECTIVES.

1.6.1 BROAD OBJECTIVE

To explore community participation and coping mechanisms following user fee increase in the improved CHF.

1.6.2 SPECIFIC OBJECTIVES

1. To explore community participation in decision to increase user fee in Kondoa district
2. To explore the coping mechanisms of the community members after user fee increase
3. To explore the relationships between of user fee increase and utilization of health

services.

4. To explore the challenges in accessibility to waivers and exemptions.
5. To explore the relationships between user fee increase and the improved CHF enrolments.

CHAPTER TWO

LITERATURE REVIEW

2.1 Health financing in Tanzania.

As in many sub-Saharan African (SSA) countries, Tanzania introduced cost sharing policy in health services in the form of user fees in 1993 [6]. Subsequently, Community Health Fund (CHF) and the National Health Insurance Fund (NHIF) for people in the formal employment were introduced in 1996 and 2001 respectively [6,7]. Later, NHIF extended coverage to private and self-employed people.

Tanzanian health system is financed by Taxation (21%), CHF (2%), social insurance schemes (3%), and user charges paid at the point of services (25%)[26]. General taxation is the main health financing modality of which it averages 10% of the total National budget; this is below Abuja target of 15% [17,18]. With restricted tax base, similar to many LICs, donor support represents 40% of the total spending on health in 2012 [17]. Per capita allocation was 9 USD in 2012[18].

National Health Insurance Fund (NHIF) is a mandatory scheme based on payroll deductions for government employees and of recent private and self-employed have been included. The NHIF covers only 7% of the population in 2012 [19]. Typical of LICs, private insurance contributes only 1% of the cumulative health financing in Tanzania [17].

Like in many LMICs, over 80% of the Tanzanian population is engaged in informal sector [18], to them CHF is the insurance of their choice. There has been an increasing recognition of the role of CBHIs in the progress toward UHC [33]. Low CHF enrolments and dropouts remains the biggest challenge in effective and sustainable progress toward UHC in LMICs [28,29]. In Tanzania CHF coverage remains painfully low at 10% [20]. Dropout is also very high due to lack of motivation to renew membership.

Researchers have suggested that lower user fees act as a disincentive for the enrolments in CHF (people choose cheap option) in that regard Kondoa district council increased user fees to accelerate CHF enrolments as part of the wider approaches employed by HPSS project operating in Dodoma Region.

2.2 Community participation in decisions to increase user fee.

The community Health Fund in Tanzania operates in decentralized fashion with multiple districts pooling [30] to foster autonomy in decision-making. Planning and management of CHF activities were vested to the community to foster greater community ownership and participation [44].

In a systemic review of factors affecting uptake of voluntary Community Based Health Insurance Scheme in LMICs, Panda et al shows that absence of community involvement in premium setting were among the reasons for low uptake of the CBHI in LMICs [34].

In another study done in Hanang district, it was found that community participation in CHF was unsatisfactory. Further, communities were not involved in decision about the fund [6]. Many previous studies focused on exploring whether CHF members and the community at large participated in setting CHF premium and management of the fund. However, in the improved CHF funds are not pooled at health facility level but management of the fund lies with the CHF management. Community participation does not seek to indulge the community into complex actuarial mathematics of settings new user fees but only a dialogue that creates a sense of ‘’ownership of decision’’ by the community and empowers them to the core rationale of raising user fees. This would make them more conscious of the alternative cheaper option (that is CHF) and get rid of the ‘’top-down’’ decisions disputed by the communities.

Little is known on the participation of the community in setting user fees in the improved CHF. This study will therefore explore whether community opinions regarding user fees increase were sought.

2.3 Community coping mechanisms after user fee increase.

Several studies, both qualitative and quantitative, have been done across LMICs to explore strategies to cope with costs of health services.

In a review done in 15 Africa countries on *‘’coping with out-of-pocket health payments’’* borrowing from friends and families, selling assets and taking loans were the predominant method by which families coped with acute OOP payments when health needs exceeded household's income [35].

Hospitalization carried the highest OOP spending and therefore attracts more borrowing and selling of assets [35]. The household's capacity to successfully cope with costs of services depended on the social capital and the assets profile of the household [35]. The poorest of the households resorted to cost prevention strategies such as non-treatment, delayed treatment and wait and see approach because of limited social capital and assets profile [35].

In a systemic review by Russel (2004) on the ‘’*economic burden of illness for households in developing countries’’* he showed that coping strategies took the form of cost avoidance and cost management strategies. Cost avoidance approaches included neglecting sickness, delaying treatment until the disease is a threat to life and even deterring treatment at all. Cost management approaches involved borrowing, selling assets and labour substitution [36].

For acute and mild diseases, households coped with use of savings, jewelry, borrowing and temporary cuts in other spending [36]. Vulnerable families with constrained assets were shaken and hugely indebted even by short time mild diseases while Chronic and long-term illnesses like TB and HIV/AIDS triggered extensive mobilization of resources that ultimately plunged households into extreme poverty and puts into question future ability to cope [36].

Previous studies were done in settings where user charges were modest and therefore probably its effect on the social exclusion of the poor was less pronounced than in our study setting where there has been a rise in user charges. This study explores the community coping strategies in the background of user fees increase.

2.4 The relationships between user fee increase and health services utilization.

Many studies done in LMICs, introduction or increase of user fees have been shown to cause, among others, remarkable decline in health services utilization and widen the existing inequality in accessibility to health services [12-16].

A quasi-experimental study done in Malawi to explore the effects of user fees on health services utilization where there were sequential introduction and removal of user fees, had it that the abolition of user charges led to a rapid, significant increase in facility utilization of 352 % with similar trend for malaria and HIV diagnoses [12]. Further, re-institution of user fees reversed the situation [12].

In another qualitative study done in Dodoma by Kalolo et al to explore the views and reactions of the beneficiary community of the improved CHF on the implementation approaches, respondents affirmed that higher user charges compel people to CHF enrolments [12].

Evidence shows that poor people are very sensitive to fee changes and would lower consumption of health services disproportionately more than the well-off in response to fee introduction or increase, signifying that user charges are not affordable for these groups [48].

In a study done in Cambodia on the impact of introduction of user fees at a district hospital in Cambodia, it was revealed that percentage of poor attending for care declined from 16% to 7% owing to introduction of user fees while the proportion of the attendees who were medium rich increased from 17% to 25% [49].

Previous studies were done in natural situations where user fees were introduced for some times and people used to it, unlike in this study where there has been an acute increase in user fees. This study explores the implication of user fees increase on the demand and utilization of health services in the Tanzanian context?

2.5 Challenges in accessibility to exemptions and waivers.

Theoretically waiver and exemptions policy exist but its practical application is fault [38]. The policy coherently articulates on exemptions of the vulnerable groups, but grossly incoherent on the waiver side, failing to give the feature of a poor person [39,40]. Many studies done [39-42] revealed that lack of clear criteria of who is poor leaves the whole process of granting waivers to the unchecked discretion of the local village leaders with potential for bias, misuse and preferential favors of the undeserving. In another qualitative study by Maluka et al, respondents reported that exemption policy was blind [39].

Further, there is conflict of interest between health care worker's desires for revenue generation versus financial protection of the poor [39-41]. The burden of exemption is too heavy to bear without the government subsidization [39]. Lack of mechanism by the government to reimburse the money spent in waivers to eligible beneficiaries is a major disincentive against grant of waivers and exemptions [39-41].

Maluka et al employing qualitative methods found that health managers were complaining of the heavy burden of exemptions and waivers where over 50% of the patients attending a facility were exempted and waived [39].

Absence of clear waiver-eligibility criteria leads to failure to demand for waivers by eligible poor because they don't know whether they fit in or not. The combination of stigma and sacrifice of dignity for waiver and a great deal of negotiations, scrutiny and justification of eligibility before village authorities and health care workers makes waivers virtually inaccessible [39-41]. However in some councils like Mwanga district council, the poor have been identified and given CHF card to access health care services [39].

Previous studies done in Tanzania were in the area of waivers and exemptions in the settings where there were no acute increase in user fees and people get used to it hence the demand for waivers might have been low. This study explores the challenges in accessibility to waivers in the background of increased user fees and whether there was any increase.

2.6 The relationships between user fees increase and enrolments into improved CHF.

Researchers have suggested that lower user fees in comparison to CHF premium acts as disincentives to enrolment into improved CHF [28, 29]. This assertion operates through the principle of cross elasticity of demand whereby increase in price of one of the two substitute products leads to increased demand for the other. Dodoma Region through the program of Health Promotion and System Strengthening (HPPS) ‘’Tuboreshe Afya’’ capitalized in this principle where all seven districts increased user fees to accelerate enrolments in improved CHF.

In a study in improved CHF, Kalolo et al showsLLLLL that people were discontent with the coercive approaches (user fee increase included) employed in the improved CHF operating in Dodoma Region [30]. User fees increase is one of those wider approaches employed by the HPSS project to accelerate enrolments in CHF. While user fees increase may theoretically shifts the demand into CHF thereby fostering more enrolments, however, the poor who can’t afford the premiums are not immune from deleterious effects on accessibility to health services. In addition, it is not known whether the approach results into envisaged increase in enrolments into improved CHF. There is paucity of information on the effects of user fees increase on enrolments in improved CHF that this study seeks to fill.

This study will therefore explore the perceptions of the people whether user fees rise did really push people to enroll into improved CHF. Documents reviews will also be done to power the findings of the FGDs and IDI.

CHAPTER THREE

METHODOLOGY

3.1 DESCRIPTION OF THE STUDY AREA

The study was conducted in Kondoa district Council. The district was chosen because it made an impressive gain in CHF enrolments so we wanted to see the contribution of user fee increase. The Council has a total population of 226,147 (2012 population census projections for 2016). Administratively it is divided into 4 divisions, 21 wards, 84 villages and 56,188 households and it has an area of 13,210 square KM. With the exception of 21 villages, the rest of villages receive TASAF funds transfer to poor families to which this study concentrated. The Council has 34 lower level health facilities (Health centres and dispensaries). Of these 26 are public dispensaries, 3 public health centres while 4 dispensaries and 1 health centres are owned by Faith Based Organizations (FBOs).

Dodoma Region is implementing improved CHF (iCHF) in Swahili''CHF iliyoboreshwa''under the support of Health Promotion and System Strengthening (HPSS), ''Tuboreshe Afya'' working as a pilot project since 2011 in Dodoma Region. Total number of households is 56,188, active CHF members was 7,108 as of 26th May 2017 equivalent to CHF coverage of 12.7%. Every village has an enrollment officer (EOs) who registers CHF members and uploads personal information into the IMIS. He is a custodian of the village CHF register.

Improved CHF basically, bears the following features; Separation between insurer and provider of health services, portability of CHF membership card, the web-based database called IMIS, wider benefit package, web based membership enquiry and centralized data base with online and offline mode. New higher user fees were introduced on 1st of August 2014, before which user fees were paid on the *''pay as you consume''* approach where individual services were paid separately upon utilization of each individual service. For dispensaries, average consumption ranged between Tshs 3,000 and 5,000. The user fees were fixed at Tshs 7,000 and 10,000 per single visit per person for dispensaries and health centers respectively.

3.2 STUDY DESIGN

A descriptive cross-sectional study using qualitative approach was done between September and October 2017.

Longitudinal data was used so as to compare the extent of health services utilization and CHF enrolments before and after user fee increase. Longitudinal data or sometimes referred to as panel data refers to routine data collected over a time period and the same data were extracted at different points in time.

3.3. STUDY POPULATION

We interviewed community members, health managers, CHF manager, in-charges of the health facilities, relatives of the admitted patients and community leaders. Thirty-three participants were recruited in the distribution of 23 participants in the FGDs and 10 participants from IDI with key informant interviews.

Participants of FGDs were purposively selected form community members with variability such as CHF and non-CHF members, poorest and the average, men and women etc.

For IDI, 10 participants (key informants) were purposively recruited from a variable group of participants as follows; District Medical Office (1) and Social Welfare Officer (1) to obtain views on waivers and participation of the community in decision to increase user fees, CHF manager (1), Village Executive Officer (1), in-charges of health facilities (2), Relatives of the admitted patients at the time of data collection (2) to obtain views on coping strategies to costs of health services and experienced community leaders (2) to obtain their views on the subject due to their wider involvements in community activities.

3.4 SAMPLE SIZE.

A total of 33 participants participated in this study. We recruited 23 participants from FGDs and10 participants from IDI.

In the FGDs, we planned to conduct 4 FGDs (one in each village without TASAF fund transfer but bearing a dispensary) with 32 participants but saturation was reached after the second FGDs as researchers noticed repetition of similar thoughts and nothing new came out of respondents. In qualitative studies we seek variations in opinions, views or thoughts, once there is no more insights coming out then you have reached saturation and you may consider terminating further interviews, this can be achieved from the second or third FGDs, while in some situations it can be seen from in as many 5^{th}, 6^{th} FGDs or even more. The main determinant of umber of interviews is saturation in information. Data were being analyzed after every interview to pick any critical issues and promptly rectify.

For IDIs, we planned to conduct 15 in-depth-interviews however again due to saturation seen around 10^{th} interview, only 10 in-depth-interviews were conducted.

As for document reviews, All 4 villages without TASAF funds transfer (from a stock of 21 villages) but with a health facility were selected for document review on CHF enrolments before and after user fee increase. Likewise, all four dispensaries falling in the same villages were included in document reviews on health services utilization before and after user fees increase.

3.5 SAMPLING TECHNIQUE

First, by exclusion of villages receiving TASAF funds to avoid bias in CHF enrolments as they are coerced to enroll into CHF, we selected 21 villages that do not receive TASAF funds from a total of 84 villages. Secondly, again by exclusion, 4 villages with dispensaries from a pool of 21 villages were selected into the study.

Four FGDs were to be conducted, one from each of the 4 villages, however, due to early saturation only 2 FGD with 23 participants were done. Selection of participants was purposively done in collaboration with village authorities to get the ‘’most informed participants’’. CHF and non-CHF members, poorest and average people, men and women were invited and participated in the FGDs. Ideally in purposive sampling we aim for information-rich participants who are knowledgeable and experienced with phenomenon of interest in this case community

participation and various coping mechanisms employed by the community they live in, poor and average people alike. It should not be translated as meaning those informed of issues around the globe that has a tied with higher socioeconomic status and therefore unlikely to give a true picture of the community we are targeting to study.

For IDI, 10 participants (key informants) were purposively recruited as follows: District Medical Office (1) and Social Welfare Officer (1) to obtain views on waivers and participation of the community in decision to increase user fees, Village Executive Officer (2), in-charges of health facilities (2), Relatives of the admitted patients at the time of data collection (2) to obtain views on coping strategies to costs of health services, uninsured poor people with previous history of illness or their dependents within the last 30 days (2) to get an insight on cost prevention strategies, active CHF members (2), CHF manager (1) and experienced community leaders (2) to obtain their views on the subject due to their wider involvements in community activities.

The maximum variation purposive sampling technique was used to include into the study, people from diverse backgrounds and varied group of participants giving views about a common topic to achieve the goal of triangulation in study participants. It does not mean a bigger sample size. Majority of participants of IDI discussed a common topic with only few participants like health managers who had an extra interview on the conflict of interest, of which other participant were not interviewed on. This exactly fits into maximum variation type of purposive sampling.

For document reviews, 4 villages without TASAF funds but with health facilities were included in data collection on CHF enrolments one year before and one year after user fee increase. Similarly, 4 dispensaries from the same 4 villages were selected to collect data on OPD attendance one year before and after user fee increase.

3.6 DATA COLLECTION METHODS AND INSTRUMENTS.

We gathered data from community members through 2 FGDs and 10 in-depth-interviews with a total of 33 participants.

Focus Groups Discussions (FGDs), in-depth interviews (IDI) and document reviews were conducted using semi-structured FGDs and IDI guides. The interview guides were written in English and translated in Swahili to enable easy comprehension by the local community. The questions in FGDs and IDI guides were open ended and non-leading.

On document reviews, special designed data collection forms were used to collect data on Health services utilization and CHF enrolments before and after user fees increase.

Questions for both FGDs explored community participations in decision to increase user fees and coping strategies such as cost avoidance and cost management strategies, relationships between user fees increase and CHF enrolments and demand and utilization of health services, challenges in accessing waivers following user fees increase.

IDI on the other hand, included 10 participants instead of

15 in the proposal, again was after reaching saturation around 10^{th} participant, participants from a wide variety settings allowed for diversity in views. Participants were from the following;

I. District Medical Office (1) and Social Welfare Officer (1) to obtain additional views on exemptions, waivers and participation of the community in decision to increase user fees,
II. Village Executive Officer (1) to obtain additional views on how community participated in decision to increase user fees, process of requesting waivers, among others.
III. In-charges of health facilities (2) to get additional views on relationships between of user fees increase and health services utilization and characteristics of those attending for care.
IV. Relatives of the admitted patients at the time of data collection (2) to obtain views on coping strategies to costs of health services.
V. CHF manager (1) to obtain additional views on the impacts of user fees on CHF enrolments, and
VI. Experienced community leaders (2) to obtain their views on the subject due to their wider involvements in community activities.

Five participants were not included in IDI, namely VEO (1), the active CHF members (2), and uninsured poor people from the community (2).

Saturation in the case of VEO was possible because was to be interviewed on the community participation in decision to increase user fees, among others, the same topic had been extensively covered in FGDs and one VEO interviewed repeated the same information covered in FGDs. Active CHF members were to be interviewed on, among other issues, motive behind their enrolments into CHF, the same topic had been again covered in FGDs where CHF members were among the discussants, so in the field, it was regarded as methodological repetitions. On the uninsured poor peoples from the community, the same topic was extensively discussed in FGDs where they formed part of the participants and also covered by key informant people from the village.

3.7 DATA COLLECTION PROCESS.

Two research assistants, who were Nurses versed with research issues yet anonymous to the local villagers, were trained before deployment to the field for data collection. A note taker was aiding in recording key issues and important summary and salient issues arising out of the FGDs and/or IDI. Relevant identification from Kondoa district council were sought to enable smooth working.

The FGDs were conducted in the office of VEOs, yet were cool and allowed discussion to go smoothly. Participants were introduced to the aim of the research and invited to participate. Before starting the discussion norms were laid down where group members agreed together that phones should in silence mode, if someone wants to speak he/she must raise a hand, respect for ideas from others, no wooing. They were instructed that they were free to stop and leave any time they fee to do so. The first questions were general ones to orient members and build rapport and confidence of the participants and familiarization.

Sensitive questions were reserved to the end.

Each of the two discussions took about 60-90 minutes on average. Data were collected between

September and October 2017. For IDI like FGDs the steps were roughly the same.

3.8 DATA MANAGEMENT.

Data obtained from FGDs and IDI were checked and cleaned on daily basis to ensure correctness, completeness, consistency and preliminary analysis. This was done to depict any unforeseen problems in quality of data emerging from the field to enable early corrections. However, there were no problems. Digital recorders were checked for the suitability.

3.9 DATA ANALYSIS

Interviews and group discussions were analyzed by thematic method.

Data were transcribed in its original language (verbatim transcription) and later were translated into English. The researcher did analysis every day as he gets data through reading and re-reading. Data were analyzed manually. Pre-set codes (referred to as priori codes) were created as initial codes based on conceptual framework, Research questions, and objectives. For example in this study interviewing community members on the coping strategies to user fees increase, the codes were ‘’self-medication’’, ‘’delayed treatment or wait and see’’. Emergent codes which are ideas coming up different from pre-set codes were also analyzed. Change in attitude of the health providers toward CHF, that now members were courtesy welcome, arose as an emergent code. Codes were created manually.

A list of these codes was organized into a ‘’codebook’’ upon which they were collapsed into a larger codes called themes. Data in these codes were securely preserved just like files in the folders to ensure its trustworthiness and to avoid confusion especially in cases where codes are many. Themes were searched from the general list of the codes created; some codes formed main themes or sub-themes, whereas other codes were discarded.

Repetition of the coding process was done in cases of sample that brings concern.

Subsequently, themes were reviewed and reorganized to form a coherent pattern and the relationship between themes to reflect the meaning of data. Themes were then defined and

named and later final analysis and report writing was done.

Documentary review; for health services utilization, OPD attendance Data for CHF members and user fees subscribers were collected one year before user fee increase that is 01/08/2013 to 31/07/2014 and one year after user fees increase that is 01/08/2014 to 31/07/2015. These data were compared to elicit whether there was any decline or increase in those parameters.

For CHF enrolment, CHF enrolments data before user fee increase from 01/08/2013 to 31/07/2014 and after user fees increase 01/08/2014 to 31/07/2015 were collected from village CHF registers. We used those from village registers instead of from Insurance Management System (IMIS) database because they might be low due to delays in entering the data into the system.

Trustworthiness of the findings.

Trustworthiness in this study was established on the ground of credibility, transferability, dependability and confirmability.

Generally, trustworthiness of the findings was ensured in this study from triangulation of the findings, among others. In fact, even if only FGDs and document reviews were conducted, leaving aside IDI, the findings could still be trustworthy. This is so because participants of IDI discussed the same topic discussed in the FGDs save for certain little areas like conflict of interest in granting waivers which only health managers were interviewed. The concept of saturation is still valid because of the shared common topic of discussion that was seen in this study.

Credibility

This refers to how the findings relate to the reality. This was fostered through triangulation where multiple sources of evidences corroborate each other. The use FGDs, IDI and document reviews best suits for triangulation.

Also the selection of maximal variation sample, triangulation of study settings through use of multiple dispensaries at different localities and involving people who had a real experience of certain conditions like waiver process increases credibility of the findings.

Transferability

Literally means the extent to which the findings of this study can be applied in other situations. For the findings to be transferrable there must be'' shared characteristics''.

To enable transferability to be a reality, the setting under study and/or participants is described in details. With such in-depth description, the researcher allows readers to transfer information to other settings and to determine whether the findings can be transferred to settings with shared characteristics. In this study detail of the settings and every step is done

Dependability

Refers to ability of replication of the findings if similar study is repeated in the same settings and in adherence to the methodological approach used in the parent study.

Detailed description of the methodology has been done to enable future replication.

Confirmability

This refers to a degree of neutrality in the qualitative study findings. It entails that findings emanating from the study is not based on biased methodology or manipulation of the researcher to influence his desired outcome but participant's unbiased responses. Triangulation in data sources, study settings, study participants enable confirmability. In addition, FGDs and IDI guides questions have been crafted in a manner that avoids influencing participants to the desires of the researcher.

3.10 ETHICAL ISSUES:

Ethical clearance was sought from MUHAS research and publication and ethical clearance committee. Letters to seek permission were sent to the District Executive Director. Participants were given written informed consent form to make informed decision to participate in the study.

Participant's written informed consent was sought after detailed information on the nature of the research and the expected benefits. The right to decline and to withdraw from the interview at any time was explained and that no consequences shall befall onto them. Privacy and confidentiality were highly considered. All interviews were recorded as anonymous and kept confidential. Further, they were ensured that identity of informants couldn't be shared to any third party. As for the use of audiotape, the respondent's prior permission was sought.

Only Principal investigator and research assistants had the privilege to handling the data and transcripts. Data and transcripts were stored in a secure place to ensure Security. No data were left in less secure places and electronic gadgets.

3.11 STUDY LIMITATIONS

Potential bias from households receiving TASAF money transfer to poor households

Mitigation.

Villages covered by TASAF money transfer scheme were not included in this study.

Potential for bias from research during analysis

Mitigation

Analyzed data were shared with research assistants for consistency

CHAPTER FOUR

RESULTS

4.0 INTRODUCTION

This chapter presents the findings of the study on community participation and coping mechanisms to user fees increase in improved CHF (iCHF).

A total of 33 participants participated in this study (Table 1). Majority of the participants were males 26 (78.8%). The mean age of the participants were 48.5, the age distributions of the participants are as in table 1. Majority of the participants had a standard seven education 20 (67.5%) and 6 (19.3%) had education above form four (Table 1).

Table 1: Demographic characteristics of respondents of FGDs and IDI, in Kondoa District Council, Central Tanzania, 2017

Demographic Characteristics	Variables	Respondents	
		N	%
Age (years)	20-29	1	3.0
	30-39	8	24.2
	40-49	11	33.3
	50-59	6	18.2
	>60	7	21.2
Sex	Female	7	21.2
	Male	26	78.8
Education level	<Standard seven	2	6.1
	Standard seven	21	63.6
	Form four	4	12.1
	>Form four	6	18.2

Detailed findings of this study are presented in themes in accordance to the research questions. The main themes included; community participation in the decision of raising user fees, community coping strategies after user fees increase, the implication of user fees and utilization of health services, challenges in accessibility to waivers and exemptions, and lastly, the relationships between user fees increase and enrolments in improved CHF.

4.1 Community Participation in the decision to Raise User Fees.

This objective explored whether there was an active community participation in decisions leading to user fee increase. It did not seek to indulge the community into complex actuarial mathematics of settings new user fee, but rather a merely community dialogue that would make them own the decision and get rid of the ‘’top-down’’ decisions that communities dispute. This was geared to empower them to the core rationale of raising user fees and to make them aware of the alternative cheaper option (that is CHF).

All Participants in FGDs reported that they never participated in anyhow in the decision that led to user fee increase in dispensaries and health centres across the district. Majority was informed of the new user fees in public rallies while others became aware after an encounter with health facilities. One respondent from FGD remarked:

‘’…. What I personally know is that, community was not involved whatsoever (in the decision to raise user fees) but it came as an order and we were invited to the public rally where it was announced that for those who have not enrolled in CHF (from now on), the cost sharing (user fees) will be Tshs 7,000 (per visit) for dispensaries and Tshs 10,000 for health centres, it came as an announcement’’ (FGDs K11).

Yet some participants of FGDs heavily disputed against the ‘’top-down’’ approaches in management where those at the village level are just recipients of orders from the top managements, he laments;

''.... Those at the council level were the only involved (in decision to increase UF) but for us at the village level it comes as an order that we have decided this (to increase user fee)'' (FGDs K11).

Approval of an agenda to increase user fee at the council level

Health managers during in-depth interviews and some of FGDs participants were aware that their representatives (councilors) endorsed the decision to increase user fees as a strategy to accelerate enrolments in CHF in Kondoa district council. One IDI participant remarked;

''The department tabled the proposed user fee increase as a strategy to accelerate enrolments in the improved CHF in the Council Management Team (CMT) to start with, then in the Social Services Committee (Education, health and water) and finally in the Full Council where it was endorsed. Later, the letter to village authorities and health facilities in charges giving a date to start new user fees as of 1st of August 2014 were disseminated across the district'' (IDI 01)

Another FGDs participant added;

''... I'm aware that our representative as a councilor participated (in decision to rise user fees) and for us the feedback came during village assemblies and other meetings convened by council officials. Therefore I believe we participated to some extent, we participated because as long as our leader who usually participates in meetings came to inform us (of the changes in UF) then we have participated'' (FGDs H06)

The nature of the intervention ''user fee increase to accelerate CHF enrolments'' was a purely community intervention that needed the participation of the very community so as to own the decision and foster more enrolments in CHF. Direct participation of the community would have created awareness on the cheap option which is CHF and avoid indulging into costly user fees. Participation of councilors as representatives of the community was inadequate to foster more enrolments in CHF.

4.2 Coping strategies of the community members after user fee increase.

This study explored strategies used by the community to cope with user fee increase especially the poor who might not afford the current user fee. This part is divided into sub-themes namely; cost prevention strategies and cost management strategies.

The cost prevention strategies are further sub-divided into non-treatment, self-medication and delaying treatment or wait and see approach.

4.2.1 Cost prevention strategies

Cost prevention strategies refer to a situation in which poor household resorts to costs avoidance that negatively impacts health-seeking behavior. They are usually maladaptive coping strategies with potential for serious consequences. It is sub divided as follows;

Non-treatment

Respondents both in the FGDs and in-depth interviews showed that in extreme situations, poor people resorted to completely neglecting treatment waiting for God's mercy with signs of hopelessness. Further, awareness of the risks of neglecting treatment was evident. He reports;

''But also exist some people in the villages and hamlets who because of poverty, don't seek treatment at all, he becomes sicker and sicker until God heals him, and this is a threat to their life'' (FGDs H01).

Another respondent from the IDI said;

'' There exist few poor people that decides to stay at home (because of poverty) without treatment just waiting for God's destiny'' (IDI 07)

Self- medication.

Most of the participants of FGDs and IDI cited buying medication from the Accredited Drug Dispensing Outlet (ADDO) as the most common approach used by those who can't afford paying the new user fees.

Of serious concern and with potential for consequences, some patients and/or their relatives made both self-diagnosis and self-prescription, they then headed to a nearby medical store and request medications of their choice. One respondent affirms;

''.... Nowadays we are getting used to know our illness even before investigations, therefore I usually go to buy medication relating to what I'm feeling, without tests, tests are just drawn in my thoughts. Therefore I just directly go to a dispenser in ADDO I tell him, Mr! Give me a certain medication and I take it and start using'' (FGDs K06)

Respondents also reported self-medications with herbal medicines and other ineffective treatments with potential for morbidities and mortalities. Here a participant relates;

''Because of poverty, a person decides to go and dig some roots or if he has some coins he goes to an ADDO shop to buy paracetamol and he continues with his illness or he recovers by God's mercy'' (FGDs Ko.6).

On the same note, another respondent reported;

''The inception of this (higher user fees) will encourage marketing of traditional medicines while prompting others to opt for shortcuts in treatments by saying I know my malaria and typhoid symptoms (self-diagnosis and self-treatment)'' (FGDs K11).

The main driver of self-medication seems to be poverty and the client's feelings that they are over paying allegedly due to perceived lack of value for money given the long-term problem of medications stock outs. That is the fixed user fees of Tshs 7,000 charged at health facilities seems to be disproportionately higher than the actual cost of services to be provided.

''Paying amount of money equivalent to the extent of service utilized would have been easier than this (approach) where you pay the fixed token of Tshs 7,000 perhaps the services provided is less than Tshs, 7,000, this makes a person resort to an alternative medicine or to just pass to Accredited Drug Dispensing Outlet and pick some medications and leave'' (FGDs K10).

Delaying treatment, the wait and see approach.

Poor people struggle to feed their families as such they save nothing to cater for health services costs, therefore circumstances force them to delay treatment hoping for spontaneous recovery to take place. However, when the patient's life is at risk then active mobilization of resources to finance health services is done at any cost. This option is usually taken late and therefore put patients at risk for morbidities and mortalities.

''.....as you are aware of the prevailing financial difficulties, so we told her to wait so that we look for the money meanwhile she continued to suffer, every time you visit her she would tell you that I didn't sleep the whole night, so we took decision to raise funds from amongst the family members so that she could attend the hospital for the third time''(IDI with relative of the admitted patient).

Generally, cost prevention strategies are a maladaptive coping because it negatively affects health-seeking behavior. Quite often than not, poor people struggle even to feed the household, therefore they have no saving to cater for later health care costs. It follows that when a household falls sick the only option at hand is delaying care hoping for naturally recovery to take place or mobilize funds when life is at risk.

4.2.2 Cost Management Strategies

Cost management strategy refers to approaches used by sick and relatives of the sick person to manage direct and indirect costs related to treatment.

Respondents in FGDs and in-depth interviews cited borrowing, selling properties, bonding, support from relatives and begging from religious institutions like churches and mosques and

well-wishers and as ways used to mobilize funds to finance healthcare costs. This is clearly a catastrophic spending. One respondent reported;

''Incase I do not have money to pay costs of healthcare, I can enter a contract for borrowing, selling animals like goat, selling farm/land or bonds so as to cope with the costs of admitted patient'' (FGDs H06).

Yet another participant said;

There are some illnesses one may go to a hospital and told that (he needs) Tshs 50,000 or 200,000 and he goes back home. He go to beg in churches or mosques or even individuals, he openly declare his economic status for the public's support'' (FGDs H02)

Sometimes families have to spend days to months mobilizing resources as little as Tshs 150,000 to get their loved ones out of agony. The respondents accounted how they mobilized resources to finance costs of treatment for their mother who needed an operation worth Tshs 150,000 as follows;

As a matter of fact, at home the situation is so difficult no good harvest people are in a dire situation, probably most likely something to quickly grab and sale is perhaps if you own a chicken at home you sell at around Tshs 10,000 and 12,000 and another (member of the family) likewise he struggles in his ways, if he has a goat he sells or he borrows somewhere, he knows his secrets. For me I had to sell a chicken of mine to contribute into her care costs…. So in that way we managed to mobilize the required money'' (IDI with relative of the admitted patient)

Selling little things like eggs in the past when user fees were paid in the fashion of ''pay as you consume the services'' and as little as Tshs 2,000 would suffice to access OPD services. A respondent asserts;

''...Some are using traditional medicine because they don't have Tshs 7,000 (user fees for dispensaries), previously it was a norm perhaps Tshs 2,000 was possible (to get treated) of which selling at least 10 eggs would enable someone to access services'' (FGDs H01)

Selling properties were the main stay means of mobilizing resources to finance health care costs especially for those paying out-of-pocket, however, because of restricted resource profiles, the poor were selling properties that were of survival value to the household such as crops or livestock used for farming. This has potential to plunge the household deeply into poverty and hunger. One participant reported;

‘*’’You don’t have insurance and suddenly someone falls sick such as fracture of the limb and you send him to hospital, then it is just to take risk by selling farm, if you have a cattle you sell it or even crops so as to save his life, consequently you deeply sink into poverty’’(FGDs H06)*

4.3 The relationships between user fees increase and the utilization of health services.

The study looked at whether the user fees increase has had implication on the demand and utilization of health services in selected health facilities.

In this objective, data were collected through document reviews, FGDs and IDI for triangulation of the findings.

Health services utilization was measured through Out Patient Department (OPD) attendances using routinely collected data. Patterns of OPD attendances one year before user fees increase that is from 1st of August 2013 to 31st of July 2014 were compared with OPD attendance a year after the user fees increase, from 1st of August 2014 to 31st of July 2015 to elicit any change in utilization of services.

The document review revealed that OPD attendance for those paying user fees declined by 47.4%, surprisingly, there was 257.8% increase in OPD attendance for CHF members (Table 2&3). Total OPD attendance for the non-exempted group declined by 17.9% (Table 2&3).

The increase in OPD attendance by CHF members (257.8%) was disproportionately higher compared to the enrolments in CHF during the same period (Figure 1) raising speculations of moral hazards by the CHF members.

Table 2: Annual OPD attendances for CHF members and the User fee paying group in Kondoa District Council, Central Tanzania, 2017.

Variables	Period 1: Before user fees increase [a] August 2013 to July 2014			Period 2: After user fees increase [b] August 2014 to July 2015		
	UF	CHF	Total	UF	CHF	Total
Haubi Disp	1,240	92	1,332	754	474	1,228
Kisaki Disp	761	153	914	160	300	460
Hebi juu	285	11	296	243	86	329
Bura Disp	100	0	100	97	56	153
Total	2,386	256	2,642	1,254	916	2,170

Abbreviations; UF-User fee; CHF- Community Health Fund.

Total attendance in this study was just a simple summation of attendances by CHF members and user fees subscribers.

OPD attendances for CHF members in all studied facilities increased after user fee increase while those subscribing to user fees declined following user fees increase. The decline in total OPD attendance was slight due to compensatory increase in attendance by CHF members.

OPD attendance for those subscribing to user fees declined by 47.4% while that of CHF massively increased by 257.8% (Table 2 and 3). There was only modest decline in total OPD attendance allegedly due to compensatory increase in attendance by CHF members.

The findings of the document reviews on the implication of user fee increase on health services utilization are congruent with that of the FGD and IDI.

Table 3: Estimated changes in health services utilization after user fee increase in Kondoa district council, Central Tanzania, 2017.

Variable	Percentage change in OPD attendance		Total attendance
	User fee group	CHF members	
Haubi Dispeansary	-39.2	415.0	-7.8
Kisaki Dispensary	-79.0	96.0	-49.7
Hebu juu Dispensary	-14.7	681.0	11.1
Baura Dispensary	-3.0	Undefined	53.0
Total	-47.4	257.8	-17.9

Table shows that OPD attendance for those paying OOP declined by 47.4% while the one for CHF massively increased by 257.8%, leading to suspicion of moral hazard. Note the slight decline in total OPD attendance allegedly due to compensatory increase in attendance by CHF members.

Respondents of both FGDs and IDI reported that health services utilization by those paying OOP has significantly declined owing to user fees increase. Further, it was reported that majority of the attendees were CHF members and the exempted groups (under fives, pregnant women and elderly). The OPD attendance for CHF members increased significantly which signify an improvement in health seeking behavior owing to lack of financial barrier. One respondent remarked;

‘’*…. even if you go check data at the dispensary (Haubi Dispensary) you will find that those attending for treatment without CHF have declined. You may find that its pregnant women, under fives, elderly and those with CHF that make the biggest percentage than those paying user fees. The community is stack (with this user fee increase)’’ (FGDs H01).*

Along the same line, another respondent reported;

''...If you look into the data of the health facilities previously (before user fees increase) had the highest attendance for those paying out-of-pocket, but now (after user fee increase) those paying out-of-pocket has been in constant decline'' (IDI health manager).

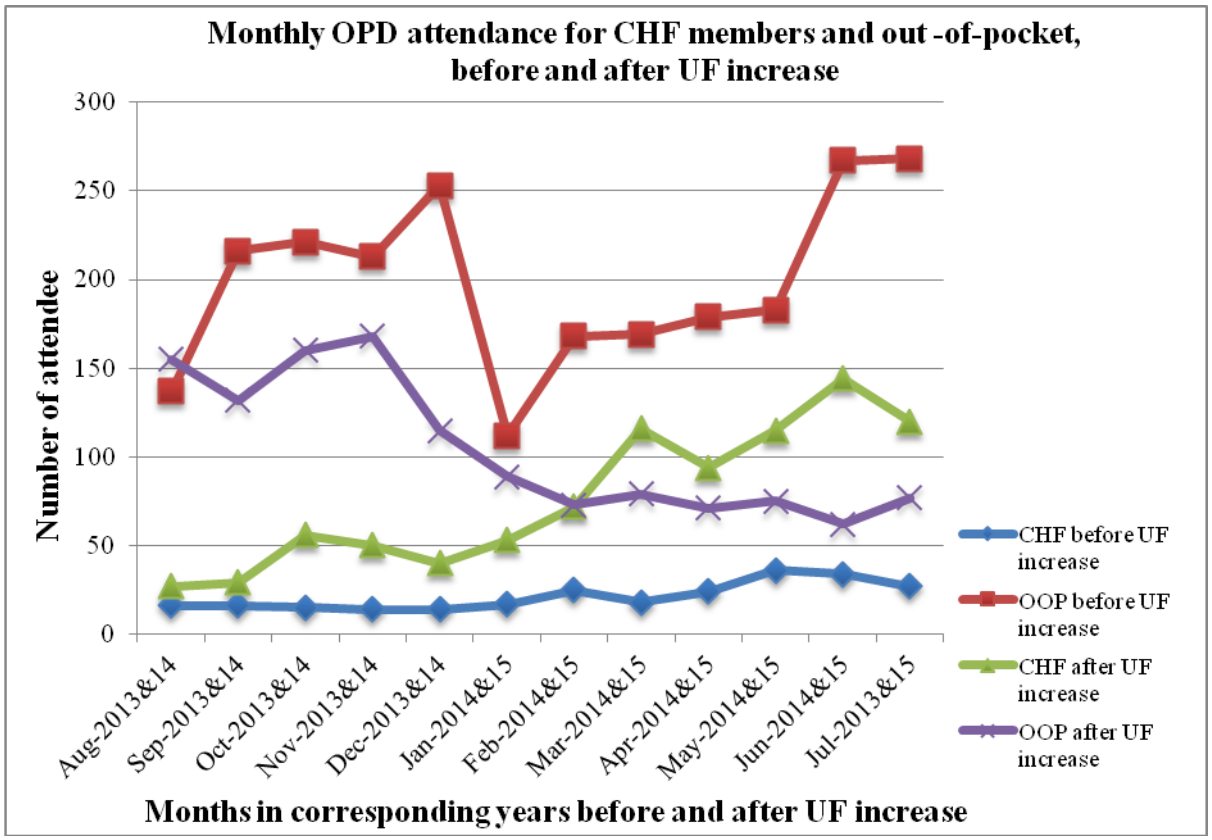
Respondents categorically showed the big problem in accessibility to health services in public facilities due to higher user fees. Put another way, higher user fees are deterrent for the patients to attend.

''What I personally understand is that those people living in poverty, this (new fee) Tshs 7,000 has become deterrent for them to seek and access health services ''so much than thought'' those in extreme poverty are really in trouble'' (FGDs-H10).

Interestingly, one participant cited a decline in malaria burden following to ITNs distribution as an alternative explanation to account for the decrease in OPD attendance in all studied HFs. Further he points to the increasing role of non-communicable diseases such as injuries.

''I think currently in all health facilities patients have declined after distribution of ITNs, nowadays there is no diseases as previously used to be. Malaria was very prevalent due to mosquito bites (previously) you go to health facility from morning to afternoon you are yet to get treatment (more than 8 hours). Currently, even if you enroll into CHF it can just expire without getting ill to use it. Therefore diseases have declined what is now coming up is motorcycle injuries'' (FGDs H03).

Chart 1: Monthly OPD attendances for CHF and out-of-pocket before and after user fee increase.



Abbreviations; OOP- out-of-pocket, CHF-Community Health Fund, UF- user fees.

Before user fee increase, majority of the OPD attendees were those paying out-of-pocket (OOP). Note the declining OPD attendance by those paying out-of-pocket and the exponentially increasing CHF members among health seekers.

4.4 Challenges in Accessibility to Waivers and Exemptions.

In the settings where user fees have been increased, waivers are probably the only door for poor to access health services. This study was geared to explore challenges encountered by those applying for waivers and how easy is it to request and get waived by the eligible people. This part is sub-divided into sub themes namely; eligibility criteria and procedures for application of

waivers, haw easy is it to get waivers? Conflict of interest between motive for revenue generation and grant of waivers, and addressing observed challenges in waivers.

4.4.1 Eligibility Criteria and Procedures of Applications for Waivers

Majority of respondents of FGDs and some of IDI, based on local individual experiences, suggested features of those deserving exemption and waivers as pregnant women, elderly above 60 years, children under five years, disabled, chronic diseases, vulnerable peoples and those living in poverty. One IDI participant said:

''.... they (exemption and waivers criteria) are clear and they are like elderly above 60 years, pregnant women, disabled, children under five years, peoples living in vulnerable environments, this is irrespective of whether he is a young adult, elderly or children under fives, only that he is poor and can't afford costs of care'' (IDI with health manager)

Another respondent added;

''Others are like widows, orphans and elderly who are economically incapable (FGDs K09).

However, some participants of IDI reports that they sometimes use humanity to grant waivers implying that there is no written document that clearly articulates eligibility criteria for grant of waivers, as here under;

''For those whom we receive them accidentally, perhaps he is admitted and do not have even money to pay for treatment, we only use humanity (to grant waivers)'' (IDI with health manager)

Respondents of FGDs and IDI reported mixed feelings on whether Village leaders were fair to everyone who requests waivers and whether lack of clear stipulated eligibility criteria for waivers merits abuses of power and biases. Some respondents reported that there were no such problems with approval of waivers from the village authorities. One participant substantiated;

''The way I personally understand and perceive the manners in which things are run here in my village, I don't see any ill motives. ....Leaders (village) know exactly his income, if he is disabled or overwhelmed by huge family and can't support it'' (FGDs-H01).

On the contrary, some respondents raised concern of favors where approval of waivers is based on familiarities between parties. He remarked;

''In my opinion this issue of requesting for waivers is too difficult because the processes being run by those dealing with the approval relies on familiarities between the two party's''(FGDs K11)

Regarding the procedures for requesting waivers, most of participants of FGDs and IDI reported that letter of authorization directed to the District Medical Officer through the Ward Executive Officer detailing the inability of the applicant to pay user fees has to be drawn/approved by the Village Executive Officer. One participant of the IDI said;

'*Some people are in extreme poverty (can't afford paying user fees), they have to be authorized from the village governments then at the ward level then we receive those signed and stamped letters, that's the procedure even for elderly'' (IDI with health manager)*

Another participant of the FGDs said;

''We write letters for those who are economically incapable, own nothing…. Therefore we identify them and write letters for them and they get treatment'' (FGDs K13).

Absurdly, participants of the IDI were unaware that waivers can also be requested at the point of care for admitted patients who run bankrupt while in treatment. This subjected them to heavy debts that impoverished them as resources they could rely on were depleted. One respondent remarks;

''Had I knew of the existence of exemptions and waiver's office where I can get waived, I think I could have met them on that very day and my mother wouldn't have gone home (For resource

remobilization), I would have requested waiver so that she start treatment''(IDI with relative of the admitted patient).

4.4.2 How easy is it to get waivers?

Respondents of both FGDs and IDI were discontent with the long procedures for application of waivers, a sequence of approval from village to ward authorities and finally hospital were time consuming and not compatible with illnesses that need urgent intervention. One relative of the admitted patient relates;

''... starting application for waivers at the lowest (village) level, they will make you meanders a lot and we were in harry to catch up with these specialist in mobile hospital before they leave, therefore requesting for waivers needs no hurry. A village chairperson writes a letter for you, then you go to Village Executive Officer (VEO) then to someone, this takes time''(IDI with relative of the admitted patient).

Some respondents reported that people gave up requesting waivers because of long unclear process to request waivers. One respondent laments;

The process to access waivers is difficult because it has never been friendly to the needy. It has not been clearly stipulated who to see, you may visit a certain place and you are told go there, you go there you are told again wait we are verifying your requests; you reach a point you give up (FGDs-K11).

Double checking and a great deal of negotiations with approvers of waivers at the district level to enquire the financial power of the applicant signifies partial trust in approved letters for waivers from village and ward authorities which adds to bureaucracies disputed by the communities. One IDI respondent related;

''When people come with (approved) letters requesting waivers, we sensitize them to enroll into CHF so as to reduce extent of waivers and we also conduct interviews (to enquire on ability to pay) like how many children do you have'' (IDI with health manager 01)

Surprisingly, ‘’those who need the most get the least’’ poor people were less likely to request for waivers because of shyness and sacrifice of dignity in exposing poverty to village leaders. Further, they were generally less informed of the required procedures and lacked confidence. One respondent asserts;

‘’Poor people are present but feel shy to disclose their poverty before village authorities; they do not know procedures for requesting waivers. Some feel if they go to the Office (for request of waiver) perhaps he/she will be told ‘’leave’’ (FGDs H02)

Respondents reported that the exemption and waivers office had no signboard for easy visibility by the clients which signify that there were attempts to conceal the office to discourages requests for waivers. One respondent reported;

‘’*…. For the social welfare to openly display the signboard that waivers services are available here ‘’No’’ that thing doesn’t exist’’ (IDI with health manager 01)*

4.4.3 Conflict of Interest between Motives for Revenue Generation and Grant of Waivers.

As long as revenue generated from facilities are used to improve quality of services in the same facility and payment of allowance to employees, therefore granting of waivers at the expense of loss of revenue is likely to generate huge conflicts of interest.

Motives toward revenue generations by health managers pose a huge conflict of interest that seriously jeopardizes grant of waivers.

Respondents of both FGDs and IDI pointed out that there is huge scrutiny in meetings when there is reductions in revenue collections or when revenues foregone through grant of waivers increases. One participant articulated;

‘*’ In meetings as a member of Council Health Management Team (CHMT) and sometimes in the morning report when statistics of revenues (collected) are being read and it seems that waivers have exceeded and the like, it brings controversies, creating perceptions that ‘’they are just recklessly approving waivers’’(IDI with health manager).*

Further, motives for revenue generation has trickled down to general staffs because of the perceived need for money to improve quality of care and personal benefits such as allowances, thus exempted patients are looked down by health providers. One respondent asserts;

''It does seem sometimes that when a person comes and don't have anything (not paying) even the warm Doctor-patient relationship that he is entitled to get from the health provider becomes cold'' (IDI with health manager).

Of serious concerns, this study has revealed that waived patients were subjected to segregation and treated as second-class citizens. Prompted by conflict of interest between motives for revenue generation against grant of waivers, waived patients were given cheap drugs said to be of comparable effectiveness compared to their paying counterparts. One IDI participant substantiated this;

'…there are strategies for doctors which they agreed upon (to implement) but I don't know its implementation status, that there are some drugs (expensive ones) should not be prescribed to exempted patients but you can give substitute drugs of comparable effectiveness. For instance if Coca cola is expensive than Pepsi then give Pepsi…. Several times if waivers exceeds they were reminding themselves of the agreement'' (IDI with health manager).

4.4.4 Addressing Observed Challenges in Waivers.

Many respondents of both FGDs and IDI proposed Government-subsidized CHF cards similar to those of premium paying counterparts to be given to the poor people who can't afford paying user fees. This will address stigma and discrimination in the waiver system. He asserts;

''In my opinion, the Government should provide the cards (CHF cards). Those who are poor should be identified so that the government can give those cards that will enable them access services'' (FGDs-K07).

Some respondents proposed that government should find a mechanism to refund the costs of waivers extended to the poor to address challenges of conflict of interest.

''Compensation obviously will catalyze (grant of waivers), there will be no mindset that we are just losing revenues, after a while we calculate the amount required as compensation for exemptions. Quality of health services provided will also increase''.

Others proposed that there should be a different department for approving requests for waivers from the villages and from the admitted patients. While others said the list of the poor should be identified and made available in the facilities so that they can easily be waived upon visiting the facility without the need to apply. One participant remarked;

''There should exist a different department for authorization of waivers in the hospital instead of health providers (authorizing waivers). Even in the past approvers of exemptions of head tax were judged by non-tax collectors'' (FGDs-H06).

4.5 The relationships between user fees increase and enrolment into iCHF.

This study explored whether user fees increase led to the targeted outcome in CHF enrolments. Both document review using data from village CHF registers, FGDs and IDI were used for triangulation of the findings.

Document review shows that CHF enrolments modestly increased from 7 to 77 members one year after user fee increase, this is equivalent to 91% increase (Table 4 and Chart 2).

Participants of FGDs and IDI suggested that user fees increase as a standalone strategy to accelerate enrolments in CHF was critically inadequate; it needed a combination of approaches top among which was education. Education would empower the community on the alternative ways to avoid costly payment of user fees which is enrolment in CHF. Community participation would also do the same. One respondent substantiated this claim;

''…but they don't know alternatives (low cost options)… therefore we need more than just increasing user fees to make people enroll (in CHF), they need to know if user fees are high what are the other options (less costly) then'' (IDI with health manager).

On the same note another respondent related;

''A class to educate them is needed, and that education should not be at the level of Village Executive Officer's only, it has to start at the lowest level, the ten cell leaders. Because if you say it should start at the village assembly, some do not attend. It has to start right at the streets level, leaders should only insist in meetings'' (FGDs H02).

Yet another respondent linked the modest increase in CHF enrolments to user fees hike.

''...These new prices (increased user fees) has helped boost CHF enrolments and helped change our health facilities (better quality of care)'' (IDI with health manager).

Respondents of FGDs implied that the core rationale of increasing user fees to compel people to consciously choose CHF as a less costly alternative were poorly understood and was linked to insignificant increase in CHF enrolments following user fee increase. Here remarked;

They have not yet understood *its core concept that here we are getting a loss. Paying Tshs 7,000 and next time a person gets sick again you pay the same is costly than joining CHF* (FGDs H11).

Interestingly, some respondents of IDI translated the move to increase user fees as punishment for those who do not want to enroll in CHF, again stressing the need for community participation. This further provoked boycott of the very CHF you want them to enroll.

''...you know human being has got something (to motivate or demotivate) psychologists know the whole concept of ''reward and punishments'' in other words the increase in user fees in health services is like punishment'' (IDI with health manager)

Lack of community participation in the decision to increase user fees was bitterly disputed by respondents and that these top-down orders were linked with the overall lack of success in interventions of that nature. Here one respondent remarked;

''....it (user fees increase) comes as an order without incorporating ideas from the people in order to have the common understanding so as to reach the objectives…this is what I personally see as deterring people from implementing government instructions..'' (FGDs K11).

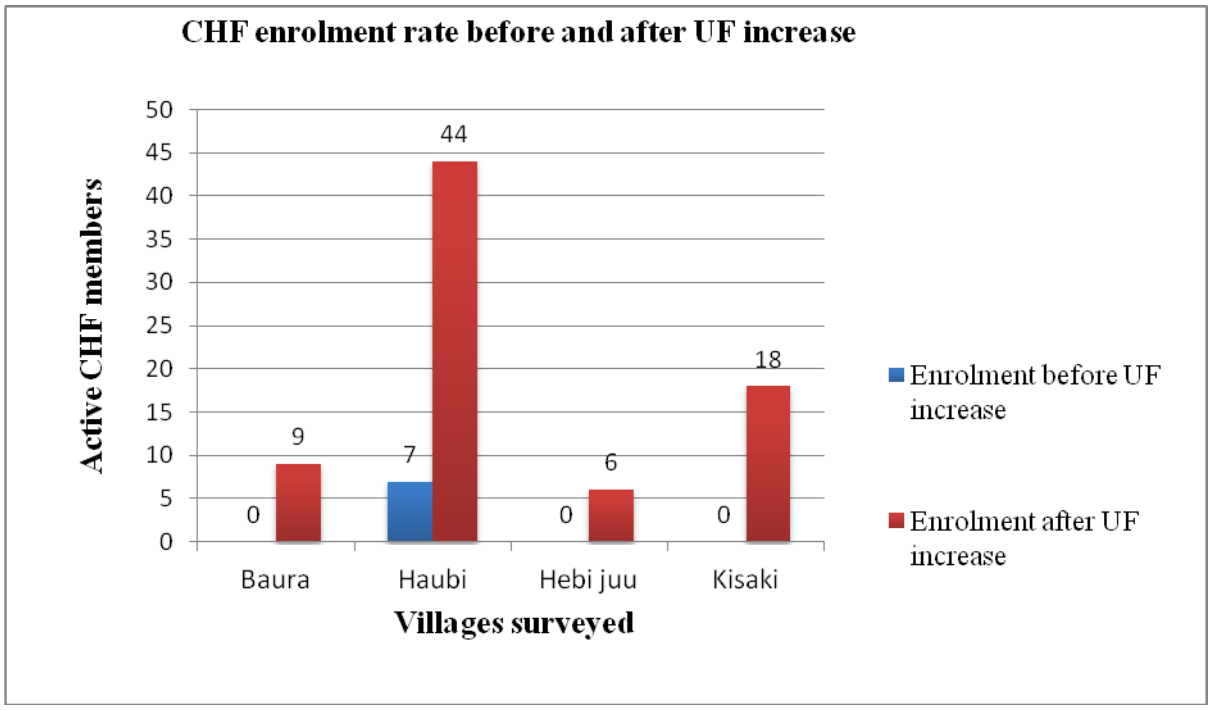
Table 4. CHF enrolments before and after user fees increase in Kondoa District Council, Central Tanzania, 2017.

Variable	Period 1: Before user fee increase	Period 2: After user fees increase	Change (%)
Haubi Disp	7	44	528.6
Kisaki Disp	0	18	
Hebi juu Disp	0	6	
Baura Disp	0	9	
TOTAL	7	77	90.9

Source; Village CHF registers. Period 1;Before user fees increase was from 01/08/2013 to 31/07/2014 Period 2; After user fees increase was from 01/08/2014 to 31/07/2015.

Community Health Fund enrolments before user fees increase was zero in some facilities and therefore we are unable to calculate percentage change in CHF enrolments.

Chart 2: CHF enrolment before and after user fees increase in Kondoa District Council, Central Tanzania, 2017.



Abbreviations; UF-user fees, CHF-Community Health funds (CHF).

Enrolments before and after UF increase were from 01/08/2013 to 31/07/2014 and 01/08/2014 to 31/07/2015 respectively. Note zero enrolments in CHF members in 3 dispensaries visited.

Haubi village had the highest increase in enrolments following user fee increase.

Respondents reported a drastic change in attitude of health care providers toward CHF as opposed to previously conventional CHF where CHF members were segregated and abused. One respondent said;

''People are refusing to enroll into CHF in memory of the segregation and abuse in the old conventional CHF. By then CHF members were not valued while user fees payers were entertained. Nowadays you will never find such an abuse'' (FGDs-K03).

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter discusses the results of this study as presented in chapter 4 in accordance with five research objectives which were to explore community participation in the process of raising user fees, to explore the coping strategies of the community members after user fee increase, to explore the implication of user fees increase on the utilization of health services, to explore the challenges in accessibility to waivers and exemptions, to explore the implication of user fees increase on enrolment into improved CHF (iCHF).

The study combined document review with FGDs and IDI so as to power the findings.

5.1 Community participation in the decision to raise user fees.

The findings of the FGD and IDI show that there was no community participation in the decision to increase user fees. Opinions and views of the community regarding user fees increase was not solicited and was a top-down approach in decision that affects the community ‘’deciding on behalf of the community’’. Many participants associated the lack of community participation with low enrolments in iCHF.

This findings echo similar findings of a qualitative study of views from rural communities [30], Kalolo et al observed that awareness of the communities on any activities that require their participation in planning, experience sharing or managing scheme processes were absent and were associated with poor enrolments in iCHF. In a systemic review by Panda et al studying factor**s** affecting uptake of voluntary and community-based health insurance schemes in low- and middle-income countries, he found that absence of community involvement were among the reasons for low uptake of the scheme [6].

The issue of community participation and education on CHF before raising user fees featured in many of the respondent's comments. It does seem that lack of participation and education in the decision to increase user fees were two most important factors that led to only modest increase in CHF enrolments. There is no way a community project like this CHF can be successful without involving the very community in its processes. Community participation was an avenue for empowerment of the community on the rationale of raising user fees so as to shift people into cheaper alternative in this respect CHF in the same manner higher price of coffee would shift demand into tea. But without community participation, the move might even be negatively translated as geared to punish those who do not want to enroll in CHF further affecting enrolments.

5.2 Coping strategies of the community members after user fees increase.

The findings of this study revealed that most of the poor households embarked on cost prevention strategies which entails avoidance of costs with sub-themes; neglecting or non-treatment, self-medication with traditional medicine and modern medicine, delaying treatment with a wait and see approach.

Study findings show that, because of extreme poverty some people were neglecting treatment, not seeking treatment at all, and were waiting for God's mercy or destiny. This strongly displays signs of hopelessness. This finding is similar to findings in previous studies [36,45] where it had been shown that deterring treatment at all were the main coping mechanisms by the poorest households. Poor families struggle for food therefore they don't have saving and have limited assets and social networks profile as such if disease hits they are left with no any other option.

Self-medication is the process whereby a sick person or relative decides to take medication, modern or herbal without a formal consultation. Self-medication was achieved using traditional medicines or modern medicines usually bought without consultation. This study has uncovered a serious concern with potential for severe consequences, whereby some patients and/or their

relatives were making both self-diagnosis and self-treatment and go to Accredited Drug Dispensing Outlet (ADDO) and request specific medications.

A lay person just judges the symptoms he is experiencing and says ‘’I know my malaria or typhoid’’ and rushes to a ADDO and request a drug he thinks fits his problem. This approach is dangerous as it may predispose a person to intoxication due to incorrect doses, but can lead to long-term problems and development of drug resistant microbes. This finding coincides with previous studies [36, 41, 45] where it has been shown that self-medication using modern drugs, local plants and traditional healers have been used for treatment.

Amid extreme poverty there is usually competing priority. Cost prevention strategies are maladaptive responses where because of poverty households choose to avoid cost while awaiting for spontaneous recovery.

Poverty seems to be the main driver of cost prevention strategies because the poor struggles to feed their families and therefore save nothing, when an illness hit a family definitely have no any other option than the wait and see, should the disease worsen then they look for any asset to sell to obtain money to finance treatment. These delays attract complications which are more costly to manage and at the risk of morbidities and mortalities.

Demand and final utilization of health services is a function of ability to purchase health services. When a household do not have financial muscles to pay for health services then the easy option is delaying treatment while waiting for spontaneous recovery or mobilizing funds to send a sick person for care. Respondents in this study reported that people were delaying treatment because of lack of money albeit with potentially serious consequences. This findings correlate with previous studies [36,41,45-46] where it was shown that

On the cost management here households struggle to mobilize funds for treatment through various means. Our findings reveal that poor families cope with costs of care by selling assets, borrowing, bonding, support from relatives and begging from religious institutions like churches and mosques and well-wishers as ways used to mobilize funds to finance health care costs.

Properties that were being sold to mobilize money were chicken, goats, crops, and farm. Selling of some of properties like crops and farm which are of survival value to the family predisposes to further poverty as it permanently damage the productivity of the family and it signals catastrophic health spending. Caring for the admitted patients carried more costs and therefore provoked more intense mobilization of funds hence exerting severe impact to the economy of the household. These findings are congruent with previous studies [35-36,45,46], which showed that households coped with cost of care by borrowing, selling assets such as land or farm, cereals, bonding, and labour substitution. High cost services like admission provokes the family to sell properties usually plunging households, stretched to the limit, into deeper poverty.

Cost prevention strategies are the worst mechanisms of coping with user fees increase as it results into delay in seeking health services further attracting complications and mortalities. There is a need to cover these income poor households with subsidized CHF card. These findings are significant and evidence that any policy changes has to be pro-poor otherwise it is bound to causing inequality.

5.3 The relationships between user fees increase and the utilization of health services.

Our findings show that user fee increase is related with modest decline in OPD attendance. Both total OPD attendance and OPD attendance by those paying user fees declined while there was a massive increase in OPD attendance by CHF members. Majority of respondents of FGDs and IDI categorically assert that after user fees increase OPD attendance is mainly for CHF and the exempted groups such as elderly, children less than five years, pregnant women. These findings are similar to many studies done in LMIC where introduction or increase of user fees caused a remarkable decline in health services utilization and widened the existing inequality [12-16]. In a quasi-experimental study done in Malawi to explore the effects of user fees on health services utilization, it was shown that abolition of user fees led to a rapid, significant increase in facility utilization of 352%. Further, re-instatement of the user fees reversed the situation [12].

Generally the previous conventional CHF in which members were being abused and discouraged

from accessing health services has changed; CHF members are now courteously welcome in health facilities. Further, in a show of sympathy for the costs they incur, clients paying out of their pocket are advised by health workers to join CHF.

This dramatic shift in preference toward CHF members is allegedly due to motivation brought about by the direct refund of the facility upon submission of the claim forms in the improved CHF as opposed to the old conventional CHF where funds were pooled at the district level and the facilities were paid in kind via procured medicines and medical supplies. Lack of mechanisms to directly refund facilities in old conventional CHF in monetary terms sounded like they were providing free services to CHF members thus health care providers conceived various ways of discouraging CHF members to deter furthers enrolments.

This finding is in line with previous study done in Cambodia where it was revealed that percentage of poor attending for care declined from 16% to 7% owing to introduction of user fees while the proportion of the medium rich increased from 17% to 25% [49]. Evidence shows that poor people are very sensitive to fee changes and would lower consumption of health services disproportionately more than the well-off in response to fee introduction or increase, signifying that user charges were not affordable for these groups [48].

Respondents in this study show that people paying out-of-pocket (user fees) were reluctant to use health facilities after user fees increase because the fixed token of Tshs 7,000 regardless of extent of utilization of services did not match the actual costs of the consumed services ‘’*perhaps the services provided is less than Tshs, 7,000’’.* This matches the findings of a study by Lucy Gilson titled ‘‘the lessons of user fee experience in Africa’’ where she suggests that general consultation fee deter patient utilization because it is not linked to the services received [46]. .

5.4 Challenges in accessibility to waivers and exemptions.

The findings of this study show that there were no clearly written eligibility criteria that gave the feature of a poor to aid in the grant of exemptions and waivers. This is consistent with previous studies [40-42,45], which reported that failure to give the feature of a poor leaves the whole process of waivers to the unchecked discretion of village leaders with potential for bias and

abuse of power. Absence of clearly articulated criteria explains the wide variations in the implementation of waivers across Tanzania. Those who were mentioned in the FGDs as deserving waivers were local experiences on the improvised criteria created to aid screening in that locality.

Regarding how easy is it to access waivers; this study has shown that waivers are virtually inaccessible due to arrays of barriers from application to final access of services. Respondents of both FGDs and IDI were reluctant to request for waivers citing long unfriendly bureaucratic procedures for application of waivers, a sequence of approval from village to ward authorities, double scrutiny coupled with great deal of negotiations with approvers at point of care were time consuming and not compatible with illnesses that need urgent intervention. Miserably, findings show that poor people who need waivers the most stand little chance of getting waivers because they were generally less informed of both the presence of policy and required procedures, lacked confidence to dare to request for waivers and plight of sacrificing dignity. These findings are congruent with previous findings [25,40,41], which reported that the poor faced stigma in requesting for waivers, the same group were less informed of the existence of both policy and of the procedures for requesting waivers. Further, the whole approval was left to the discretion of village leaders with loopholes for bias and preferential treatments.

At the forefront of barriers that discourage application for waivers lies the conflict of interest. Of serious concern, this study has unearthed the intentionally orchestrated practice where waivers-beneficiaries are treated as second-class citizen-being prescribed cheap medications, said to be of comparable effectiveness, compared to their paying counterparts. A respondent gives the like of cheap medications prescribed to the waived as *''if Coca cola is expensive than Pepsi then you give Pepsi''*

The motive for revenue generation has trickled down from top management down to normal health staffs because revenue generated is linked to improvements in quality of care and to some extent allowances that benefit staffs. Conflict of interest has been shown in this study to turn the health providers cold upon spotting an exemption letter subjecting a waived patient to unfriendly

Doctor-patient relationship. These results replicate findings from other studies [39-42], which report that conflict of interest between the attempt to generate revenues and protection of the vulnerable social groups, deter grant of waivers.

Respondents proposed that free subsidized card be given the poor who can neither afford CHF premium nor user fees. Majority of respondents suggested that the government should devise mechanisms to refund the costs of waivers extended to the needy while others proposed that the final approving authority should not be vested to health providers to relieve them of conflict of interest. These proposed solutions to address observed challenges in the waiver system are similar to those found in other studies [39-42] where subsidized CHF ID cards for the poor were proposed.

5.5 The relationships between user fee increases and enrolments into improved CHF.

Our findings show just a modest increase in CHF enrolments following user fees increase, though it seems exaggerated when presented as percentage increase because of the very low enrolments before user fees increase, some facilities had zero enrolments. The implication of user fee increase on enrolments in improved CHF is relatively new area of study with limited citations.

Respondent's views across this theme pointed out that lack of community participation and education was the major obstacle toward successful enrolments in CHF after user fees increase. Their reactions demonstrated discontent with exclusion of the community in the process of user fee increase, some describing it as ''imposed on us as orders from top''. In addition, there have been feelings that user fee increase was orchestrated to punish those unwilling to enroll in CHF and negative perceptions such as ''they want us to die''.

The core motive for the user fees increase was to make the people shift from expensive option (user fees) to a lesser expensive one (CHF), however, lack of community participation and education means that people might not be aware of the cheap alternatives (which is CHF) leading to low enrolments. Further, exclusion of community in the process pave ways for negative

interpretation of the move to raise user fees, such as orchestrated to punish those unwilling to enroll into CHF or negative perceptions like ‘’they want us to die’’.

It was theorized that increasing user fees would compel the community to shift to a less expensive option which is CHF in the same manner raising price of tea would shift the demand into coffee. Therefore, community participation was critically necessary for the community understanding of the rationale for increasing user fees and those cheap options available which is central for the realization of envisaged goal that is increasing enrolments into CHF.

This study has uncovered a dramatic shift in preference toward CHF members allegedly due to motivation brought about by the direct refund of the facility upon submission of the claim forms in the improved CHF as opposed to the old conventional CHF where funds were pooled at the district level and the facilities were paid in kind via procured medicines and medical supplies. Lack of mechanisms to directly refund facilities in old conventional CHF in monetary terms sounded like they were providing free services to CHF members thus health care providers conceived various ways of discouraging CHF members to deter furthers enrolments. Generally the previous conventional CHF in which members were segregated and discouraged from accessing health services has changed, CHF members are now courteously welcome in health facilities.

The increase in enrolment in iCHF was just modest however the increase in of OPD attendance for CHF member was disproportionately bigger (257.8%) raising suspicion of moral hazard. Further, this increase in health services utilization buffers the otherwise big reductions in total OPD attendances creating a milder picture of the extent of reduction in health services utilization following user fees increase, giving a false hope.

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.0 Conclusion.

This study explored community participation in decision to raise user fees and the subsequent coping mechanisms. Households can cope with increased user fees by reducing health services utilization, enrolling in iCHF and increasing demand and utilization of exemptions and waivers.

Community did not participate in the decision to increase user fees and this was linked with poor enrolments in iCHF, this has again re-emphasized the link between community ownership of decisions and the subsequent performance of a community program or intervention.

On the strategies to cope with user fee increase, poor people embarked mainly on cost prevention strategies and in extreme cases were marked with neglecting treatment with signs of hopelessness; others were delays in health seeking behavior and self-medication. Cost management strategies mainly took the form of selling properties some with survival value to the household like cereals, livestock used as oxen, land used for subsistence farming. Others were borrowing and even begging from well-off individuals, churches and mosques.

Generally, raising user fees as a standalone strategy to accelerate enrolments in iCHF comes with a heavy price tag that offset potential benefits of modest increase in CHF enrolments found in this study. There has been a reduction in utilization of health services following user fees increase, likely affecting the poor and vulnerable.

This study has unearthed arrays of barriers that render waivers virtually accessible. Even when waivers are accessed, beneficiaries are looked down by the health care providers because they contravene their motive for revenue collection, worse still they are given cheap drugs the so called ‘’substitute drugs with comparable effectiveness’’ being treated as second class citizen.

The study has shown that health providers are now pro-iCHF, having changed from bad attitudes during conventional CHF, allegedly due to motivation brought by the direct refund of the facility in the improved CHF as opposed to the old conventional CHF where funds were pooled at the district level and the facilities were paid in kind via procured medicines and medical supplies.

6.1 Recommendation.

The author recommends the following to be done in order to effectively exploit useful information brought by this study.

I. Kondoa district council should give community participation a due priority in activities targeting the community for the realization of benefits.
II. Kondoa district Council should consider going back to previous user fees to enhance demand and utilization of health services and get way with mal-adaptive coping strategies.
III. Kondoa should identify the poor and give subsidized CHF ID cards similar to those of the paying counterparts to protect the poor who cannot afford CHF premiums.
IV. The Government of the United Republic of Tanzania through the MoHCDGEC and PO-RALG should consider going into mandatory CHF using the iCHF model to attain Universal Health Coverage to address the challenge of waivers.
V. More studies are needed to establish whether the observed decline in services utilization was due to user fees increase.

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Appendix A: Informed Consent (English version).

ID NO: ……

Introduction

Hello! My name is **Ikaji Zulkaranain Rashid**, a student of Masters of Public Health at Muhimbili University of Health and Allied Sciences (MUHAS). On behalf of Muhimbili University of Health and Allied Sciences (MUHAS), I am conducting a research on **user fee increase in improved CHF in Kondoa District Council: Community participation and coping mechanisms.**

Purpose of the study

User fees have been shown by a sizeable volume of research to contribute to exclusion of the poor and therefore causing reductions in utilization of health services. This is even critical in LMICs where waivers, though theoretically exist to rescue the paupers, are virtually inaccessible by the poor. The information on how do households struggle with increased user fees and to what extent services utilization has been affected is crucial for evidence based policy/decision making. Therefore, findings from this study can be used to commend the practice or to ban the processes that widen the social exclusion in health services.

Participation

I would like you to participate in this study. You have been chosen to participate because I think you can provide valuable information related to community participation and coping strategies to increased user fees in Kondoa district council. If you consent to participate in this study, you will be personally interviewed by a researcher or participate in a group discussion for about 45-60 minutes. You will be asked questions on community participations in the process of increasing user fees and coping mechanisms to increased user fees.

Benefits

If you agree to participate, it will be for the benefits of the wider community including yourself because the findings generated from the study can be used to make changes that foster more accessibility to health services by the poor part of the community.

Risks

I do not anticipate that any harm will occur to you as a result of your participation in this study. The information requested is by no means going to affect any human being or generate interest with negative consequences.

Confidentiality

All responses will be kept confidential and will be used only for the purpose of this study and will be private. No identification information will be collected from you during the interview, except your age, sex and education level.

Right to refuse or withdraw

Participation to this study is voluntary. You may decide to participate or not to. No measure will be taken upon your refusal to participate if you decided not to. You are free not to answer any question or any part of the discussion.

Whom to Contact

In case of any question or query concerning this study, please contact the principal investigator, Dr Ikaji Zulkarnain 0784 753447. If you have any question about your rights as a participant you may contact Professor Mohamed Aboud, Chairman of the research and Publications Committee, MUHAS. P.O. Box 65001, Dar es Salaam-Tanzania, Tel +2552150302-6)

I …….... have read the contents of this form and understand and my questions have been adequately answered. I agree to participate in this study.

Signature of participant……Date…….

Signature of research assistant…… ….Date……..

Appendix B; FOMU YA RIDHAA YA KUSHIRIKI KATIKA UTAFITI (KISWAHILI)

Namba ya utambulisho……

Utambulisho

Habari, naitwa Ikaji Zulkaranain Rashid, ni mwanafunzi wa shahada ya uzamili ya Afya ya Jamii katika chuo Kikuu cha Afya na Sayansi ya Jamii Muhimbili. Katika sehemu ya mafunzo yangu ninafanya utafiti wenye kichwa cha habari ‘’ ***ongezeko la gharama za matibabu za ‘’papo kwa papo’’ kwenye CHF iliyoboreshwa katika Halmashauri ya wilaya ya Kondoa: ushirikishwaji wa jamii katika mmamuzi hayo na mbinu zinazotumiwa na jamii kumudu ongezeko hilo’’ .***

Madhumuni ya utafiti

Malipo ya papo kwa papo yameoneshwa katika tafiti mbali mbali kuwa yanachangia kuwanyima fursa za matibabu watu maskini wasioweza kumudu malipo hayo na hivyo kusababisha watu kutotumia kabisa au kupungua kwa matumizi ya huduma za afya. Hali hii ni mbaya katika nchi za uchumi wa chini na kati ambako pamoja na kuwepo kwa mifumo ya misamaha ya matibabu kwa wasio na uwezo lakini upatikanaji wa misamaha hiyo umekuwa mgumu kwa watu maskini.

Matokeo ya utafiti huu wa jinsi kaya zinavyohangaika kumudu ongezeko hili la gharama za papo kwa papo na kwa jinsi gani mahudhurio ya wagonjwa kwenye vituo vya huduma yameathirika ni muhimu kwa watunga sera na watoa maamuzi yanayotokana na uthibitisho wa kitafiti. Hivyo matokeo ya utafiti huu yanaweza kutumika kuimarisha mifumo hii au kufuta sera hii ya ongezeko la gharama za papo kwa papo.

Ushiriki

Ningependa ushiriki katika utafiti huu kwa kuwa ninahisi unaweza kutoa taarifa zitakazoweza kufanikisha utafiti huu juu ya ushirikishwaji wa jamii kwenye maamuzi ya ongezeko la gharama za matibabu za ‘*’papo kwa papo’’* ulifanywa kwa lengo la kusukuma watu kujiunga na Mfuko wa Afya ya Jamii (CHF) na mbinu zinazotumiwa na jamii kumudu ongezeko hilo.

Endapo utaridhia kushiriki utahojiwa/ au kupewa dodoso ujaze kwa muda wa dakika zisizozidi 15-20. Endapo unaridhia kushiriki katika utafiti huu, utafanya mjadala na mtafiti au pamoja na wenzako katika kundi la watu 8 hadi 10 kwa takriban dakika 45 hadi 60. Utaulizwa maswali juu ya ufahamu wako kuhusu ushirikishwaji wa jamii kwenye maamuzi ya ongezeko la gharama za matibabu za *''papo kwa papo''* ulifanywa kwa lengo la kusukuma watu kujiunga na Mfuko wa Afya ya Jamii (CHF) na mbinu zinazotumiwa na jamii kumudu ongezeko hilo.

Faida

Endapo utaridhia kushiriki katika utafiti huu itakuwa ni kwa manufaa ya jamii nzima ikijumuisha na wewe mwenyewe kwasababu matokeo yake yanaweza kutumika kufanya mabadiliko yatakayoweza kuongeza uwezo wa kaya maskini kutumia/kupata huduma za afya.

Athari

Sitarajii mshiriki kupata madhara ya aina yeyote kwa kuamua kushiriki kwake. Ingawa baadhi ya maswali ni binafsi, lakini matokeo ya utafiri huu yatakuwa ya jumla kwa washiriki wote wa wilaya Kondoa. Taarifa utakazotoa kwa namna yoyote ile haziwezi kuathiri mtu yeyote.

Usiri

Taarifa zitakazokusanywa ni siri na hakuna mtu yeyote atakayeambiwa ulichosema bali zitatumika kwa madhumuni ya utafiti huu tu. Hapatakuwa na utambulisho wa mshiriki kwenye dodoso, isipokuwa mwaka wa kuzaliwa, jinsi na kiwango cha elimu tu.

Haki ya kukubali au kukataa kushiriki

Ushiriki katika utafiti huu ni wa hiari. Unaweza kukubali kushiriki au kukataa. Hapatakuwa na adhabu yeyote itakayochukuliwa dhidi yako kama utaamua kukataa kushiriki. Pia jisikie huru kutokujibu swali ambalo hutapenda kulijibu.

Mawasiliano

Kama uatahitaji ufafanuzi zaidi juu ya utafiti huu, usisite kuwasiliana na Mtafiti Mkuu ***Dr. Ikaji zulkaranain Rashid***, mwanafunzi wa shahada ya Uzamili ya Afya ya Jamii katika chuo cha Afya na Sayansi ya Jamii, S. L. P 65001, Chuo kikuu cha Afya na Sayansi ya Jamii Mhimbili, Dar es Salaam au namba ya mkononi 0784753447. Kama una swali juu ya stahili zako unaweza kuwasiliana na Prof. Mohamed Aboud, ambaye ni mwenyekiti wa kamati ya utafiti na uchapaji, S. L. P 65001, Chuo kikuu cha Afya na Sayansi ya Jamii Mhimbili, Dar es Salaam au simu namba +2552150302-6.

APPENDIX C: IN-DEPTH INTERVIEW GUIDE FOR HEALTH MANAGERS (ENGLISH VERSION)

This is a health Manager's In-depth Interview (IDI) Guide for exploring community participation and coping mechanisms following user fees increase in improved CHF in Kondoa district Council. Health Managers in the district will be interviewed on community involvement in decision to increase user fees, the relationships between user fees increase and CHF enrolments, demand for health services and perceptions regarding waivers and exemptions.

DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENT

1. Respondent number……....
2. Profession/cadre……...
3. Position
4. Age (years)……...……..
5. Sex……...……..
6. Level of education…….
7. Work experience in that position (years)……...

INTERVIEW QUESTIONS.

1. To what extent were the community and stakeholders involved in the process of increasing user fees as a strategy to accelerate enrolments in improved CHF in Kondoa District Council?
2. What do you understand by waivers?
3. From your experience of granting waivers; what challenges are you facing?
4. How is eligibility for waivers determined at your area? Probe about
    - Existence of clearly laid eligibility criteria for waivers.
    - Preferential favors of the undeserving being recommended by letters from Village Executive Officers (VEOs) to be waived.
    - In patients requesting for waivers.

5. What are your general feelings about the lost revenues from waivers and exemptions? Probe about
    - Conflicts of interest between motives for revenue generation and granting of waivers.
    - Motivation for granting waivers.
    - Challenges of running health services in the wake of exemptions and waivers.
6. What are your recommendations on how best to comprehensively address the observed challenges in waivers?

Probe about

- Eligibility criteria for waivers.
- Addressing lost revenues through waivers eg government compensation etc.
- Improving waivers accessibility for the needy.
- Conflict of interest between needs for revenue generation and granting waivers
- Subsidized CHF card to the poor who can't afford CHF premiums.

7. What do you consider to be effects (both positive and negative) of raising user fees?

    Probe about
    - Revenue generated from user fees pre and post user fees increase.
    - Services utilization in Primary health facilities pre and post user fees increase.
    - Increase in request for waivers
    - CHF enrolments.

8. If you fall sick and can't afford paying for health services, what do you do?

Probe on;

- Wait and see approach/ delay treatment until its threat.
- Self medication eg herbal intake, Accredited Drug Dispensing Outlet (ADDO)
- No treatment
- Traditional healers.

APPENDIX D: MUONGOZO WA MAJADILIANO YA KINA KWA VIONGOZI WA AFYA (KISWAHILI)

Huu ni muongozo wa majadiliano ya kina kwa viongozi wa Idara ya Afya kwa ajili ya kutambua ushirikishwaji wa jamii kwenye maamuzi ya ongezeko la gharama za matibabu za ‘*’papo kwa papo’’* na mbinu zinazotumiwa na jamii kumudu hali hiyo kufuatia ongezeko hilo kwenye CHF iliyoboreshwa katika Halmashauri ya Wilaya ya Kondoa.

Viongozi wa afya katika wilaya ya Kondoa watahojiwa juu ya ushirikishwaji wa jamii katika maamuzi yaliyopelekea kuongezeka kwa gharama za papo kwa papo kwa lengo la kuwafanya watu wajiunge na Mfuko wa Afya ya Jamii (CHF). Aidha, pia watahojiwa juu ya mahusiano ya ongezeko hilo na mahudhurio ya wagonjwa, Idadi ya wateja waliojiunga na CHF kabla na baada ya kuongezeka kwa papo kwa papo na mtizamo kuhusu misamaha ya gharama za matibabu.

MAELEZO BINAFSI YA MHOJIWA

1. Namba ya mhojiwa……..
2. Kada.....
3. Cheo……..
4. Umri (miaka) ....
5. Jinsia ....
6. Kiwango cha elimu .....
7. Uzoefu katika nafasi hiyo (miaka) ....

1. Je ni kwa kiasi gani wananchi na wadau walihusishwa katika mchakato wa kuongeza gharama za ‘’papo kwa papo’’kama mkakati wa kuharakisha usajili katika mfuko wa CHF iliyoboreshwa katika Halmashauri ya Wilaya ya Kondoa?
2. Je! Ni nini ufahamu wako kuhusu misamaha ya matibabu?
3. Kutokana na uzoefu wako wa kutoa misamaha; Je, unakabiliana na changamoto zipi?
4. Katika eneo lako la kazi ni utaratibu gani unaotumika kuwatambua wanaostahili kusamehewa matibabu? Dodosa kwa kina hususani;
    - Uwepo wa vigezo vya ustahili wa msamaha.

- Uwezekano wa upendeleo kwenye barua za kuwaombea msamaha wa matibabu kutoka Mamlaka za Vijiji kuwaombea misamaha.
- Maombi ya misamaha kutoka kwa wagonjwa waliolazwa

5. Je, kwa ujumla ni nini hisia/maoni yako kuhusu mapato yaliyopotea kutokana na makundi yaliyosamehewa matibabu kisera (wajawazito, watoto chini ya miaka 5) na wale wanaopata msamaha. Dodosa;
    - Mgogoro wa maslahi baina ya jitihada/msukumo wa kuongeza mapato kwa upande mmoja na kutoa msamaha kwa upande mwingine.
    - Msukumo/motisha wa utoaji wa misamaha ya matibabu.
    - Changamoto za kuendesha huduma za afya katika mazingira ya misamaha.
6. Je, ni nini mapendekezo yako juu ya namna bora ya kuondokana na changamoto zilizopo kwenye misamaha ya matibabu? Dodosa kuhusu;
        - Vigezo vya utambuzi wa watu wanaostahili kusamehewa.
        - Kutafuta ufumbuzi wa mapato yaliyopotea kwa njia ya misamaha; mfano serikali kutoa ruzuku kwa ajili ya misamaha etc
        - Kuboresha upatikanaji wamisamaha kwa wahitaji.
        - Mgongano wa maslahi kati ya hitaji la kuongeza mapato na utoaji wa misamaha
        - Utoaji wa ruzuku za kadi za Mfuko wa Afya ya Jamii (CHF) kwa watu masikini ili kuwasaidia ambao hawawezi kumudu malipo ya CHF.
7. Je! Unafikiria ni athari zipi zinaweza kutokea kwa kuongeza gharama za papo kwa papo? Dodosa;
    - Mapato yaliyozalishwa kabla na baada ya ongezeko la ada ya mtumiaji.
    - Matumizi ya huduma katika vituo vya huduma kabla na baada ya kuongezeka kwa papo kwa papo.
    - Ongezeko la maombi ya misamaha kabla na baada ya kuongezeka papo kwa papo.
    - Ongezeko la wanachama wa CHF kabla na baada ya ongezeko la papo kwa papo.

APPENDIX E: IN-DEPTH INTERVIEW (IDI) GUIDE FOR RELATIVES OF THE ADMITTED PATIENTS (ENGLISH VERSION)

This is an in-depth Interview (IDI) Guide for exploring coping mechanisms and accessibility to waivers by the admitted patients who experience financial difficulties following user fees increase as a strategy to accelerate enrolments in improved CHF.

DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENT

1. Respondent number……....
2. Age (years)……...……..
3. Sex……...……..
4. Level of education…….

INTERVIEW QUESTIONS

1. Now then you are caring for a sick admitted relative, tell me how did you reach into decision to take him/her to health facility? **Probe for;**
    - How long did it take to decide to take the patient for healthcare?
    - What were the major bottlenecks that led to delay in seeking care, if any? Financial, transport, who to take care for the home etc.
    - Any pre-treatments given like herbal medicines, buying from nearby pharmacies?
    - Watchful waiting for self-recovery.
2. How did you raise the funds for financing treatment of your patient?
    - The savings he accumulated.
    - Borrowing and from who? Social networks
    - Selling of assets. Specify the assets sold
    - Selling of assets that are of survival value eg cereals, shamba.
3. In your opinion how do these coping strategies destabilize the households?

Probe for:

- Food insecurity as a result of paying for health services
- Ability to cope shall next attack hit.

4. What factors do you think makes some people to cope successfully while others can't? Probe for assets profile and social networks eg having economically stable children etc.
5. What are community social reorientations like solidarity schemes for the purpose of supporting each other in the wake of increased user fees in primary health facilities?
6. How easy is it to request and access waivers in this facility? Probe for;
    - Procedures require for getting waivers? Can she enumerate eligibility criteria?
    - Any discouragements and challenges encountered from approvers of waivers eg preferential grant to undeserving, compromise of dignity of disclosing poverty, great deal of negotiations with approvers

APPENDIX F; MWONGOZO WA MAJADILIANO YA KINA KWA NDUGU WA WAGONJWA WALIOLAZWA

Huu ni mwongozo wa mahojiano ya kina (IDI) kwa ajili ya kuchunguza mikakati ya kukabiliana na changamoto za fedha baada ya kuongezeka kwa gharama za papo kwa papo kwa wagonjwa waliolazwa na upatikanaji wa misamaha kwa wagonjwa wasio na uwezo.

MAELEZO BINAFSI YA MHOJIWA

1. Namba ya mhojiwa..... ....
2. Umri (miaka) ....
3. Jinsi ....
4. Kiwango cha elimu .....

MASWALI

1. Kwa sasa unamhudumia mgonjwa wako ambaye amelazwa, Je! unaweza kunieleza juu ya namna ulivyofikia maamuzi ya kumleta mgonjwa wako hospitali? Dodosa juu ya;
    - Ilichukua muda gani hadi uamuzi wa kumleta hospitali kufanyika?
    - Mambo yaliyochnagia kucheleshwa mgonjwa kuletwa hospitali. Kama ukosefu wa fedha, usafiri, mtu wa kwenda kumuuguza ect.
    - Mgojwa kujitibu akiwa nyumbani kama dawa za kienyeji, DLDM au vinginevyo.
    - Kusubiria pengine hali itaimarika.
2. Gharama za matibabu zinaweza kuwa juu hasa kwa wagonjwa waliolazwa, nieleze njia ulizotumia kupata fedha za kumtibu mgonjwa wako. Dodosa juu ya;
    - Akiba aliyokuwa ameweka
    - Kukopa kutoka kwa watu, ndugu na jamaa (aainishe)
    - Kuuza mali (taja)
    - Kuuza mali ambazo ni muhimu kwa maisha ya kaya (mf; nafaka, shamba pekee)
3. Kwa mawazo yako, ni kwa namna gani mikakati hii ya kukabiliana na gharama za matibabu inateteresha kaya? Dodosa kuhusu;
    - Kaya kuishiwa kabisa na hifadhi ya chakula na pengine kupatwa na njaa
    - Je ikitokea maradhi tena kipo cha kuuza ili kulipia gaharama?

4. Unadhani ni sifa zipi zinafanya baadhi ya watu waweze kukabiliana bila matatizo na gharama za matibabu na wengine washindwe? Dodosa kuhusu;
    - Umiliki wa mali katika kaya (uwezo wa familia)
    - Mtaji watu (social capital/networks) ambao anaweza kukopa kwao, au misaada. Kukopa benki nk.
5. Je! Ni mabadiliko gani ya kijamii yamefanyika kama kuanzishwa kwa mifuko ya mshikamano kwa lengo la kusaidiana wakati wa maradhi yaliyoletwa na ongezeko la papo kwa papo kwenye zahanati na vituo vya afya
6. Je! Ni rahisi kiasi gani kuomba na kupatiwa msamaha wa matibabu?

Dodosa juu ya;

- Mchakato unaotakiwa ili kupata msamaha wa matibabu. Kama anaweza kujua sifa za anayestahili kupatiwa msamaha. Je yeye anastahili msamaha?
- Je kuna changamoto kutoka kwa viongozi wa vijiji/hospitali wanaoidhinisha misamaha hiyo kama; upendeleo kwa wasiostahili, athari za kiutu katika kujieleza hali yako ya umaskini, kazi kubwa ya majadiliano na wanaoidhinisha misamaha.

APPENDIX G: IN-DEPTH INTERVIEW GUIDE FOR POOR UNINSURED PEOPLE FROM THE COMMUNITY (ENGLISH VERSION)

This is an in-depth interview guide for exploring coping mechanisms and accessibility to waiver by the poor people from the community following user fees increase as a strategy to accelerate enrolments in improved CHF.

DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS.

1. Respondents number..... ....
2. Age (years) ....
3. Sex ....
4. Level of education .....

1. Referring to the last 30 days when you were caring for the sick relative, will you account in sequence how did you take care of him/her? Including issues like if you had difficulties deciding to send him/her to health facility,

Probe on;

- Severity of the disease
- Whether was sent to health facility.
- Time spent before reaching any decision to send him to health facility. What prompted decision to send him/her to health facility? Worsening condition?
- Reasons for such delays.
- Financial difficulties, transport, lack of some one to take care of the children/home. etc

2. If the patient was not sent to health facility for treatment, tell me in some detail how did you cure the patient and what was the outcome of the illness?

Probe for;

-Wait and see, delay treatment approach, non-treatment, self-medication eg herbal intake, Accredited Drug Dispensing Outlet (ADDO), traditional healers.

3. In your opinion, what consequences to the patient do these strategies employed carry? Probe for morbidity and mortality.
4. If the patient was finally sent to the health facility, please tell how did you solicit the money to finance treatment?

Probe for;

- Selling assets (name them)
- Borrowing from family friends
- Selling assets of survival value to the household.eg cereals, selling the only plot for farming

5. Waivers policy exist for poor who can't afford paying for health services, what challenges did you encounter while requesting for waivers?

Probe for;

- Unclear eleigibility criteria
- Preferential grant of waivers to undeserving by local authorities.
- Compromise of dignity by disclosing poverty,
- Great deal of negotiations with approvers

6 What do you propose as a solution to improve accessibility to waivers?

Probe about

- Clearly defined eligibility criteria for waivers.
- Poor who can't afford user fees or CHF should be identified and waived in advance of illness and the list be available to authorities.
- Subsidized CHF card to the poor who can't afford CHF premiums.
- Approvers of waivers shouldn't be among health care providers/managers

APPENDIX H: MWONGOZO WA MAJADILIANO YA KINA KWA WATU MASKINI WASIO NA BIMA KUTOKA NGAZI YA JAMII (KISWAHILI)

Huu muongozo wa majadiliano ya kina kwa ajili ya kutambua maoni ya jumla ya jamii juu ya ongezeko la gharama za papo kwa papo na jinsi wanavyoendana/wanavyokabiliana na ongezo hilo na upatikanaji wa misamaha ya matibabu kwa wasio na uwezo.

MAELEZO BINAFSI YA MHOJIWA

5. Namba ya mhojiwa..... ....
6. Umri (miaka) ....
7. Jinsi ....
8. Kiwango cha elimu .....

1. Rejelea kipindi ulipokuwa unauguza mmoja wa wanafamilia, nieleze hatua kwa hatua ugumu wowote uliopata juu ya masuala ya gharama za matibabu na maamuzi ya kumpeleka kwenye kituo cha matibabu.

Dodosa juu ya;

- Hali ya uhatari wa ugonjwa
- Kama alipelekwa kwenye matibabu katika kituo cha huduma
- Aliugua siku ngapi nyumbani kabla ya kumpeleka hospitali? Kama alipelekwa maamuzi hayo yalisukumwa na nini? Hali kuwa mbaya?
- Sababu zilizopelekea kuchelewa.
- Ukosefu wa fedha, usafiri, kukosekana mtu wa kubakia na watoto/kukaa na nyumba

2. Ikiwa mgonjwa hakupelekwa katika kituo cha huduma, nieleze kwa kina jinsi ulivyofanikisha matibabu yake na hatma ya ugonjwa ilikuwaje?

   Dodosa juu ya;

   - Kusubiri na kuangalia hali itakavyoendelea,
   - Hakupata matibabu yoyote
   - Matibabu ya nyumbani, matumizi ya dawa za asili, huduma kutoka kwa mganga wa tiba asilia, kwenda kwa mpiga ramli, kununua dawa kutoka DLDM.etc.

3. Kwa maoni yako, je unadhani hatua hii ya kutompeleka mgonjwa kwenye matibabu inaweza kuwa na athari gani kwa mgonjwa?
    - Dodosa juu ya hatari ya kifo na madhara mengineyo

4. Ikiwa mgonjwa hatimaye alipelekwa katika kituo cha huduma, je ulitumia njia gani kupata fedha za kughamia matibabu yake? Dodosa juu ya;
    - Kuuza mali (zitaje)
    - Kukopa kutoka kwa ndugu na jamaa
    - Kuuza mali/vitu vinavyohusika na maisha ya kila siku kama nafaka, kipande cha ardhi pekee inayotumika kwa kaya nk.
5. Sera ya msamaha wa matibabu kwa wasio na uwezo ipo, je ulipata changamoto zipi wakati unaomba msamaha?

Dodosa juu ya;

- Vigezo vya utambuziwa watu wanaostahili kusamehewa kutokuwa wazi
- Upendeleo kwa wasiostahili unofanya na viongozi wa vijiji
- Kudidimiza utu wako wakati unajieleza kuwa huna uwezo
- Majadiliano marefu na waidhinishaji yanafanya mtu kuacha kuomba na kubaki bila matiababu.

6. Nini mapendekezo yako kama njia ya kuboresha upatikanaji wa misamaha ya matibabu kwa wahitaji? **Dodosa juu ya;**
    - Vigezo vya kutambua wanaostahili msamaha wa matibabu vianishe wazi sifa za anayestahili.
    - Maskini wasioweza kumudu ada ya CHF na papo kwa papo watambuliwe na orodha yao iwekwe wazi katika mamlaka husika ili wapate misamaha.
    - Serikali iwalipie kadi za CHF maskini wasioweza kulipa ada hiyo
7. Kwa maoni yako, je hatua ya kuongeza gharama za papo kwa papo ili kuwasukuma watu wajiunge na CHF ilileta madhara gani? (chanya na hasi)

Dodosa juu ya;

- Masikini kushindwa kumudu huduma za afya,
- Idadi ya watu waliojiunga na CHF kbala na baada ya ongezeko la papo kwa papo.
- Hali ya mahuhdhurio ya wagonjwa katia vituo vya huduma kabla na baada ya ongezeko hilo.

APPENDIX I: IN-DEPTH INTERVIEW (IDI) GUIDE FOR HEALTH FACILITY INCHARGES (ENGLISH VERSION)

This is an In-depth Interview (IDI) Guide for exploring relationships between user fees increase and CHF enrolments and health facility utilization following user fees increase as a strategy to accelerate enrolments in improved CHF. Further, it explores whether there is changes in extent of requests for waivers and revenue generating capacity before and after user fees increase, health services utilization for uninsured people before and after user fees increase.

1. Respondent number……....
2. Profession……...
3. Position
4. Age (years)……...……..
5. Sex……...……..
6. Level of education…….
7. Work experience in that position (years)……...

1. In your opinion, ever since the beginning of new increased user fees in 1st of August 2014, what changes has been observed in the number of insured and uninsured clients attending this facility compared to the way it was before price changes? Which group dominated attendance before user fees increase? What are the current trends in OPD attendance?
2. Compared to before increasing user fees, how is user fee increase affected user fees revenue collections?

Probe about

- Revenue generated from user fees pre and post user fees increase.
- The main source of revenues of the facility before and after user fees increase.

3. Compared to before increasing user fees, how has user fee increase affected CHF enrolments?

Probe about

- Revenue generated from CHF pre and post user fees increase.

4. Compared to before increasing user fees, in your opinion, what are the trends of requests for waivers?
5. In your opinion, where do those who don't attend health facility for treatment solicit treatment?

APPENDIX J: MWONGOZO WA MAJADILIANO YA KINA KWA WAKUU WA VITUO VYA HUDUMA (KISWAHILI)

Huu ni mwongozo wa majadiliano ya kina kwa lengo la kutambua mahusiano baina ya ongezeko la gharama za papo kwa papo na idadi ya watu walioandikishwa kwenye CHF na mahudhurio ya watejwa kwenye huduma za tiba. Aidha, mwongozo utajaribu pia kubaina kama kuna mabadiliko ya watu wanaoomba msamaha wa matibabu, makusanyao ya fedha za papo kwa papo, baada ya ongezeko hilo la gharama.

MAELEZO BINAFSI YA MHOJIWA

1. Namba ya mhojiwa..... ....
2. Kada……..
3. Cheo……...
4. Umri (miaka) ....
5. Jinsi ....
6. Kiwango cha elimu .....
7. Uzoefu katika nafasi hii (miaka)……

1 Kwa maoni yako, tangu ongezeko la gharama za papo kwa papo lilipoanza mnamo tarehe 01/08/2014 je, kumekuwa na mabadiliko gani ya idadi ya mahudhurio ya wagonjwa wasio na bima na wale wenye bima ukilinganisha na kabla ya ongezeko hilo?

Dodosa juu ya;

- Kundi liloathirika zaidi (ambao mahudhurio yamepungua sana) na ambalo mahudhurio yameongezeka.
- Hali ya mahudhurio ya sasa ikoje?

2 Ukilinganisha na kabla ya ongezeko la gharama za papo kwa papo, ni kwa nanmna gani ongezeko hili limeathiri makusanyo ya mapato yatokanayo na papo kwa papo?

Dodosa juu ya;

- Makusanyo ya papo kwa papo kabla na baada ya ongezeko la papo kwa papo (interview and document review)

- Chanzo kikuu cha mapato ya kituo ilivyokuwa kabla na baada ya ongezeko la papo kwa papo.

3. Ukilinganisha na kabla ya ongezeko la gharama za papo kwa papo, ni kwa kiasi gani ongezeko hilo limeathiri idadi ya watu wanaojiunga na CHF?

Dodosa juu ya; Mapato yataokanayo na CHF kabla na baada ya ongezeko la papo kwa papo.

4. Ukilinganisha na kabla ya ongezeko la gharama za papo kwa papo, je maombi ya misamaha ya matibabu ikoje kabla na baada ya ongezeko la gharama za papo kwa papo.

5. Kwa maoini yako, je wale ambao hawahudhurii katika vituo vya huduma wapougua unadhani wanapata wapi matibabu wanapougua?

Dodosa juu ya;

- Kujitibu mwenyewe kwa kutumia dawa asili, DLDM
- Kwenda kwa waganga wa jadi
- Kusubiri kuon jinsi hali itakavyoendelea

APPENDIX K: FOCUSED GROUP DISCUSSIONS (FGDs) GUIDE (ENGLISH VERSION)

INTRODUCTION.

My name is……. We are doing a research that aim to explore the community participation and coping strategies in response to user fees increase to accelerate enrolments in improved CHF in Kondoa district. The information will give light as to the extent of community participation on the processes that led to user fee increase and the findings will help policy makers to review the approach.

In a group of 8-12 people we will discuss issues related to how the community participated in the process of user fees increase and various coping mechanisms for people who experience difficulties in paying for user fees. Further, we will discuss on the implications of user fees increase on CHF enrolments and health services utilization, waivers and challenges encountered while requesting.

The information you give us is completely confidential, and we will not associate your name with anything you say in this focus group discussion.

We would like to tape the discussions to make sure we capture the thoughts, opinions, and ideas we hear from you. No names will be attached to the focus groups and the tapes will be destroyed as soon as they are transcribed.

Here are some norms that we can agree together to make our discussion as smooth as possible.

- Everyone should participate.
- Switch off your phones.
- Information coming out of this discussion must not be shared to any third party. It is confidential.
- No side conversations, stay in the group.
- We are not seeking for a common view, so be free no one is wrong.
- Have fun

1. To what extent was the process of increasing user fees participatory within your local community?
2. How were collections of community opinions regarding user fees increase coordinated? How did you get the information on the change in user fees?
3. Generally, what are the opinions of the community regarding this approach of raising user fees? Approve the approach or not? Why?
4. Has there been any other approach that carries elements of coercion to enroll in improved CHF? What are they? Probe for preferential treatment of CHF customers like the slogan ‘’ *mpishe mwanachama wa CHF atibiwe kwanza’’*-was it practically implemented*?,* setting aside drugs for CHF members only, use of mgambo to threaten those reluctant to enroll into CHF, user fees increase etc.
5. What do you consider to be effects of raising user fees?

Probe about

- Generate more revenue; pre and post user fees increase.
- Services utilization in Primary health facilities pre and post user fees increase.
- More enrolments into CHF.
- Social exclusion of the poor.

6. The logic is that if you raise price of coffee, people may shift to tea, how did user fees increase affected people’s choice between CHF enrolments and paying OOP for health services? Explain.
7. In your opinion, do you think CHF enrolments increased ever since raised user fees started operating in 1st August 2014?
8. Comparing before and after user fees increase, in your opinion has there been any change in demand and utilization of health services especially for the OOP paying groups? What are those changes and why?
9. Suppose someone falls sick and can’t afford paying for health services, what do they do? Probe on;

- Wait and see approach/ delay treatment until it is life threatening threat.
- Self medication eg herbal intake, Accredited Drug Dispensing Outlet (ADDO)
- No treatment
- Traditional healers.

10. Do all people in this village have equal abilities to pay for user fees in health facilities? If no, how do those who can't afford paying for health services cope at times of illness? Probe for; wait and see/delay treatment approach, non-treatment, self-medication eg herbal intake, Duka La Dawa (ADDO), traditional healers and waivers. Do these strategies employed carry any consequences to the patient? What are those consequences? Probe for morbidity and mortality.
11. Suppose one has an uninsured relative admitted in a hospital where costs are higher compared to OPD; What are strategies used by relatives of a patient to finance higher costs of treatment for an uninsured admitted patient? Probe for borrowing, selling of assets and seeking exemptions.
12. Put yourself into the shoes of a relative caring for an uninsured admitted patient, what factors do you think makes some people to cope successfully while others can't? Probe for assets profile and social capital
13. What are the biggest challenges experienced by paupers with respect to ability to borrow and sell assets? Probe for paucity of assets to sell and limited social capital to borrow.
14. In your opinion how do these coping strategies destabilize the households? What effect do they exert on the ability to sustain the households for other basic needs?
15. For those who can't afford paying user fees, how easy is it to get waived?
16. Is there a clearly documented criteria for identifying who is poor? If no, how is eligibility for waivers determined at your area?
17. Discuss the main challenges that hinder the process of requesting and accessing waivers from the village to providers of health services.

Probes for; Identification of eligibility, awareness of the poor people whether they deserve, bureaucracies, preferential favors by those approving waivers, negotiations and sympathizing for

waivers, emotions surrounding declaration of poverty and sacrifice of dignity that may motivate not to seek waivers.

18. How are the poor capacitated to know if they deserve waivers so that they can demand them?
19. What are your recommendations on how best to comprehensively address the observed challenges in waivers and exemptions?

Probe about

- Improving waivers accessibility to the needy eg identification process.
- Should health workers approve waivers? Conflict of interest.
- Subsidized CHF card to the poor who can't afford CHF premiums.
- Should waiver follow the poor or poor seek the waivers?

CLOSING

Is there anything more you would like to add?

Thank you for your time