THE INFLUENCE OF USER FEES IN IMPROVING THE HEALTH SERVICES IN KOROGWE DISTRICT

BY

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CERTIFICATION

The undersigned certifies that he has read the dissertation titled " The influence of user fees in improving the quality of health services in Korogwe district." in partial fulfilment of the requirements of the Master of Public Health.

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DEDICATION

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ABSTRACT

To determine the extent to which user charges has contributed to improvement of health services following the introduction of health sector reform, a cross sectional study was conducted in Korogwe hospital in June 2002. The study subjects included, 412 community members, 80 health workers, and 40 patients. Data collection instruments included a structured interview schedule and focus group discussions using an interview guide.

The results showed that there was a moderate improvement in quality of care, especially in process quality as assessed by level of interaction between providers and clients. The level of satisfaction with the health services was 65% among community subjects. The mean number of drugs per prescription form was 2.5±0.6.

Forty three percent (43%) of community members and 90% of patients were of the opinion that quality of care had improved following introduction of user fees. Over a half (57%) of the community subjects perceived that there had been very little improvement in the structure of buildings and 44.9% had knowledge about the changes regarding user fees in the district hospital.

Some of the patients and of community members were unable to pay user fees, however only 33% and 13% of the above were granted an exemption respectively. Overall, 70%

of the community subjects mentioned that they would not be willing to pay more money as user fees.

The study recommends that further improvement be made on structural and process quality of care so that the community and patients can maximize benefits of user fees at the district level. Health workers should also be trained to improve their behavior and drugs be made more readily available so as to synchronize with increasing patient demand and accountability of user fees.

TABLE OF CONTENTS

ITEM **PAGE**

CERTIFICATION---------- i

DECLARATION AND COPYRIGHT---------- -iii

ACKNOWLEDGEMENT---------- iv

DEDICATION ---------- vi

ABSTRACT---------- vii

TABLE OF CONTENTS ---------- ix

LIST OF TABLES---------- xi

LIST OF ABBREVIATIONS---------- -xiii

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background ---------- 1
1.2 Statement of Problem ---------- -8
1.3 Rationale---------- 9
1.4 Study Question---------- 10
1.5 Literature Review---------- 11

CHAPTER TWO

2.0 OBJECTIVES

2.1 Broad Objectives---------- 22
2.2 Specific Objectives ---------- 22

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study area---------- 23
3.2 Study design---------- 24
3.3 Study population ---------- -25
3.4 Sample size determination ---------- 25
3.5 Sampling procedure ---------- 26

3.6 Data collection ---------- 28
3.7 Manpower ---------- 29
3.8 Data collection process---------- 29
3.9 Data management---------- 31
3.10 Ethical issues ---------- 32
3.11 Perceived constraints---------- 33

CHAPTER FOUR

4.0 RESULTS---------- - 35

CHAPTER FIVE

5.0 DISCUSSION---------- 53

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSION---------- -69

6.2 RECOMMENDATIONS ---------- 69

7.0 REFERENCES ---------- 71

8.0 APPENDICES ---------- 80
8.1 Household questionnaire (English version)---------- 80
8.2 Health personnel questionnaire (English version)---------- 87
8.3 Patient questionnaire (English version)---------- 93
8.4 Household questionnaire (Swahili version)---------- 103
8.5 Health personnel questionnaire (Swahili version) 111
8.6 Patient questionnaire (Swahili version) 117
8.7 Focus group discussion guidelines: Community 128
8.8 Focus group discussion guidelines: Health personnel 130

LIST OF TABLES

Table 1 Socio demographic characteristics of study population in Korogwe district. 35

Table 2 Community satisfaction with quality of health care services at Korogwe district hospital 36

Table 3 Perception of drug availability following introduction of user fees in Korogwe district 37

Table 4 Type of informatiom provided by health workers in Korogwe district 38

Table 5 Reasons for choice of certain type of health facility in selected communities in Korogwe district 40

Table 6 Availability of prescribed drugs to patients at Korogwe district hospital 41

Table 7 Perception of quality of care by community, patients and health workers in Korogwe district 42

Table 8 perception of community on personnel health behavior in Korogwe district 43

Table 9 Perception on the state of buildings and user fees 44

Table 10 Equity in treatment of similar disease conditions at Korogwe district hospital 45

Table 11 Postponement of seeking care due to inability to pay user fees at Korogwe 47

Table 12 Ability to pay for health care among community members and patients 48

Table 13 Waiving for user fees for people who failed to pay for their health services 49

Table 14 Knowledge of community about user charges taking place in the district hospital 50

Table 15 Knowledge about community and outpatients on who decides on exemption from user fees at Korogwe district hospital 51

Table 16 Knowledge of health personnel on types of conditions that are eligible for exemption from user fees at Korogwe district hospital 52

LIST OF ABBREVIATIONS

AIDS/HIV	Acquired Immunodeficiency Syndrome / Human Immunodeficiency virus
CI	Confidence Interval
FGD	Focus Group Discussion
M-H	Mantel Haenszel
MOH	Ministry of Health
HSR—POW	Health Sector Reform Program of Work
WB	World Bank
WHO	World Health Organization
UNICEF	United Nations International Children and Education Fund
MUCHS	MuhimbiIi University College of Health Sciences
MCHA	Maternal and Child Health Aide
SAP	Structural Adjustment Program
HSR-MOH	Health Sector Reform Ministry of Health.
TDHS	Tanzania Demographic and Health Survey.

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND

User fees are fees imposed for health care, education or other service. Historically many of the health care services were previously provided free of charge or at a nominal cost in most of the countries in Africa south Sahara.

Over the recent years (10 to 20 years ago) user fees in health care have been aggressively promoted by the World Bank, and the International Monetary Fund. These have been part and parcel of the conditions for countries to access loans from the organizations. User fees for health services are not new in many of the third world countries. It has been present, and is been practiced by non – government organizations and private for profit health care facilities (Shaw, 1995).

It is however new when it comes to government health service provision in most of the countries in Africa South of Sahara. The need to provide free, accessible, equitable, effective and sustainable health services was a political decision made soon after independence of most of these countries. User fee is an important aspect of health sector reform. It is part of the wide perspective of financial reforms. Together with other forms of reforms within the health sector, it is intended to create a sustained, purposeful and fundamental change to address significant strategic dimensions in the health system

(Berman, 1995). Health sector reforms are taking place in many parts of the world. The contents of the reforms differ from one country to another. The major motivations for health sector reforms are financial, social, economic and political. In many industrialized countries the major motivation is a concern with cost containment. Vast sums of money might be available to put into the health sector, but the society would like to get a value of service that is equivalent to what has been invested.

In some Latin American countries health reform has been a response to devastating effects that the economic crises of 1980s had on private and public spending (Frenk, 1994). In this state recovery is seen as an opportunity to restructure the system rather than going back to unsatisfactory arrangements before the crises. In Africa South of Sahara the reasons were due to chronic scarcity of resources, drought, civil unrest, and new challenges such as AIDS/HIV and the outcome of epidemiological transition. A number of countries in the advanced market economies have implemented structural changes to their health services. The design of reform programs in developing and middle-income countries is very much influenced by the concepts developed in the advanced market economies (Bloom and Xingyuan, 1997).

In the pre-independent Tanzania before the coming of the colonialists, health care consisted of traditional medical practices. This was largely functional at local level, and providing care according to culturally acceptable ways.

It is assumed that payment of user fee in kind applied traditionally at this level and is probably related to the informal payments for health service in Tanzania and in some other countries (Thompson and Witter, 2000).

In the German and British colonial era in the then Tanganyika the conventional and traditional medicine were functioning side by side. The services were mainly urban and curative oriented with little emphasis on quality especially in rural areas. As from independence in 1961, there were efforts by the government to improve the situation in line with the renewed enthusiasm and expectations of the people for better health services.

The endeavor by the government to improve the health services started immediately after independence. In 1963, the government commissioned a committee to recommend on various improvements in health to be undertaken during the first five-year plan (Titmus et al., 1964). The 1967 policy of socialism and self-reliance spelt out, among other things, to provide basic health services at no direct cost to users of all ages, status and race. To accomplish this goal the government deliberately increased the number of health care facilities (hospitals, dispensaries and health centres). This was matched by a ten fold increase in various cadres of health personnel mainly doctors, nurses, MCHA (Maternal and Child Health Aides), health officers, rural medical aids, and medical assistants (MOH, 1997).

The extensive and impressive infrastructure for health services could only continue to function with stable and growing economy. However in the early 1980s, Tanzania's economy was passing through a difficult period. As in many other countries of Latin America and Africa, Tanzania was in economic crises following global financial difficulties, drought and war with Uganda in the late 1970s. The crises manifested in Tanzania through acute shortage of consumer goods, deterioration of social sector (health, education, water, housing), declining public finance, and rising inflation. The health sector experienced adverse shortage of drugs, equipment, poor morale of health personnel, deteriorating infrastructure, and lack of supervision. The introduction of Structural Adjustment Programs (SAP) in the 1980s as a way of solving the problems could not work because loans were provided on condition that it would incorporate cost sharing in health services, and government expenditure cut in the social sector (World Bank, 1996).

Health and health care financing depends on deployable resources. Thus any negative changes in the economy would be reflected negatively in the health sector. Consequent upon this, the country resolved to reform all sectors in 1993 – 1998, including the public service and the health sector. The reforms in the health sector included ideological, managerial, public private mix, organizational, research, nutrition, population policy and health financing (HSP – MOH, 1993).

HEALTH FINANCING IN TANZANIA

Private Sector

Private sector include facilities that are not government controlled, and charges in these facilities appear to be the major source of funding. Some of the mission hospitals in Tanzania have charged user fees since 1928 (Newbrander and Sacca, 1996). The Ministry of Health finances some of the voluntary facilities under mission or religious groups. This is especially so for those facilities that have been designated by the government to provide services in particular localities (e.g. Designated District Hospitals) (Mujinja, 1990).

In addition there are contributions from private individuals and non-government organizations both locally and internationally. Insurance cover is less than 1% of the population in Tanzania This is limited to parastatal organizations and companies (Griffin and Shaw, 1995). Currently, according to the health sector Program of Work 1999 – 2002, health insurance will apply legally to all civil servants (MOH, 1999).

Public sector

Forty percent (40%) of all the health services have been provided by private and non-government organizations. The rest (60%) prior to 1993, have been provided by the central government, through the Ministry of Health as a major financier (MOH, 1994). The services involved included preventive, curative, rehabilitative, promotive, and training of health manpower. Most of these services depended for their funding on

government taxation, loans and grants. The economic crises of the late 1970s and early 1980s lead to cutting back on the grants and loans, as well as government spending. Given such a situation, health care services could not be sustained if the Government of Tanzania had to depend on loans and government revenue alone.

Alternative financing mechanism for the public health sector was adopted in 1993. User fees were introduced in stages, starting with referral hospitals, then followed by regional and then district hospitals (HSR- MOH, 1999-2002). Thereafter user fees for health centres and dispensaries were introduced in some facilities in Dar es Salaam, and Lushoto District (HSR- POW, 1999- 2002). The community health fund has been on pilot basis in Igunga district, Tabora region since 1996. This has been rolled over to nine other districts, after evaluation of the same. The National Health Insurance began in the year 2001, initially covering all civil servants only.

ASSESSING QUALITY OF HEALTH SERVICES

Quality of health services has a wide connotation. It does not apply to all situations equally. Definitions given by various authors tend to concur on certain broad issues. According to Donabedian, health service quality is quality of technical care consisting of application of medical science and technology in a way that maximizes its benefits to health without increasing its risks (Donabedian, 1980).

The assessment of quality is done through measuring structure, process and outcome. Structure assesses quality through adequacy of facilities and equipment, administrative

process, qualification of medical staff and organization (Campbell et al., 2000). Structure is considered a conduit through which care is delivered while outcome is a consequence of interaction between individual and health care system. It considers a change in the person's health care status as associated with antecedent health care. For that reason it examines recovery, survival, function restoration and patient satisfaction. The process aspects of quality involve interactions between users and health care structure. It is essentially what is done to or with users. It is the actual delivery and receipt of care. The process has a technical part of it and the interpersonal interactions between users and members of the health care system.

A study done in Tanga region to assess the quality of health services in the district hospitals of the region showed that district hospitals reported various shortcomings in terms of quality (Maier and Urassa, 1997). The shortcomings included old and inadequately rehabilitated physical structures, non-availability of drugs, staff absenteeism from their work place, patients' dissatisfaction, general lack of working tools, as well as patients' complaints about nurses being harsh and unfriendly. In addition the authors also reported that giving of bribes were common, often given out in order to shorten the waiting time for consultation, treatment, physical examination and assistance in wards.

This study will take the form of assessing the adequacy of resources and services, health care delivery and financial and physical accessibility but in relationship to client/ consumer satisfaction and the influence of user fees.

1.2 STATEMENT OF THE PROBLEM

Cost sharing in form of user fee has been in operation in Tanzania since 1993. Prior to that the services were being offered free of charge. Literature shows that these free services were already of poor quality (Mwabu and Wang'ombe, 1995; MOH, 1994; Stanton and Clemens, 1989). The decision to introduce user fees charges was a deliberate action intended to improve the quality, equity, efficiency, effectiveness and accessibility of services. Poor quality of services is a widely spread problem occurring in many of the third world countries. Tanzania is not an exception to this. The efforts to improve the situation are being done through user fees, donor funds, grants, and government revenue.

The ultimate sustainability of programs depends on user funds contributed by the community. However the administration of user fees did not try to involve the community from where the client is coming from. In some studies the district leaders failed to consult the community regarding the introduction of user fees (Konde- Lule et al., 1998). While there is some evidence to show that cost sharing has led to significant improvements in the quality of service, consumer satisfaction and availability of drugs and supplies, still the improvements have not yet met consumer expectations.

In some areas the implementation of user fees is still far from satisfactory in achieving its goals. Increasing user fees is associated with decreased utilization of health services. Study done in Lesotho on the increase in the price of user fees resulted in 72% decline in

the utilization of health services by children aged 0-4 (Matji et al., 1995). Similarly there are several other studies that show a similar trend in low utilization and poor referral when user charge prices go up (Matji et al., 1995).

In some other areas people were willing to pay for services despite increase in price as long as they were of good quality and especially if they could be assured of drug availability (Litvack and Bodart, 1995). Equity is only guaranteed when the poor and indigent are able to get services despite the introduction of user fees. This is done through a functional exemption system. Poor exemption system denies the poor of the essential health services (Hecht et al., 1995). This report will present the extent to which the quality of the services has improved following the introduction of user fees and how equity has been affected by the same.

1.3 RATIONALE

The community is the consumer of health services, but at the same time they are the contributors to the running of the services. From the community point of view
it is an opportunity to know how they feel about the service and whether the expected quality, equity, efficiency and effectiveness are been met. From the implementer's point of view it will help to see the extent to which the community attribute improvement in quality, efficiency, equity and utilization to user fees that is contributed by the community. In turn this will help to focus more closely to the issues that are acting as impediments in the full realization of quality of health services from the user fees.

1.4 STUDY QUESTION

To what extent has user fees contributed towards the improvement of the quality of the health services?

1.5 LITERATURE REVIEW

The increasing deterioration of quantity and quality of health services in the late 1970s and early 1980s sparked out a World Bank recommendation of increased cost recovery as part of publicly provided health services in developing countries (World Bank, 1987)

In many countries in sub-Saharan Africa health services were being offered for free and often with high subsidies from their respective governments.

Chronic shortages in inputs such as drugs, equipments, and finances to the health sector severely curtailed the effectiveness and quality of the health services leading to the World Bank's proposition for cost recovery. User fee is taken as a way to improve efficiency and equity of the health system. Through user fees, clients get directed to obtain services where they are available at a lower cost, but at the same time discouraging excessive use of services.

Despite a series of debate on the implications of user fee in government facilities, it was agreed that some kind of cost recovery in health service couldn't be avoided (WB, 1995). The biggest concern in the introduction of user fee in previously free of charge government facilities is the possibility of denying the poor and the indigent access to modern health care. Those who are denied access to modern health care retreat to self-treatment, or seek alternative services from traditional healers, or fail to seek care completely. Studies done at household level found that the poor did not seek modern treatment instead they waited to see, or they sought alternative care from traditional

healers. (Stanton and Clemens, 1989). Apart from the direct cost for medicines, transport had a negative impact on access to modern care (Ainsworth and Shaw, 1995). The majority of clients who elect to use the health services often anticipate that the services will improve through their contributions in cost sharing.

The tangible benefits of cost recovery in government health services must include the change of the previously poor condition to what the community is able to discern as an improvement in the service. Revenues can be used to expand the available services by freeing resources or financing services that are under financed for instance drugs, rehabilitation, equipment, and increasing morale of health workers. Efficiency is increased through reduction of excessive use of services but increasing capacity according to the need of clients and their willingness to pay for such services. User fees have been found to be capable of increasing equity through charging those who are better able to pay and channeling the income to those who are least likely to pay such as the poor.

Payment of user fees in Sub-Saharan Africa is not quite new as a way of financing the health services. Even before the World Bank's recommendation to adopt cost recovery, there have been private and voluntary organizations that ran cost recovery health services. According to Shaw (1995) some of these services have been recovering between 55% and 80% of all costs to be used for funding the services. It is conflicting to

note in the same study that recovery rate for government health facilities were reported to range between 2% – 12% of all revenues.

Countries that have started user fees differ in the emphasis they put on the mobilization and use of such fees. User fee surveys by the World Bank in various countries in sub-Saharan Africa revealed a number of countries participating in the user fee scheme (Shaw, 1995). Out of 27 countries, 30% saw the revenue collection as a primary objective. The rest apart from collection of revenue, put emphasis on improving primary health care services including staff incentives and drug procurement (Shaw, 1995) Moreover mobilization of user fee without targeting improvement of health service quality cannot convince the community on the need for user fees.

In health centres, members of communities tend to be much more affiliated to the service, as well as its ownership. Due to the closer affiliation, members of communities tend to be ready to pay for what appears to be improving services e.g. making drugs easily available, contributing to purchasing of equipment and improving the morale of workers. According to countries that have agreed to operate on the Bamako Initiative, it is an incentive to retain some of the user fees at local level where local contributors can manage it, and at least people can see what the output is, and how it is being used. The power to make decisions to spend money especially for items that are used widely is subject to waste if uncontrolled, hence it helps if people can see the importance of any money paid and its accountability.

According to Shepard et al (1995), the contribution of user fees on the running costs of many hospitals appear to be small ranging from 13 – 32% of the cost recovery. This is because of the acute (catastrophic) expensive events, charges that make a small fraction of the cost items and the low possibility of recovering debts due to a wider area of coverage by hospitals (Shepard et al., 1995). Despite poor affiliation of members of the community to the incentive of paying user fees, the motive for continued support of user fees appears to be based on the improved quality of services (Lavy and Germain, 1995).

According to Nolan and Turbat (1993) user fees should encourage clients to move across the various levels of referral system without easily bypassing any of the levels. Clients feel secure when they are referred officially to the next level. Only the right signals are able to enhance improvement in quality using the user fees (Nolan and Turbat, 1993). When there is an escalating user fee charges coupled with improved quality, then individuals are given an incentive to enter the health system. At a higher level they pay more, but they also expect more in terms of expertise and efficiency.

User fees would be able to promote equity if the right practice prevails. Equity has to do with fairness and implies that the most vulnerable and needy groups in the society would be accorded greater access to resources, than those communities that are better off. Although equity is geographical, cultural, functional and financial, the equity in user fee is both financial and functional.

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The use of services by the better off people in the public facilities provides chances to pool resources to help the poor who are unable to pay for the services. Available studies in Tanzania show that 45 – 55% of the rich use the public facilities, as compared with 50% by the poor (World Bank, 1993), who may opt to use alternative health care either private, traditional or self-medication. Retention of some of the collections at the local level confers more equity if they can be used to make good drug and stock outs, maintain emergency equipment etc (McInnes, 1993). Some countries e.g. Kenya and Tanzania are practicing fees retention at the level of collection.

Within the context of cost sharing equity can only be guaranteed if every one can pay for the services, or if there are concrete arrangements that enable the vulnerable and indigent to get the services. In a study on evaluation of cost sharing in Tanzania, households reported that some individuals tend to fail to pay for their health services in the hospital. Of these 55% failed to pay, 43% had to borrow money, 20% opted for self-medication, 10% to traditional healers and only 16% got exempted (MOH, 1999).

User fees enhance decentralization and sustainability of health services as part of health sector reform. Retention of user fees at local levels tends to make central government budget allocations free for primary care activities and use at the local level. At the level of the community, community management committees have been formed in some countries for instance, Nigeria, Congo and Guinea to represent the perceived roles and decisions of community members on how they would like their own facilities to be

managed. With communities that have been empowered, they can make decisions on cost sharing, exemption and accountability. User fees are intended to generate revenue, improve quality, effectiveness and equity of health services.

The availability of user fees is related to the ability and willingness to pay for conventional health services. People who are capable of paying for health services sometimes they do not pay if they perceive the services to be of too low quality. Others still have been shown to be ready to pay if the services were packaged to adequately treat an episode of disease at a lower cost. Household expenditure surveys show that people pay a lot of out of pocket payment to pharmacists, traditional healers and private practitioners. In Ghana, Nigeria and Cote d'Ivoire the expenditures were almost equal to what the government would spend on such services (Shaw, 1995).

Opinion polls in 1992 before the introduction of user fee in Tanzania showed that 87% were willing to pay for health services on condition that the service was good (Mujinja and Mabala, 1992). A similar study in Zambia reported that 4% of people could not seek care as a result of inability to pay. Forsberg (1993) in evaluating countries participating in Bamako initiative reported that there were problems with affordability of user fees in 10 – 30% of household. Various studies show that people are willing to pay for traditional healers (Mwabu, Ainsworth and Nyamete, 1995). In Ethiopia 20% of household expenditures were paid to traditional healers as compared to 47% on conventional medicine (Dunlop and Donaldson, 1987). Likewise in Kenya a visit to

traditional healer cost KShs46 compared to KShs14.2 in private facilities yet it did not become a barrier to seek care from the traditional healers place (Mwabu et al., 1990). This would imply that not everyone who seeks care from a traditional healer is unable to pay at a government or private facility. Even in case of free health services some people have tendency to give out informal payments. According to Thompson and Witter (2000) informal payments are poorly understood, creates uncertainty to the cost of health services and probably occur due to lack of information and blurring of charging guidelines. In Kazakhstan informal payments reach the extent of about 25% to 30% of the official payments (Thompson and Witter, 2000).

The need to pay appears to be related to ability to pay, as well as the perceived quality of service. How much of the perceived quality brings a client to the orthodox medicine instead of other alternatives is not very clear. The choices that a client makes depend on the price of the service as well as the quality of the same. The decision to discontinue a modern service will be determined by other available alternatives and their effectiveness. The factors that have been seen to affect choice depend on prices, income and assets, distance, travel, cost, opportunity cost of travel, waiting time, quality of service, type of illness, cultural perception or acceptance. Amidst a number of factors, the possible choices include attendance to government facilities, mission, private not for profit, private for profit, traditional healers and self-treatment.

The introduction of user fee is faced with problems unless the need for equity and exemption mechanisms are considered. A certain proportion of population will need to be exempted from paying. Part of this proportion may be obvious and community could identify some and others may be exceedingly difficult to identify. Among 29 countries in sub-Saharan Africa with cost sharing schemes only 1 (4%) had an official ceiling of income below which people could be exempted. Fourteen percent (14%) claimed to have an exemption option in their national health policy but there was no criteria set for it and 40% of the countries had exemptions provided at local level and on adhoc basis (WB, 1995).

The capacity to offer exemptions to meet equity is extremely limited. Lesotho exempts people on the basis of their having no land, livestock or other belongings (Matji et al., 1995). On this basis other people including elderly people, chronically ill, single parent family (mothers) may not be availed with an exemption. Coupled with exemption of health workers it creates a basis of equity violation. Consequently, there is no regional guideline on exemptions in cost sharing. The practical approach has remained for individual countries and communities to work out their own ways of exemptions. According to Mujinja and Mabala (1992) private and voluntary health facilities in Tanzania experience problems in having their patients to pay. Some of these individuals pay in kind, in exchange for labor in hospital or defer their payment. Some of the very poor patients are also exempted.

The idea of using identified components of basic packages of services that are believed to contain very strong public benefits, as contained in World Development Report (1993) and in Better Heath for Africa is attractive. The services would be exempt from charges if they were not heavily subsidized. Examples of such services include the National Immunization Days (NIDS), which have a great public benefit. Informal types of payments are sometimes applied to these services, which in turn is likely to decrease their utilization.

The administration of user fee did not try to involve the community from where the client is coming from. Many clients and especially the community do not know what charges to expect at their health facility. According to Fabricant and Kamara (1990) letting community know about prevailing charges helps them to be more receptive of the charges and any changes and tends to increase confidence by community especially with regard to cost sharing. They also become less suspicious on any payments and reduce the incidence of overcharging. The position of health facility staff in relationship to collection of user fee must be clear both to themselves and the community. The struggle to raise quality of health services is futile unless they are motivated and knows their position in relation to this goal (World Bank, 1995). In order to raise the quality of services using user fees, this must be properly administered. Centralization of user fees expenditure is often not the best option. In 19 countries where collecting facilities retained revenue, local actors were best utilized and decentralization given a priority. (Russel and Gilson, 1997).

The involvement of facility management boards, local health committees, health staff and community representative will increase transparency, acceptability and effectiveness of expenditure decisions. In these countries the guidelines prioritized drugs, building maintenance, equipment and staff incentives. According to Russel and Gilson, (1997), drug availability and staff attitudes seem to be the most important factors in the poor persons' perception of service quality. Evaluation of cost sharing in Tanzania has shown that only 50% of the stakeholders admitted to the fact that drugs were available from the health facilities that were studied. Among the stakeholders, 54% of the patients and 40% of the households had the opinion that drugs were available. When the hospital staffs were asked about the availability of hospital supplies, only 34% admitted that there were enough supplies in the hospitals (MOH-1999).

Because of the ability of public hospitals to collect both inpatient and outpatient charges in large amounts indicate the need for having strong commitment if substantial quality of health services is to be achieved. The performance of user fees in Zimbabwe during the 1980s was poor due to laxity, poor billing system, poor commitment and low fees (Hecht et al., 1995). The effectiveness of user fees as a method of improving quality depends on its ability to purchase the services that are being offered. User fees that have been eroded by inflation are unlikely to contribute towards the goal in improving the quality of health services. For user fees to effective it must be adjusted to keep pace with inflation as observed in Ghana, Zambia and Zaire (Shepard et al., 1995)

Poorly structured user fees for service has been criticized due to failure to portray the right picture in terms of each value of service and thus negatively affecting the amount of revenue generated from user fees. Each client would like to perceive the exact value of service one is paying for. Flat user fees, although simple in administration, are unpopular and do not necessarily help clients to appreciate the value of the services provided. A flat user fees in Uganda was also associated with frequent shortage of drugs and staffing as a result it elicited a negative response by the community (McPake et al., 1992).

The ability of some clients to pay cash as a form of user fee is sometimes limited. This is especially so in rural areas where people have property in form of grains or animals but are not able to dispose them of immediately, as a result payment in kind is sometimes accepted by traditional healers. According to Mujinja and Mabala (1992) payment in kind is allowed in privately operated hospitals and clinics but especially for the poor.

CHAPTER TWO

2.0 OBJECTIVES

2.1 BROAD OBJECTIVES

To determine the improvement in quality of health services contributed by introduction of user fee charges.

2.2 SPECIFIC OBJETIVES

1. To determine the extent of satisfaction with the quality of health services after introduction of user fees.
2. To determine the perception of community of user fees on the quality of health services.
3. To assess how user fees has influenced equity /access to health services
4. To assess knowledge about user fees of health personnel and community
5. To assess the knowledge of the community and health personnel on exemption from user fees.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Area

The study was conducted in Korogwe District, which is one of the six districts of Tanga region. This district has been selected because it has a district hospital that has implemented health Sector Reform as a public health facility. The district covers an area of 3756 km^2 and boarders Muheza on the east, Lushoto on the north, and Handeni on the southwest. Climatically it has lowland plains with rains ranging from 800 to 1000 mm. per annum. The mountainous areas have rains from 1000 to 1200mm per year. The long rains occur from October to December.

The district has 4 divisions, 20 wards and 133 villages. The population projection of the district for the year 2001 based on the 1988 census is 261628. The annual population growth rate was 1.4%. The socioeconomic activities in this district include subsistence agriculture for crops such as maize, rice, cassava and beans. Tea and sisal are grown as cash crops but are mainly owned by foreign companies.

The district has a total of 53 health facilities, which includes 2 hospitals, 4 health centers and 47 dispensaries. Out of these the government facilities are 37 dispensaries, 4 health centres and 1 hospital. The rest are private and non-government facilities. Cost sharing was introduced in the district hospital since the year 1993. Cost sharing at the level of health centres and dispensaries was introduced in February 2002, i.e. 4 months before

this study was undertaken. The utilization rate of hospital out patient department for the year 2001 was 49.4%.

The most common disease conditions in Korogwe district are malaria, acute respiratory infections, diarrhoeas, intestinal worms, pneumonia and eye conditions in that order.

The Demographic and health survey (1996) reported that the literacy rate for Tanga region at household level for females was 39.6% and males 27.6% (TDHS, 1996)

3.2 Study design

The design was a cross sectional study.

The study was conducted under the auspices of Muhimbili University College of Health Sciences for partial fulfilment of the Master of Public Health course. The study was carried out during the second and the third weeks of June 2002 in the wards that serve as the immediate catchment area for the district hospital of Korogwe. This was based on the assumption that the respondents must have been in a position to use the hospital before they could be assessed. However their choices to use the hospital or not formed part of the reasons why the study was carried out in that area.

3.3 Study population

The study population consisted of adults of 18 years and above comprising of male and female subjects from the community, hospital personnel and clients attending the district hospital.

3.4 Sample size determination

The sample size was determined by use of the following formula:

$n = z^2 pq / d^2$

Where n = desired sample size

z = standard normal deviate set at 1.96, and corresponding to 95% confidence Interval.

P = proportion in the target population estimated to have satisfaction with quality of health services which in this study is taken to be 50%.

$q = 100 - p$

d = degree of accuracy desired, and set at 7%

Using the above formula; n = 196. Using a design effect of 2 as is technically applicable to multistage/ cluster sampling; the sample size of 196 was multiplied by 2 to bring it to 392. With allowance of 5% to cater for problems in the availability of some of the respondents the sample size became 412.

The district hospital has approximately 125 employees in its various sections. At the time of the study 80 staff were studied as previously proposed. The staff for study was obtained from the outpatient department, the theatre, all the hospital wards pharmacy, laboratory, and maternal and child health clinic.

Forty exit interviews were done involving clients and patients as they were leaving the last point of service to go home.

3.5 Sampling procedure

The wards that are in the immediate catchment area of the hospital were listed. Four wards were identified as forming the immediate catchments of the district hospital. These were Magunga Msambiazi, Korogwe, Kwamndolwa and Mgombezi. A simple random sampling of the wards that form the immediate catchment of the hospital was done using lottery. Through this sampling three wards were obtained namely Magunga-Msambiazi, Korogwe and Kwamndolwa. Three villages one from each ward were then selected randomly. Eleven hamlets were finally randomly selected from the three villages. These hamlets provided the sample size of 412 people on which part of the study was based. All the houses in the hamlets with adults capable of participating in the study were enumerated and randomly picked by balloting.

The number of hospital personnel who were taken into the study was 80. This was the health personnel available in the hospital at the time of doing the study. While intending to include all the hospital personnel in the study, this was not possible because 20 were

on leave, 10 were off duty following a night duty, 5 on off duty emergency permission, 5 on seminar, while 5 were sick. The cadres of staff included in the study were 11 clinical officers, 7 nursing officers, 21 nurse midwives, 3 laboratory assistants, 1 medical recorder, 1 registry assistant, and 36 medical attendants.

Selection of study sample

Catchment wards	**Selected wards**	**Number of villages**	**Selected villages**	**Number of selected hamlets**	**Number of people intervie-wed.**
Magunga	Magunga	3	Semangube	4	160
Korogwe	Korogwe	6	Manundu	4	160
Kwamndolwa	Kwamndolwa	4	Kwameta	3	92
Mgombezi	–	–	–	–	–
Total	3	13	3	11	412

Forty (40) clients and patients attending the hospital were recruited to the study. No formal sampling was attempted but patients were interviewed after they had gone

through the processes of getting service and when they were ready to exit from the service.

Three focus groups were recruited. Two groups were recruited from the community and one group from the hospital personnel. The common criterion for all the members of the groups was that they be adults of eighteen years or above. Half of each group from the community were members of the village government. The rest were made to represent those from the poor family, well to do family and frequent attendees to hospital. These two groups were selected, informed and assembled through the efforts and help of the village leaders and especially the chairpersons and secretaries of the village governments using the criteria as stipulated above. The hospital focus group consisted of one clinical officer, two nurses, laboratory assistant in charge, one person from pharmacy and one involved in cost sharing.

3.6 Data collection

Instrument: Three sets of questionnaires were used for collecting data. These were questionnaires for community, hospital health personnel and clients/patients. The questions were both open ended as well as closed ended. The Swahili version questionnaires were used in the field for collecting data.

The village leaders made arrangements for the focus group discussions to take place. They contacted the relevant participants, arranged for a meeting place and date for the meeting. A suitable place was initially hard to come by but finally a place was secured.

The principal investigator was the moderator while the recorder was selected from among the health staff. Information from members of the group was recorded in writing and also tape recorded. Each of the discussions took an average of one and a half hours to complete.

3.7 Manpower

Interviewers were recruited from the health staff of Korogwe district health office and the Public Health Nursing Training School- Korogwe. They were mainly public health nurses and health officers. They were all trained on interviewing skills as well as how to communicate with community. The questionnaire was used as a basic tool for training purposes. This enabled the interviewers to be conversant with the questions and the format. A short practice of interviewing among themselves was undertaken to aid the understanding of the interviewing process, knowledge and skills. This was also a useful procedure because it was possible to estimate the time taken to interview one person and be able to extrapolate the amount of time that was to be taken for the whole exercise. The principal investigator met individually with the in charge of the wards, the out patient department, the theatre, and the maternal and child health clinic and explained to them the purpose of the whole exercise and how it was to be done.

3.8 Data collection process

Information about the study was disseminated to the chairpersons of the selected hamlets by using the village leadership. The chairpersons were informed to be available at the

appointed time as well as to inform the people of the households under their juris - diction. At the appointed day and time, the interviewers met with the hamlet chairpersons who went with them to the respective households. The plan of the visits was done according to how the chairpersons had arranged. Respondents who were found to be absent during a household visit were revisited the next day to minimize selection bias. Each interviewer had to ensure that he/she explained the purpose of the visit and interview, allayed any anxiety and encouraged free conversation between interviewer and interviewee. Privacy was ensured during the interview by keeping a distance from other people or securing an isolated area in the house to use for interviewing.

Every evening at the end of day's work, the forms were checked in terms of the correctness of filling. This was done in collaboration with the interviewer. The principal investigator had to satisfy himself that the forms had been properly filled. This was also the opportunity to discuss the problems experienced during the whole exercise for the day including the missed respondents, who were then rescheduled to be visited the next day to get them.

Patients/clients who were attending the out patient department were interviewed using exit interview questionnaires. Those who had finished getting services and were now ready to go home were earmarked for interviewing. They were approached and the whole issue and purpose explained to them. If they consented and were not too seriously sick to communicate, then they were interviewed. The interview took place in a room given to the interviewers for that purpose. The interview started by explaining to the

patient the basis, the purpose, the benefits of such interviews, the use to which the information was going to be put and the confidentiality of the information. Thereafter the main part of the information was obtained and filled in the form.

Information from health workers was obtained through use of questionnaires after a thorough explanation on the background of the research. In charges of hospital wards were contacted and explained on how to fill the questionnaire forms. Each of these in charge was given enough forms for the staff under his/ her department. For some of the staff, interviews were done to them using their in charges in the wards or sections and also by the principal investigator. All in all the principal Investigator was wholly responsible to guide and supervise filling of the forms and make sure all of them were in good order. Using the relevant questionnaires each of the subjects were asked to provide background sociodemographic characteristics including age, sex, marital status, education and occupation. Clients were asked about perceived quality of service, waiting time, information about diagnosis, treatment plan, prescribed drugs and availability of the prescribed drugs. Community members were asked whether they were satisfied with quality, user fees, and availability of drugs and staff communication with clients.

3.9 Data management

Completed interview schedules were sorted out. Codes were assigned to open ended questions. Data entry, cleaning and validation was done with help of computer operator. Data analysis was done using computer and in particular the Epi- Info version 6 program

(Dean et al., 1994). The dependent variables that were analyzed included accessibility (distance and time), consultation time, and quality of care (prescribed drugs, percentage of patients who were refused treatment). The social demographic variables that were included are sex, age, and occupation. On focus group discussions the author and recorder went through the notes taken during the sessions. Report of the discussions was prepared reflecting the opinions expressed by session participants. The key statements and attitudes expressed for each theme discussed was listed. Opinions expressed by each focus group were compared.

3.10 Ethical issues

Ethical clearance was dealt with through MUCHS, Ministry of Health, Regional Administrative Secretary of Tanga, District Executive Director of Korogwe District Council, ward and village leaders. Letters were written by the institute of Public Health to the District Executive Director of Korogwe District Council to inform him of the study that was going to be done in his area and that he was requested to give consent and cooperation during the implementation. The ward and village leadership were in turn informed and communicated to the interviewees.

In addition informed consent was sought from individual interviewees while the right to decline interview was explained and emphasized as a right of any respondent.

In order to prevent adverse and negative reactions during the data collection, and subsequent conflicts between the current standards of services offered and what appears to be ideal from what was been discussed a short concept and explanation of services

and responsibilities for each party was given. This was done during the introduction in focus group discussions and before starting the interviews.

3.11 Perceived constraints / limitations of the study

The study coincided with the time that many people were still in the fields. They were either scaring away birds and other animals or planting crops such as beans. Prior inquiry before the beginning of the study indicated that there would be very few adults at home during the whole daylong. It was anticipated that they would not be easily available until very late in the evening. The problem was solved through giving prior information to hamlet chairpersons and in turn to the heads of the households that would be involved in the activity. Even then a few were not available and had to be followed up in the second day or occasionally in the fields. Twenty-five community members (6%) were followed up during the second day of whom all were found. The focus group discussions posed problems in assembling the members. For both community focus groups they had to be postponed once before they were successful during the second attempt in assembling them. There was much pressure for everyone who participated in the study wanting to be paid despite the limited finances. To solve this problem I had to use the hamlet chairpersons for a short period only but at the same time using interviewers who were conversant with the study area and would know how to trace those people who might have been missed during the house-to-house survey.

Interviewer Bias

In this study the interviewers were district health office staff and public health nurse students. The use of health staff as research assistants in the field of health and in their areas of responsibility may on the one hand confer an advantage in that they are conversant with the area, the people and may even be conversant with research methodology skills. However this can be a potential source of bias especially if they have to work within their own areas of responsibility.

Recall bias

Respondents were expected to remember issues that had occurred from less than a year to nine years, which describes the period from 1993 to 2002 for which user fees has been in existence. This is likely to cause recall bias, as some may not be able to remember issues occurring within all this long period.

CHAPTER FOUR

4.0 RESULTS

Table 1: Socio-demographic characteristics of the study population in Korogwe district

Characteristics	Community n=412		Patients n=40		Health personnel n=80	
	No	%	No	%	No	%
Sex						
Male	253	61.4	13	32.5	19	23.8
Female	159	38.6	27	67.5	61	76.2
Age (years)						
< 20	1	0.2	4	10.0	0	0.0
20-29	60	14.6	9	22.5	4	5.0
30-39	116	28.2	11	27.5	35	43.8
≥40	235	57.0	16	40.0	41	51.2
Education						
None	50	12.1	4	10.0	0	0.0
Up to std 7	278	67.5	29	72.5	58	72.5
Secondary	57	13.8	6	15.0	13	16.2
Other	27	6.6	1	2.5	9	11.2
Occupation						
Civil servants	23	5.6	3	7.5	80	100.0
Private and parastatal	75	18.2	4	10.0	-	-
Self employed	274	66.5	4	10.0	-	-
Peasant	37	9.0	17	42.5	-	-
Other	3	0.7	12	30.0	-	-

Of the 532 people interviewed, 412 were community members, 40 were patients attending treatment at the district hospital, while 80 were health personnel. Males were twice as many among community members than patients, 61.4% versus 32.5% respectively while among health workers they were approximately a quarter (23.8%). The majority of the subjects had primary education. Two thirds of the community subjects were self-employed and forty percent of the patients were peasants (Table 1).

Table 2: Community satisfaction with quality of health care services at Korogwe district hospital

Status	Number	Percentage
Not satisfied	146	35.4
Satisfied	266	64.6
Total	**412**	**100.0**

Table 2 presents community satisfaction with quality of health care services at Korogwe hospital.

Community satisfaction with health services was assessed according to whether clients mentioned they were satisfied either with the quality of health services, staff behavior and attitude, drug availability, promptness of services or the state of the hospital buildings. All those who responded affirmatively by reporting that the situation had improved in either one of these five aspects were categorized as a proxy of satisfaction.

Of the 412 of the community members who were asked whether they were satisfied with the services or not after introduction of user fees, approximately two thirds of the subjects responded that they were satisfied compared to 35% who were dissatisfied with the quality of health services (Table 2). The differences between the two 29.2% (95%CI = 28.1%, 30.2% df=1; p=0.0001) was statistically significant. When the above respondents were asked if they would be ready to pay more money in terms of user fees in order to further improve the health services only 30% of them were ready to do so.

Table 3: Perception of drug availability following introduction of user fees in Korogwe district

Prescribed drugs	Community (n=402)	Patients (n= 40)	Health personnel (n=80)
Available	44.3%	90.0%	28.2%
Not available	13.4%	10.0%	71.8%
Rarely available	42.3%	0.0%	0.0%

χ^2 =54.9, df = 2, P-value = 0.00000.

Community members and patients were asked whether introduction of user fees has made drugs more readily available or not. Around 44% of the community subjects compared with 90% of the patients reported that drugs were readily available while approximately 42.3% of the community members mentioned that drugs were rarely

available (Table 3). In one of the community focus group discussions they reported that:

"Some drugs are available and others are not available. While 400/= may be enough to purchase drugs in the hospital, the same amount of drugs may cost 2000/= in private shops. A patient may be admitted to the ward and stay there overnight without the necessary drugs. This state of affairs may make a difference between life and death" (FGD- discussant- Semangube village)

Table 4: The type of information provided to patients by health workers in Korogwe district

Type of Information	Provided		Not provided		Total	
	No	%	No	%	No	%
Explanation about problem	28	70.0	12	30.0	40	100.0
Told to come back if not better	26	65.0	14	35.0	40	100.0

Seventy percent (70%) of the patients received an explanation about the nature of their problem while 30% did not. Similarly 65% of the patients were also told when to come back if they do not get well (Table 4). Despite the good communication shown by the health personnel, one focus group discussion in one of the villages had a contrary opinion, as reported below:-

"The workers, especially females use very bad language towards their patients. You call a worker to help you out for a problem and he/she tells you. Don't trouble me. I did not call you around."(FGD-Semangube village).

Table 5: Reasons for choice of a certain type of health facility in selected communities in Korogwe district

	Reasons for attending a health facility					
Type of facility attended	Short Distance No (%)	Affordable No (%)	Good Service No (%)	DrugsAvailable No (%)	Other Reason No (%)	Total No (%)
Government dispensary	37(63.7)	4(6.9)	8(18.3)	6 (10.0)	3(5.2)	58(14.0)
District hospital	190(55.7)	58(17.0)	55(16.1)	28(8.2)	10(2.9)	41(82.8)
Others*	7 (53.8)	1(7.7)	3(23.1)	1(7.7)	1(7.7)	13(3.2)
Total	234 (56.8)	63(15.3)	66(16.0)	35(8.5)	14(3.4)	412(100)

*Others include private, traditional healers etc

Members of the community were asked to give reasons why they chose to attend a given type of health facility. The commonest reason was short distance (56.8%) followed by availability of good service (16%) and the question of affordability (15.3%) (Table 5). Short distance appeared to be the commonest reason among the different types of health facilities including both private and public. The majority of the people mentioned the district hospital as the place they attend most often when they have a health problem followed by a government dispensary, 83% and 14% respectively. However short distance as the commonest reason for choice of a hospital and a dispensary was similar 55.7% and 63.7% respectively. Only 16.1% and 13.8% of those who attended

government dispensary and the district hospital respectively said that they chose these two places because the services were good.

Table 6: Availability of prescribed drugs to patients

Number of drugs prescribed	Availability				Total	
	Yes	%	No	%	No	%
1-2	21	95.5	1	4.5	22	56.4
3-4	14	82.4	3	17.6	17	43.6
Total	35	89.7	4	10.3	39*	100.0

*One subject had missing information.

The number and availability of prescribed drugs to patients in Korogwe district is presented in Table 6. Thirty-nine patients visiting the district hospital for health care were asked what is the number of drugs that were prescribed to them and how many they did not get? The mean number of drugs per prescription form was 2.5 (standard deviation ± 0.6). Fifty six percent (56.4%) of the patients were prescribed one to two drugs and the majority (95.5%) got all of them. About 43.6% of the patients were prescribed three to four drugs per form, but 82.4% got them. Overall, 10.3% did not get their drugs. The information is also shared by a focus group discussion with the community. One of the discussants said that:-

"People are contributing towards the running of the hospital, but only some of the drugs are available. It would be better if all the drugs were to be made available

rather than one having to go and buy them from individual drug shops outside the hospital."(FGD- Manundu village).

Some of the health personnel also reported that some of the drugs were not readily available as narrated by one of the health workers in a focus group.

"Some other drugs are not available, and therefore they have to be purchased outside the hospital. If the drugs cannot be obtained from the shops, the clinicians have to try and change their medication to enable the patient to get them. Currently there are not any 5% dextrose solution or diclofenac tablets."

Table 7: Perception of quality of care by community, patients and health workers in Korogwe district

Perception of quality of care	Patients (n=40)		Community (n=402)		Health workers (n=80)	
	No	%	No	%	No	%
Not changed	0	0.0	130	32.3	5	6.3
Quality has improved	36	90.0	174	43.3	74	92.5
Quality has deteriorated	4	10.0	98	24.4	1	1.2

$\chi^2 = 88.7$, df = 4, p = 0. 000000

About 43% of the community members and 90% of the patients perceived that quality of care has improved following the introduction of user fees in Korogwe district (Table 7). On the contrary, approximately a quarter of the community (24.4%) perceived that the services have deteriorated while one third were of the opinion that the quality of care has not changed. It is interesting to note that the majority of health workers (92.5%) reported that quality of care has improved (Table 7). About one quarter (24.4%) of the members of the community said the quality of care had deteriorated, while about a third (32.3%) said the quality had not changed. The difference between the two groups, 7.9% (95%CI =4.7%, 11.1%) was statistically significant.

Table 8: Perception of community on health personnel behavior in Korogwe district

Perception on health personnel behavior	Community (n=403*)		Patients (n=40)	
	No	%	No	%
Has deteriorated	116	28.8	5	2.0
Not changed	128	31.8	14	35.0
Has become better	159	39.4	24	60.0

$\chi^2 = 11.57$, df = 2, P-value = 0.003

*Nine subjects had missing information.

Twenty-nine (29%) of the members of the community compared to 5% of the patients perceived that the behavior of health workers has deteriorated. Such deterioration in behavior of health personnel is also supported by a focus group discussion from the community when they reported that: -

"The workers, and especially the female ones, have very bad behavior towards their patients. You call a worker to help you with a problem and she tells you- don't trouble me. I did not call you around (FGD-Semangube village)

*A*pproximately 40% of community members compared with 60% of the patients perceived that health workers' behavior has become better following the introduction of user fees (Table 8), while one third in each group thought health workers' behavior has not changed.

Table 9: Perception of community on the state of buildings and user fees: -

Perception	Respondents	Percentage
No change /Not rehabilitated	83	20.7
Very little change	232	57.7
Improved a lot	87	21.6
Total	402 *	100.0

*10 subjects did not respond to the above question because they had not attended hospital treatment

The majority of respondents 232 (57.7%) perceived that the state of buildings in terms of rehabilitation, surroundings and cleanliness have improved very little and one fifth reported that the buildings have improved (Table 9). The perceptions seem to tally with sentiments of the focus group discussions done in the two villages of the hospital catchment's area. They expressed the following: -

"The hospital is not often clean. Most often there is water on the corridor and it appears there is no intention to clean it out. Cooking of food takes place anywhere. At night there are patients who urinate on the corridor as it appears like they cannot go to the latrine at that time" (FGD -Semangube village)

Similar information was expressed through another focus group discussion that had this to say: -

"The hospital was built a long time ago in 1952. It has not been repaired for a long time. In addition, it is dirty, unattractive and the latrines are not functioning" (FGD- Manundu village).

Table10: Equity in treatment of similar disease conditions at Korogwe hospital

Status	Frequency	Percentage
Yes (differently treated)	4	10.3
No	35	89.7
Total	39	100.0

Thirty nine (39) patients were asked on whether they had noticed any differences in the treatment they received compared to people with a similar disease condition. The majority of patients (89.7%) reported that they had been given equal treatment to other patients with a similar disease condition(Table 10). However 10.3% felt that they had received unequal treatment. The issue of dissimilar treatment for the same disease condition was also commented upon by one of the focus group discussions that ran as follows: -

"You can queue for drugs at the dispensing window just to be told that the drugs that have been prescribed to you are not available, yet there are other people who get similar drugs that the other person has missed. We cannot understand this double standard" (FGD -Semangube village).

Similarly a FGD with some of the health workers, while dwelling on the laboratory had this to say: -

"Investigations are very late and you may be required to collect the results the next day. Meanwhile there are no drugs prescribed while waiting for the results. It is very discouraging. The arrangements for doing the investigations are never very fair. Some patients get their results in a very short time, while others have to wait until the next day" (FGD-Semangube village).

Table 11: Postponement of seeking care due to inability to pay user fees at Korogwe

Postponement	Respondents	Percentage
None	334	81.7
Rare	54	13.2
Frequently	21	5.1
Total	409*	100

* 3 subjects had missing information.

Community members were asked if they had ever postponed seeking care due to inability to pay user fees. Three hundred and thirty four people (81.7%) responded that they have not had such an experience while 54 (13.2%) considered the event to be rare (Table 11). However, 21(5.1%) have had frequent postponements due to inability to pay for the service, which constitutes a barrier to equity in form of financial accessibility. Three people declined for an answer, as they had not gone to the hospital recently. A further explanation was given by one of the focus group discussions in which one of the participants reported that:

"Services to children are readily available but at times one is advised to go and buy drugs outside the hospital in private shops. We have had to buy giving sets, syringes and gloves. Because of problems of this nature you may find it is more desirable to stay at home." (FGD-Semangube village)

Table 13: Waiving of user fees for people who failed to pay for their health services.

Waiver Status	Exemption					
	Patients		Community		Total	
	No	%	No	%	No	%
Yes (exempted)	3	33.3	4	12.9	7	17.5
No (Not exempted)	6	66.7	27	87.1	33	82.5
Total	9	100.0	31	100.0	40	100.0

Forty members of the community and patients were interviewed to find out if they had ever received a waiver of user fees after they had failed to pay for their health services and over all 17.5% responded affirmatively (Table 13). Over eighty percent mentioned that they have never received any waiver of user fees. However, patients attended recently were 2.6 times more likely to be granted a waiver of user fees compared to the community members. It appears the demand for a better mechanism for granting a waiver of user fees especially for those who cannot afford to pay all the charges is required as supported by a focus group discussion from the surrounding villages.

" There is no consideration of the financial ability of someone. You may just have slightly less than the minimum amount of money for payment of service, but no body will give you the service." (FGD- Semangube Village).

Another discussant had the following to say about exemption and user fees:

"If you have no money you are just destined to die. If you have no money and you are just occupying the hospital bed for nothing you won't get any service." (FGD - Semangube village)

Table 14: Knowledge of the community about user charges taking place in the district hospital

Status	No of Respondents	Percentage
Know what is taking place	185	44.9
Don't know	227	55.1
Total	412	100.0

Community members were asked whether they knew about the changes regarding user charges that are taking place at the district hospital. Over half (55.1%) answered that they did not know anything about the changes while 44.9% claimed that they knew (Table 14). The community focus group discussions in both villages had the following to say: -

"We are not in a position to know about the changes and we do not have any communication about these issues of changes in user fees." (FGD – Semangube village).

Table 15: Knowledge of community and outpatients on who decides on exemption of user fees at Korogwe district hospital.

Decision maker for exemption	Community n= 412		Outpatients n=40	
	No	%	No	%
Hamlet chairperson	189	45.9	8	20.0
Doctor	143	34.7	25	62.5
Social worker	43	10.4	2	5.0
Nurse	10	2.4	5	12.5
Hospital clerk	7	1.7	0	0.0
Others	20	4.9	0	0.0

Community members and outpatients were asked to give information on the most appropriate person to give exemptions according to their knowledge. The community was more likely to mention the hamlet chairperson (45.9%) as the most appropriate person to grant exemptions compared with 20% for outpatients (Table 15). On the other hand the doctor was mentioned by 62.5% of the outpatients as the most suitable person for granting exemptions compared to the community (34.7%). Among the community and outpatients the hamlet chairperson and the doctor featured highly as the most suitable person to give exemption.

Table 16: Knowledge of health personnel on types of conditions that are eligible for exemption from user fees at Korogwe hospital.

Category for exemption	Answered (n=80)
Tuberculosis	62.5%
Diabetes mellitus	55.0%
Immunizations	70.0%
Under fives	82.5%

The category for exemption that is best known to the health workers is the under five children (82.5%), followed by of immunization, tuberculosis and diabetes mellitus. In the community focus group discussions when they were asked about whether they knew that people can be exempted and the conditions that are eligible for exemption of user fees they responded affirmatively as below: -

"Yes. We know that people can be exempted but we do not know the details about it. The people who can be exempted are those with chronic diseases, children below five years and pregnant mothers." (FGD - Manundu village)

CHAPTER FIVE

5.0 DISCUSSION

Patient satisfaction is the final common outcome of quality. It is used in many countries of Asia, Africa and Latin America to assess the extent to which the services have complied with the standards in terms of the expectations of the clients. If the patients are satisfied it is often the case that they also comply with treatment guidelines, counseling and advices. In this study only 9% of the community respondents were peasants. This is not representative of a typical rural population where abject poverty often prevails.

User fees were started in 1993. Over this period of time several policy changes have taken place. Health staffs as well as the members of the community have not been the same. Even if they have continued to stay in the same area for all this time they are likely to forget some of the issues pertaining to their health care. This might have contributed to the picture that is depicted currently in this study.

Satisfaction with quality of health services

The study has shown that a moderate level of satisfaction (65%) has been reached, according to community members interviewed. The issues that were considered included the availability of drugs, the promptness of service, the behaviour of health personnel and quality of the service. Msamanga et al, (1996) did a study on satisfaction with quality. This was based on assessment in terms of prescribed drugs, waiting time, client provider interaction and information sharing. He found out that 25% of the patients got

their drugs, 70% reported short waiting time, 97% reported adequate consultation time while 91% reported adequate explanation. The present study was limited to perceptions of clients and patients on the quality of care and did not take into consideration some of the objectively measured standards of service. Respondents tend to be very conversant on conduct of health personnel practices as well as the health care delivery. However they tend to be less positive on items relating to resources, physical and financial accessibility some of which may be in the domain of management and administration.

Availability of drugs for patients.

Availability of drugs is usually perceived as a measure of quality in many communities, although this perception may be different in some communities (Msamanga et al, 1996). Where the community is convinced that availability of drugs is the most important factor in quality, patients will get satisfied if all the drugs are available as soon as prescribed. The study has shown that drugs are available to a level that can be considered to be moderate since 44% of community members and 90% for patients got their prescribed drugs (Table 3). A study done in Zambia reported that people criticized cost sharing because it doesn't improve the quality of services in terms of drug availability (Van der Geest et al, 2000). It is not always the case however that low availability of drugs is associated with poor service quality. This may indicate high demand and intensive utilization of a health facility. The issue of whether the shortage of drugs was due to high demand was not addressed in this study. One outcome of quality health service is the ability to restore function, enhance survival and create satisfaction to the patient and

client. In the event that drugs are not available the quality of care becomes questionable to the patient. Another factor associated with availability of drugs is the ability for a health facility to purchase them when required. Due to the policy of cost sharing and user fees patients have to purchase their drugs. In case they are unable to purchase them then they are denied to have them.

From the public health perspective it is desirable that people get drugs from credible sources that are effective and cheap. However the intermittent and interrupted supply of drugs to a district hospital cannot enhance this situation. Maier and Urassa, (1997) in their study of quality of health services in the district hospitals of Tanga region reported that drug availability has been a problem during that time and even before the survey. In particular they observed that a quarter (26.3%) of the patients could not get their drugs because they were out of stock. In the present study 10.3% didn't get the drugs prescribed to them (Table 6). A similar finding was also observed during another countrywide study in which 28% of patients, 36% of households and 48% of hospital management said that drugs were not available (MOH, 1999).

The study design limits itself to responses from the members of the community, patients and health personnel. Although they have their part to play in terms of their knowledge and responses in drug availability, the realistic physical counting, ordering and out of stock drugs were not taken into consideration.

Health provider communication with patients and clients

The quality of health service takes into account the interaction between provider and receiver of service. It is essentially the actual giving or delivery of service. The process part of quality has a technical component and the component of interpersonal communication. The receiver of the health service expects smooth, welcoming, logical and sympathetic interaction that is both informative and educative about the problems the client has. The study has shown that 70% of the patients had good communication with their attending health personnel (Table 4). Good communication between patients and health personnel is essential for adequate compliance and advice for patients and improves quality of health service.

Maier and Urassa,, (1997) in a study in Tanga region found out that poor staff- patient interactions was a problem. In addition, this was also associated with low staff morale. They observed patients and other users complaining of unfriendly attitudes and harsh language on the part of nurses, while at the same time leaving patients to be looked after entirely by relatives. The reasons mentioned in the study, as being the cause e.g. that of low salaries are probably still functioning but they were not addressed in this study. In another study in two regions of Tanzania (Msamanga et al, 1996) on equity of access to public, private not for profit and private for profit health facilities they found out that patients were satisfied because they received information on how their problems were

going to be managed, received adequate instructions on their treatment and potential adverse effects of the medications.

The study design that was adopted in the study is not exhaustive. It does not look into the technical part of the interaction e.g. the appropriateness of the technique for eliciting the information on the problems of the patient and the correctness of the information itself. From these limitations it is not possible to conclude on the aspects that were not investigated

Choice of facility for health care

The client has the right to make a choice she/ he desires when the need arises for him to seek health care. The need is however not absolute for it appears to depend on several factors. Among them are availability of drugs, human resource availability, number of medical staff, availability of basic adult and child health services, availability of water and power. Other factors that are postulated to influence such choice also include gender, age, education, distance and ability to pay (Lavy and Germain, 1995).

In this study members of the community were asked to mention the type of facility they would choose to attend if they had a health problem and the reasons for such a choice. The majority of the people (82.8%) mentioned the district hospital, followed by government dispensary (14%) (Table 5). The reasons given for the choice included short distance to the district hospital (56.8%) followed by good service (16%) and affordability (15%). Only 16.1% and 18.3% of those who chose the district hospital and

the government dispensary respectively did so because they thought it was offering good service. As the study population was deliberately chosen to be within the catchment area of the hospital so as to examine the issues of quality then it is difficult to say what would happen to the choice if the conditions were varied. Though it might appear that distance was the major reason for visiting both the district hospital and the government dispensary, the other reasons that people gave out e.g. affordability, providing good service and easy access and availability of drugs, are all related to quality of service. The results are not substantially different from those of Msamanga et al, (1996) who reported that the commonest reason for choice of a health facility were short distance (59%). However, availability of affordable services (46.4%) seems to be substantially different from the findings of this study. The main reason for the difference could be due to clients in the former study having a culture of paying for their services for a longer period in comparison to those who have most of the time been attending government health facilities. Their findings also show that short distance was the commonest reason, followed by drug availability (58%) but this was in respect to private health facilities. Short waiting time and polite workers all featured in his study but this was mainly with the private and non-profit facilities. As it appears from the reasons given by the patients, it seems that they have limited choices for making them visit particular facilities or areas of service. For patients to have as wide a choice as possible the services must be improved in the aspects that have shortcomings including e.g. poor drug availability and good service. Despite the fact that 90% of the patients in this study received their drugs, the community whose responses cover a longer period of observation did not perceive

that drugs were regularly available and hence the former could be just a temporary phenomenon.

Some of the information related to choice of a health care facility was not included. In the study design the respondents were not given the opportunity to give their opinion on whether they would still go to the district hospital if they had other alternatives. The theme on this alternative could also have been included in the focus group discussions but this was not done. The design of the study did not try to collect information on the reasons for coming to the district hospital for the people who are coming from far. This would have required having comparison group of those who come from far compared to those who come from the vicinity of the district hospital.

Perceived quality of care by community, patients and health workers

To the client, good quality of care may mean something different from that of a health planner and a health professional. Patients value the consequences of care as they affect their own health differently to those of professionals. They may expect too much or too little. Even then these values held by patients may be different from what a professional may judge to be the best for the patient. Hence assessment of care through what the client perceives is a reflection of values of health care in relation to structure, process and outcome quality by patients and the community.

The study assessed community perception of quality of health services in relation to what they knew before and after the start of user fees charges.

Table 7 shows percentages of community members, patients, and health personnel and how they perceived quality of health care services. Members of the community were asked whether quality of care has changed following the introduction of user fees. The study has shown that there is a low perceived quality of care. A countrywide study done in Tanzania for evaluating cost sharing reported that the majority of the stakeholders including 73% of patients, 81% of hospital management teams and 74% of general hospital personnel perceived that the quality of care had improved following the introduction of use fees. On the other hand 47% of the households perceived that quality of services had deteriorated (MOH, 1999). In a study by Russel and Gilson, (1997) in 10 out of 26 countries (38%), respondents did not perceive that user fees revenue had had any positive effect on service quality. The negative perception of quality of care as expressed by many of the stakeholders seemed to be based on the lack of respect for patients and possible abusive behavior by health staff. Such behaviors have negative impact on perceived quality of care. The assessment of quality in Tanga region (Maier and Urassa, 1997) showed that poor perception quality can arise from long waiting times, lack of physical examination to patients and lack of accessibility to prescribed drugs thereby requiring some of them be bought from outside the hospital or from health workers. This situation is similar to what happened in one of the community focus group discussions in our study that had the following to say: -

"When you are admitted to the ward you are told there are no equipments and materials,- but later you are told to give out 500/= so that they can get materials for you. Where do these materials come from when you give out the money?" (FGD- Semangube village)

The other aspect of care assessed in terms of perceived quality of care was the condition and state of repair of the buildings of the district hospital. Members of the community were asked if they perceived that there had been any change in the condition and state of the buildings of the district hospital. About 20% of the community members said that the buildings had deteriorated as compared to 21.6% of those who said that there was a lot of improvement (Table 9). Information about the condition of the buildings was also expressed through focus group discussion of the community that had this to say:

"The hospital was built a long time ago in 1952. In addition it is dirty, unattractive, and the latrines are not functioning." (FGD- Manundu village).

From the foregoing information one tends to believe that the condition of the hospital buildings has not improved remarkably. The cleanliness, hygiene and appearance of health facilities create a first impression for anyone who visits it. The most obvious way for the public to know that their cost sharing money has been used properly can be visibly seen in the state of buildings. From the study design the information obtained from patients and community members may not represent the best method of arriving at a conclusion about the state and condition of the buildings. Incorporating these elements in the study will permit the direct physical assessment of buildings and their state of

repair. Sometimes the community-based information may be out dated. This happens when members may not have visited the hospital for a long time and so are not kept up-to-date on the status or if there have been any improvements done to the hospital buildings. Cultural barriers can also affect the judgment of what constitutes a hygienic, and a clean building. This has not been taken into account in this study.

Equity in health services

Equity is the principle by which one determines what is just or fair in distribution of care and its benefits among members of the population. Equity is one of the attributes of care. In assessing and ensuring quality, professionals must take into account the preferences and views of the patients (Donabedian, 1990). Equity must entail equal access to available care irrespective of the income, health status, education, age, sex and geographical location.

(a) Differences in the treatment of similar disease conditions.

The study has shown that 10% of the patients were uncomfortable because they thought that they were getting treatment that was different from other individuals with similar disease (Table 10). The 10% of the people, who believed in this, cannot be easily associated with user fees. However in a situation where everyone is supposed to be paying for the services, a few who are not paying may tend to think that they are getting a different treatment compared to people with similar disease condition. In their study, (Msamanga et al, 1996) found out that a higher percentage of people (42%) believed that

they got a different treatment compared to other people with similar disease condition. The lower figure in this study is probably due to a small sample size of the patients who were studied. This problem was also voiced by the village focus group discussion as follows:

" You can be queuing for drugs at the dispensing window just to be told that the drugs that have been prescribed to you are not available, yet there are other people who get similar drugs to those the other person has missed. We cannot understand this double standard." (FGD- Semangube village)

The issue of different treatments for conditions that are similar is a concern in terms of suspicions that the services are not given out equally. The different rates that are obtained in different studies seem to be related to individual and societal values. While it might appear like an ordinary complaint involving favoritism and suspicion of bribing, the implication for this phenomenon is not very clear. An investigation into this may be called for.

(b) Postponement of seeking care due to inability to pay.

The purpose of user fees is to generate revenue in order to improve the quality of the health services. However the introduction of user fees is faced with problems unless the need for equity and exemption is considered. If the poor cannot pay for their services at the expense of improving the quality of health services this will not guarantee equity. This study showed that 5% of the community members who were studied had postponed seeking health care because of lack of affordability (Table 11). This occurred because

they could not pay for their health service at the district hospital. Given the prevailing policy in which every one is supposed to pay for the services one can assume these people are not well informed, or the system of exemption is not functioning in which case the user fees system cannot guarantee equity to the poor and vulnerable.

In a study in Bangladesh (Stanton and Clemens, 1989), about 43% of the study participants had to postpone seeking care due to perceive high cost of services. Affordability in our study has been done through questioning of service users. The respondents though they cited financial reasons for postponement of seeking care, it is difficult to establish whether their answers relate to affordability or to willingness not to pay. In a study by Newbrander and Sacca, (1996) on cost sharing and access for the poor, the authors reported that 68% of the poor waited for more than a week before seeking care compared to 54% for the non poor. The possible explanation that the authors gave included looking for money from friends and selling personal belongings to pay for health care. The same authors reported that of the people who were asked if they knew someone who could not go for care because they could not pay, 69% stated that they knew such a person.

(c) Ability to pay for health care among community members.

Among the patients attending the district hospital, and the community members within the immediate catchment area of the hospital, 22.5% of the patients and 7.8% of the community members were unable to pay for their health care (Table 12) If at one time

the patients and community members may have failed to pay for their health care it implies lack of effectiveness in the strategies to promote access for the poor and vulnerable groups within a user fees system.

A total of 397 community members when they were asked whether they were able to pay for their health service, 92% said they were able to, while 7.8% said they could not pay for the service. In a well functioning exemption system, those who had failed to pay for their user fees would have been required to be waived for their user fees. For this reason the study also further interviewed those who had failed to pay for their user fees to find out if they were waived. In table 13, it shows that 17.5% of these were exempted, while 82.5% were not. This issue was also discussed by the community focus group discussions that had this to say: -

"There is no consideration of financial ability of someone. You may just have a slightly less than the minimum amount of money to pay for a service, but no one will give you the service." (FGD- Semangube village).

Another FGD had the following comment on user fees and exemption:

" If you have no money you are just destined to die. If you have no money and you are just occupying the hospital bed for nothing you wont get any service"(FGD – Semangube village)

In this study it was not possible to know whether the 82.5% who were not exempted actually needed to be exempted. This is so because there are criteria and guidelines for effecting exemption and waivers. However the guidelines may be corrupted and lead to

ineffective exemption and waiver mechanism. According to the World Bank, in the year 1995 fourteen percent of the countries that had exemption in their policy didn't have clear criteria for it. Also about 40% of those countries that had exemptions at local level very often depended on adhoc mechanisms. User fees should not be allowed to violate equity to health care. Newbrander and Sacca, (1996) reported that those health facilities which failed to give waivers at the detriment of the poor did so because of over concern with leakage in the system. In addition they identified lack of staff training as a hindrance to waivers for the poor. While exemptions, waivers and other pricing mechanisms are essential to guarantee equity in health service delivery and access it is exceedingly important that a balance be ensured between cost recovery and affordability.

Knowledge of community and patients on user fees and exemption.

The community is one of the stakeholders in the health sector reform program. For effective collaboration and implementation of the health sector reforms, the stakeholders must have adequate knowledge of what is going on. In our study 412 community stakeholders were interviewed to find out whether they knew what was taking place in the district hospital with regard to user charges (Table 14). The study showed that more than half of the stakeholders (55.1%) didn't know what was taking place with regard to user charges in the district hospital. Knowledge about user fees can avert a lot of problems in conducting services at the district hospital. Compliance with payment of user fees is most likely to happen when the community is aware of and informed about,

Knowledge of health personnel on exemption.

The health personnel were asked on categories of health problems that are subject to exemption. These included tuberculosis, diabetes mellitus, Immunizations and children below five years. (Table 16). The health staffs were capable of mentioning all the categories. However the best known condition by many of the health workers was exemption for under fives (82.5%) and the least known was diabetes mellitus (55%). The knowledge of Health staffs on the issues of cost sharing and exemption facilitates efficiency and cooperation among staff members. The peoples' understanding of the user fees and exemption depends very much on the knowledge of the health staff because they are close to them. In this context the cost sharing system becomes easy to implement.

The limitation of this is that it didn't include adequate number of questions to elicit knowledge. On top of that the questionnaire depended on a spontaneous response that limits the amount of information from a respondent when compared to questioning by probing.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSION

6.1.1 There was a moderate improvement in quality of care especially in process quality as assessed by level of interaction between providers and clients. This was based on whether the provider was able to communicate the problems to the clients as well as advising him or her to come back when the need aroused.

6.1.2 The state of the hospital buildings in terms of repair and cleanliness were perceived to have improved very little.

6.1.3 There was low knowledge of community about user fees based on what they knew was taking place in the district hospital concerning user fees charges and policy changes.

6.1.4 About 23% of the patients and 8% of the community could not pay for their user fees and of these only 33% and 13% respectively were granted exemptions and waivers.

6.2 RECOMMENDATIONS

6.2.1 It is recommended that efforts be made to improve the structural and process quality of care so that the community can realize the benefits of the user fees they pay at the district hospital.

6.2.2 Health workers should be trained to improve their behavior which pertains to the

interpersonal interactions between users and health care structure. The determinants of this behavior may have to be investigated separately to aid such training.

6.2.3 To make drugs more available so as to synchronize with the increasing patient demand and accountability of user fees.

6.2.4 Health and other allied staff of district hospital should be made well informed on user fees and exemption, and this should be done frequently and regularly in order to enlist their assistance in the user fees scheme as these are the people with the most frequent contacts with patients and other members of the community.

6.2.5 The community should be made aware of new policy changes at local and national level including use fees so as to improve their implementation.

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