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Global Fund Districts:

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<tr>
<th>Morogoro Urban: HACOCA</th>
<th>Jali Watoto Districts:</th>
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<td>Daudi Tano</td>
<td>Iramba: World Vision</td>
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<td>Veronica John</td>
<td>Emmanuel Edward</td>
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<td>Mpoki Jongo</td>
<td>Samson Mang’amba</td>
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<td>Lilian Mgalla</td>
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<th>Morogoro Rural: Faraja Trust Fund</th>
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<td>Norbert Massay</td>
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<td>Hilda Msemo</td>
<td>Venance Gomegwa</td>
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<td>John Mbelle</td>
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<td>John Pinini</td>
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<td>Dickson Mang’ombe</td>
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## Acronyms

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>CHF</td>
<td>Community Health Fund</td>
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<td>CBHI</td>
<td>Community-Based Health Insurance</td>
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<td>CSO</td>
<td>Civil Service Organization</td>
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<td>GHS</td>
<td>Ghana Health Service</td>
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<td>GWU</td>
<td>The George Washington University</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MVC</td>
<td>Most Vulnerable Children</td>
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<td>MVCC</td>
<td>Most Vulnerable Children Committee</td>
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<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<td>OOC</td>
<td>Out-of-Pocket Payments</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PETS</td>
<td>Public Expenditure Tracking Systems</td>
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<tr>
<td>PHI</td>
<td>Private Health Insurance</td>
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<td>SHI</td>
<td>Social Health Insurance</td>
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<td>TIIKA</td>
<td>Tiba Kwa Kadi</td>
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<tr>
<td>TSH</td>
<td>Tanzanian Shillings</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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I. EXECUTIVE SUMMARY

In 1996, Tanzania’s Ministry of Health (MOH) introduced the Community Health Fund (CHF) in an effort to increase access to health care for the country’s poor and vulnerable groups. Within this national framework, Pact Tanzania has been providing health care for Most Vulnerable Children (MVC) since 2005 through the Jali Watoto (Care for Children) and Global Fund OVC programs.

In February 2009, Pact Tanzania invited a group of Master’s candidates from The George Washington University (GWU) to Tanzania for a two-week study/evaluation of project activities in an effort to better understand the implementation of the CHF card program component and the role of health cards in improving access to health care for most vulnerable children. The general purpose of the evaluation was two-fold: first, to provide Pact Tanzania with an unbiased and researched perspective on project implementation; and second, to offer GWU students studying international development the opportunity to meet a graduation requirement and apply their classroom learning in the field. This report presents the group’s research, findings, and recommendations.

The evaluation methodology developed for this research consists of two parts. First, a survey was developed and distributed to Pact’s partner organizations to gather information on specific aspects of project implementation in the Jali Watoto and Global Fund OVC programs, as well as on district-specific aspects of CHF. Second, interviews and focus groups were conducted in five districts with key stakeholder groups, including government officials, health providers, village volunteers, Most Vulnerable Children Committees (MVCC), caretakers, and children. Limitations of the evaluation are attributed mainly to time and financial constraints, and include occasionally poor quality of translation, participant selection bias, and limited coverage.

Implementation of the CHF program, both by the government and by partner organizations, varies widely from district to district, yet lessons can be drawn from the aggregate information collected. The findings are analyzed within four thematic areas: usage, benefits, barriers, and sustainability.

FINDINGS

Usage

One of the primary objectives of the evaluation study is to gauge the extent to which program beneficiaries are actually using their CHF cards. The study concludes that the majority of Pact’s program beneficiaries involved in the study (73.7% of children and 65.5% of parents/caretakers) have used their card at least one time since receiving it. The most common reason cited for not using the card was that the child or household members did not get sick during the card coverage period, and thus, did not perceive a need for health care services.

Misunderstandings appeared to limit card usage, as many beneficiaries were confused about what services they could access and how many people could use the card. The study finds possible breakdown of information flow from MVCCs and village volunteers, who struggle to make regular visits to beneficiaries and sometimes are not equipped with accurate information themselves.
Benefits

Benefits of the card, which are widely recognized by beneficiaries and other stakeholders, include free health services for most vulnerable children, free access to medications, and in most cases, free health services and medication for their families. In interviews with caretakers across all districts, 89% of respondents gave positive answers to the question of whether or not they think their family’s health has improved since receiving the card. Participants in the study generally appreciate the quality of services they receive and believe the card is valuable.

Barriers

Despite a number of significant benefits to using the CHF card, there remain barriers to its usage. The study sought to capture both external barriers that affect card usage, but are outside Pact’s control, as well as internal barriers directly related to Pact’s implementation. Frequently cited external barriers include wait times at health facilities, distance to health facilities, the cost of transportation, quality of health services, and drug availability. Internal barriers include verification of identity methods (photos and receipts), understanding of services, stigma and discrimination, and expiration of the card.

Advocacy and Sustainability

The sustainability of CHF card benefits for project beneficiaries is largely contingent on four factors: one, the government’s commitment to promoting CHF card use and to strengthening the health sector in general; two, existing and projected demand for CHF cards, particularly among most vulnerable children and households; three, the existing health structures and how the program is strengthening them; and four, economic stability of caregivers. Although there are some challenges within the health system that lie beyond the scope of both projects, the evaluation finds that Pact has made attempts to integrate sustainability in its project design and that, to a certain extent, the government is making the necessary investments to strengthen CHF.

Recommendations

From these findings flow a series of recommendations for Pact to increase the benefits of the card for beneficiaries. Our recommendations fall into three categories: implementation, new directions, and advocacy.

Implementation

A key component of Pact’s work globally is capacity building of local partners and other stakeholders. Local partners serve as a powerful linkage between all the stakeholders involved in the program, yet there are vast discrepancies in terms of successful implementation on the part of partner organizations. For that reason, Pact should **unify guidelines for partner organizations’ implementation of the CHF card program across districts, as well as between the Jali Watoto and Global Fund Program.** Another recommendation to improve partner organization performance is to **conduct exchange visits between partner organizations to share lessons learned and various CHF implementation techniques.**

Other stakeholders in the program are equally in need of capacity building. The study findings show that some MVCCs, village volunteers, and health providers still lack critical competencies.
for serving their communities, including in some cases, inadequate understanding of the CHF program. To address this issue, this report recommends Pact to increase training for village volunteers and MVCCs to ensure they understand their role and the CHF card system and educate health providers about how the CHF card system works and how best to support cardholders in accessing services.

New Directions

The report also recommends two possible “new directions” for the CHF program component that aim to increase its efficiency. The first new approach is to consider a partial subsidization plan for CHF cards to help program beneficiaries to purchase their own card once their fully funded Pact card expires. The second innovative approach is to develop information communication materials to be posted at health facilities. Clear documentation of rules about CHF card usage would contribute to increased knowledge among cardholders and health care providers about what the CHF card covers, where it can be used, and by whom, among other issues.

Advocacy

Pact has the opportunity to be a catalyst for more civic engagement on the part of Civil Service Organizations (CSOs), MVCC members, and volunteers. To this extent, it is recommended that Pact invite government authorities to attend MVCC, volunteer and local partner trainings to facilitate information-sharing between MVCCs and local government authorities, encourage government buy-in to the program, and build trust between the government and community stakeholders. Another recommendation is to form an MVCC advisory committee composed of key stakeholders, including MVCC members, volunteers, caretakers, and health providers, that would meet regularly to provide input on policies and implementation. Finally, the creation of Public Expenditure Tracking Systems (PETS) to increase information flow between the government, communities, and other stakeholders to increase accountability and respond to the finding that health providers want more transparency in the management of CHF.
II. INTRODUCTION

Pact has worked in Tanzania since 2002 strengthening civil society organizations with the overall goal of building a strong, democratic society that protects the rights of and provides opportunities to vulnerable children, women, and marginalized groups. Currently, Pact is undertaking four programs aimed at improving the lives of orphans and vulnerable children: Jali Watoto (meaning “Care of Children” in Swahili), the Global Fund OVC Program, the Anti-Stigma Campaign, and the WORTH project. To implement these projects (namely Jali Watoto and Global Fund), Pact is working with local partner organizations to provide health insurance to the most vulnerable children and their families. To do this, Pact purchases CHF cards, which allow children and families to receive free health services at facilities in their districts.

In February 2009, Pact Tanzania began working with a group of Master’s candidates from The George Washington University’s Elliott School of International Affairs to develop and implement an evaluation of Pact’s use of the CHF card program to provide health services to orphans and vulnerable children. The overall purpose of this evaluation is to provide a snapshot of how Pact’s CHF card component is running on the ground, as well as to assess if the provision of CHF cards is indeed an effective way of delivering health services to most vulnerable children, given both the internal factors of the program and external factors of how the government operates the CHF scheme from one district to the next. Findings from this study are detailed in this report.

III. BACKGROUND

To situate the study findings and recommendations within a thematic context, this section provides information about the current health situation in Tanzania, the national CHF scheme, Pact’s MVC support programs in Tanzania, and the evaluation’s objectives and methodology.

A. Health Context in Tanzania

Although it has been regarded as an “island of political stability” in the middle of a region regularly in turmoil or conflict, Tanzania still faces severe development challenges, particularly in the area of health. The health system is acutely overburdened by the emergence of pandemic and epidemic diseases such as HIV/AIDS and malaria. The majority of the poorest populations do not have a chance to access health care for prevention or treatment of any illness due to various barriers related to access and quality. Tanzania consistently ranks low on the Human Development Index, falling at number 159 out of 177 countries (UNDP 2005). Children are particularly burdened in Tanzania, and are more negatively impacted by the problems of access and resources. As of 2006, the infant mortality rate was 74 per 1,000 live births and the maternal mortality rate stood at 950 per 100,000 live births in 2005. The most common causes of death for children under five years of age include malaria (23%) and pneumonia (21%) (WHO 2006).
**HIV/AIDS**

Most East African nations have been battling the HIV/AIDS epidemic for many years. Tanzania has been no exception. The prevalence rate of HIV/AIDS in Tanzania was estimated at 6.2% at the end of 2007, with an estimated 58% of HIV cases occurring among women (UNGASS 2008). Approximately 140,000 children, ages 0-15 years, were living with HIV/AIDS and an estimated 1.3 million people (adults and children) were living with the disease that same year (UNAIDS 2008). AIDS in Tanzania has resulted in over 900,000 orphaned children (Avert 2007).

**Health Human Resources**

The health human resources situation in Tanzania is currently in crisis. A shortage of personnel, regional imbalances, and weak productivity at health facilities negatively impact the health of the general population. The number of health workers has been in decline for years, with a greater shortage predicted in the future as demands on the health sector rise due to HIV/AIDS. Data from 2002 reveals less than one physician per 10,000 people and 27.4 nurses and midwives per 1,000 people, both low ratios according to international staffing norms (Maestad 2006).

**Health Financing**

Much like other countries in sub-Saharan Africa, Tanzania faces competing demands related to improving access to health services, particularly in light of a tight public health care budget. In 2006, government spending on health, which makes up nearly 60% of all health spending, comprised 5.5% of GDP. Meanwhile, private expenditures on health comprised 40.8% of health spending. Out-of-pocket expenditures make up most private expenditures (83.4%), driven by user fees, which were introduced in 1993 after free health service was draining resources from the system. Social security expenditures comprised another 3.9% of private spending (WHO 2006).

**B. CHF in Tanzania**

In 1996, Tanzania's Ministry of Health introduced CHF in an effort to increase access to health care for the country's poor and vulnerable groups. A prepaid insurance scheme, CHF was one of multiple alternate financing mechanisms to be introduced. Other strategies include the National Health Insurance Fund (NHIF), which now serves the country's civil service sector, and micro health insurance schemes (Mtei and Mulligan 2007).

In particular, CHF was introduced to increase access to basic curative and preventative health services among poor and vulnerable groups, primarily rural populations and those working in the informal sector by mobilizing financial resources from the community. In Tanzania, 85% of the population lives in rural areas and/or are employed in the informal sector (Kamuzora and Gilson 2007). Through CHF, the MOH also aimed to improve health care services management in the communities through decentralization by empowering communities to make decisions and contribute to matters affecting their health. According to Msuya et al. (2007), the objectives of CHF include:
• Establishing a strong and sustainable financial resource base for basic curative and preventive health care;
• Ensuring security and equity of access to health services to community members; and
• Improving the protection of people against the financial consequences of health shocks.

Membership in CHF entitles people to access services within their district at the dispensary and health center level, and sometimes at the district level. Currently, voluntary membership is based upon an annual fee of 5,000 TSH. While membership rates were supposed to be determined by the community, in practice, fee levels are set by the District Health Board and/or the District Council. As of 2006, 69 District Councils had CHF, comprising approximately half of the districts in the country (Mtei and Mulligan 2007).

By guaranteeing access to health services for those who pay the CHF membership fee, the government aims to increase visits to health facilities, reduce out-of-pocket expenses, and improve the overall health of rural populations. In principal, as more individuals join the scheme and pool their resources into a common fund, the more health services can be expanded to include advanced treatments. The alternative to using the CHF card is paying user fees (per person) for single visits to a health facility; several visits (3-5) to a health facility would cost considerably more than one CHF card.

In practice, CHF implementation varies significantly from district to district due to both the decentralized nature of the Tanzanian health system and the lack of clarity in the original design. For this reason, there is a lack of empirical evidence as to the effect of the CHF on a nationwide basis – although some general issues have been identified with regard to implementation. A brief overview of CHF enrollment and retention, use and management, and the scheme’s potential for sustainability follows.

**Enrollment and Retention**

Despite initial ambitious goals for the CHF scheme on the part of the Government of Tanzania, enrollment has fallen far short of the original estimate of 30%. Though CHF membership reached 23% in 1999, it then plummeted to less than 3% within only a few years (Mtei and Mulligan 2007). Studies of participation in CHF show that income is the most important factor in determining household enrollment and wealthier households are more likely to enroll (Msuya et al. 2007; Mtei and Mulligan 2007). For this reason, one of the main critiques of the CHF model – as with many similar community-based insurance initiatives – is that it does not reach the poorest of the poor. Other factors that affect a household’s likeliness to enroll include proximity to a health center and the size of the family, with families living closer to a health center and larger families more likely to participate (Msuya et al. 2007).

Low quality of health care is a central challenge to encouraging initial buy-in to CHF, particularly among average and wealthy groups. Problems with quality of services that affect CHF enrollment include shortage of drugs and essential medical supplies;
inappropriate diagnosis due to lack of diagnostic equipment, particularly laboratory equipment; staff-related problems; limited range of services provided and lack of possibility to use health facilities of members’ choice; and problems with attaining referrals. However, among poorer populations there is less concern about low quality of services (Kamuzora and Gilson 2007).

Reasons for the precipitous drop in CHF enrollment are varied and include low or unreliable household income, lack of understanding of CHF, lack of coverage for referral care, and poor quality of health care service at public facilities (Mtei and Mulligan 2007). For poor households, the most important barrier to continued participation was the inability to pay membership contributions (Kamuzora and Gilson 2007). The growth in usage of the NHIF for civil servants and the breadth of exemption policies also leave a limited number of people to contribute to the CHF scheme (Mtei and Mulligan 2007).

**CHF Use and Management**

In their study of Igunga District, Msuya et al (2007) found that membership was one of the most important variables affecting household decision in seeking medical care given an illness or injury, along with income. More CHF members sought first contact care at either a government or non-government health facility, compared to non-members (92.5% versus 69.4%). Additionally, non-members were more likely to seek alternative methods of care compared to members, especially among poor households. The study also found that participation in the CHF scheme provided cushioning against possibilities of adopting strategies that were likely to lead into negative consequences. On the other hand, Musau (2004) found that CHF members in Hanang District were over-using services, compared to non members, such that non-members are grossly underserved.

At the central level, general management and oversight of CHF is provided by the MOH and the Ministry of Regional Administration and Local Government. District Councils are charged with sensitization about CHF (in collaboration with community members) and with establishing the District Health Services Board. Composed of local government members, the District Health Services Board is tasked with implementing and monitoring CHF in the district. At the (lower) ward level, Ward Development Committees are responsible for overseeing CHF and Ward Health Committees. At the base of the pyramid, Ward Health Committees are not always functional but in principle are charged with mobilizing communities to join CHF, preparing membership lists, and supervising the collection of fees, among other responsibilities. See **Figure 1** for the basic structure of CHF management and oversight in Tanzania.

**Figure 1. CHF Management Structure in Tanzania**
Management of CHF has met with some challenges related to lack of commitment and capacity on the part of regional and district officials, leading to low enrollment and coverage (Mtei and Mulligan 2007). The granting of exemptions and waivers for CHF cards by District Councils, for example, has either been poorly executed or non-existent. Despite the fact that the CHF Act (2001) stipulates that certain individuals are eligible for free CHF cards (e.g., people too poor to pay the required contribution, pregnant women, children under 5, orphans, and other vulnerable children), in practice this is often not the case. The poorest lack information on waivers, sometimes are denied application by providers, or are deterred from applying due to lengthy and cumbersome identification processes (Mtei and Mulligan 2007). This may be linked to District and Ward Managers’ negative view of the exemptions and feeling that they are too difficult to implement (Kamuzora and Gilson 2007). In addition, the community is also supposed to participate in the planning and management of CHF, but in practice, the majority of “representatives” selected from the community are in fact, government officials (Msuya et al 2007).

**Sustainability**

The issue of sustainability is important for the long-term success of CHF in Tanzania. Despite being first introduced in Igunga in 1996, CHF only began to spread to other districts in recent years. Thus, there is still a widespread lack of awareness about the program itself, including the benefits to buying into the scheme. Where the scheme exists, member contributions commonly make up the largest portion of revenue, accompanying some combination of matching grants by the government and grants from District Councils, donors, and other organizations (Mtei and Mulligan 2007). This is problematic given that CHF membership is low and drop-out rates are increasing, which serves as a direct threat to CHF sustainability.

Ultimately, sustainability will largely depend on the success of the government and other stakeholders in raising the awareness of the general public to the benefits of CHF, facilitating an increase in those who buy into the program. Community-based health insurance schemes have the potential to be self-sustaining if the revenue generated from the purchase of cards, plus the grants from the government and other contributions are rolled back into the program at all levels.
Even though the CHF card program has been active throughout Tanzania for several years, its merits are still in debate. Proponents argue that the community-based health scheme has been a valid means of protection from the negative effects of high health expenditures for low-income populations. Critics emphasize the inability of the scheme to reach the poorest of the poor, thus discounting the overall goal of the fund. For the purpose of this evaluation, the advantages and disadvantages of the overall CHF program in Tanzania will not be discussed, outside of references that are pertinent to Pact program implementation.

C. Pact Tanzania’s Jali Watoto & Global Fund OVC Programs

Pact, Inc., an international non-governmental organization founded in 1971 as a membership organization of private and voluntary organizations, today works in 60 countries implementing over 100 projects in a range of program areas, including HIV/AIDS, natural resource management, peace building, and democracy and governance. Their mission centers on strengthening local capacities as a path to sustainability. Pact has been working in Tanzania since 2002, with a focus on capacity building and grants management activities.

Pact Tanzania supports most vulnerable children through two programs: Jali Watoto and the Global Fund OVC projects. Commencing in January 2006, Jali Watoto is funded through the President’s Emergency Plan for AIDS Relief (PEPFAR). The Global Fund OVC program began in 2005 and is a five-year project funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria. (See Appendix D for the Program Implementation Diagram of the two projects.) The two programs differ in some aspects of implementation, yet the goal of each is to support most vulnerable children according to the guidelines established in the 2007-2010 Tanzania National Costed Plan of Action for Most Vulnerable Children. Both programs work through partner organizations (local NGO’s) to implement program activities. Jali Watoto works with village-level Most Vulnerable Children Committees and the Global Fund OVC program works with village volunteers to provide support and counseling to most vulnerable children and their families based on the family’s individual needs. To these families, Pact works to provide a menu of services including psychosocial support, food and nutrition, education, shelter, legal and social protection, economic strengthening, and health care. The distribution of CHF cards is one strategy that some partner organizations use to provide health care for most vulnerable children and their families.

IV. PURPOSE OF EVALUATION

The general purpose of the evaluation was two-fold: first, to provide Pact Tanzania with an unbiased and researched perspective on project implementation and how it affects most vulnerable children and their families; and second, to offer GWU students the opportunity to meet a graduation requirement and apply their classroom learning in International Development Studies in the field.
Over the course of two weeks (March 14-29, 2009), the four-person evaluation team traveled over 400 miles into the interior of the country, conducting focus groups and interviews with various project stakeholders, including district, ward, and local level government representatives, health providers, Pact’s implementing partners, MVCC members and village volunteers, and most importantly, caretakers and most vulnerable children themselves. All data collection tools (i.e., surveys, questionnaires, discussion guides) developed by the GWU team, in collaboration with Pact Tanzania, were created with the following primary objectives in mind (see also Appendix B):

**Objective 1:** To identify the different ways in which the CHF scheme is being administered by the Government of Tanzania in various districts throughout the country.

There is some variability in how the CHF scheme is administered by the government in each district; examples include who the CHF card covers, where the cards can be utilized, and what types of services cardholders can access. Because these differences affect not only program implementation from district to district, but also the potential for impact of Pact’s program activities, understanding this landscape would be crucial for Pact and its local partners to better tailor implementation according to the particular context.

**Objective 2:** To document the benefits of and barriers to using CHF cards, as experienced by most vulnerable children households.

The benefits felt by most vulnerable and households, as documented by interviews and focus groups, rather than through partner reports, is of particular interest to Pact as are barriers to use, including internal barriers related to program implementation and external barriers related to the structure of CHF as set forth by the Government of Tanzania. Understanding both will inform future project implementation.

**Objective 3:** To evaluate the impact of project implementation on the use of CHF cards by beneficiaries.

Pact is interested in learning how different approaches to implementation affect the ability of most vulnerable children to effectively use CHF cards. It is believed that implementation may vary according to individual local partners, as well as between the two different programs. The decentralized management structure of both Jali Watoto and Global Fund OVC programs allows local partners room to tailor implementation of the CHF scheme according to the context of the district(s) and the needs of most vulnerable children. Moreover, the slightly different management structures of the Jali Watoto and Global Fund OVC programs—one uses unpaid MVCC and the other paid Village Volunteers—provides an opportunity to analyze the advantages and disadvantages of both. Overall, the evaluation of project implementation was expected to provide insights into best practices as well as challenges.
Understanding the perceived value and demand for the CHF card is critical to Pact’s ability to assess whether the provision of CHF cards is indeed an appropriate way of delivering a health service to most vulnerable children, or if there are other health services that might better meet their priority needs. This objective also aimed at assisting Pact in better understanding if beneficiaries would be willing to purchase CHF if it were not free.

Ultimately, the sustainability of benefits gained through the free distribution of CHF cards is dependent on the government’s commitment to strengthening the existing health structure. To ensure the continuation of benefits after the project end date, Pact will need to identify key advocacy issues local partners can take up with government authorities. As respected intermediaries between the state and communities, local partners are in a position to influence policy as well as government buy-in to the CHF scheme.

An overview of the evaluation objectives and tools used to collect information (described below) on each objective can be found in the Study Objective Framework, in Appendix D.

V. RESEARCH METHODOLOGY

A. Study Area and Population

The study was undertaken in both rural and urban settings throughout five districts, including Morogoro Urban and Morogoro Rural (Morogoro Region); Nzega and Igunga (Tabora Region); and Iramba (Singida Region). In Morogoro Urban, which has a population of 228,863, the study was implemented in the wards of Kichangani and Mbuyuni. (See Appendix F for a map of the study sites.) In Morogoro Rural, with a total population of 263,920, the study was implemented in the wards of Mkanbarani and Tawa. In Iramba, with a total population of 368,131, the study was implemented in the wards of Kiomboi, Kisiriri, and Shelui. In Nzega, with a total population of 417,097, the study was implemented in Bukene, Isanzu, and Hoba. Finally, in Igunga, with a total population of 325,547, the study was implemented in the wards of Mwanzugi and Igunga.

The study participants comprised six stakeholder groups. The first two groups comprised beneficiaries of Pact Tanzania’s Jali Watoto and Global Fund OVC initiatives, including both most vulnerable children and parents/caretakers of those children. Children participants

Objective 4: To determine the level of demand for CHF cards on the part of the most vulnerable children and households with whom Pact works.

Objective 5: To identify advocacy issues for partners to take up with local district health care administrators, as well as with the Ministry of Health for overall improved health of most vulnerable children.
ranged in age from 8 – 19 years; caretakers from 23 – 78 years. To qualify for the study: i) Child participants must have been previously identified in their community as a most vulnerable child; ii) Parent/Caretaker participants must care for a child in their household previously identified as a most vulnerable child; and iii) Children and caretakers must have received a CHF card from a Pact partner organization prior to their participation in the study, or are expecting receipt of a CHF card in the next round of card distribution. A third participant group comprised members from either the MVCC or village volunteers operating in the respective communities where Pact’s CHF card component is being implemented. The fourth group included health care providers (i.e., physicians, nurses, medical officers) working in health dispensaries (zahanati), health centers, or public hospitals (including district and regional hospitals) that accept CHF cards. Government officials at the district, ward, and/or village levels whose work is in some way related to the oversight or implementation of the CHF scheme at large comprised the fifth participant group. The final group included Pact partner organizations implementing either of the orphan support programs.

B. Study Design

This evaluation research was developed as a four-pronged approach for gathering information from stakeholders regarding the CHF card component of the two Pact programs. This approach included a survey of Pact partner organizations; one-on-one and small group interviews with program beneficiaries (children and parents/caretakers); key informant interviews with health care providers and government officials; and focus group discussions with program beneficiaries, village volunteers, and MVCC members (see Appendix A). Instruments for data collection were designed through collaboration by the GWU research team and Pact Tanzania staff. Interview tools were piloted during the first two days of the study and questions modified and integrated into the study design accordingly.1 Copies of the survey tools can be found in Appendix C.

The self-administered survey for Pact partner organizations gathered quantitative and qualitative information on the implementation of the CHF card activity under both the Jali Watoto and Global Fund projects. Initial survey questions were developed by Pact Tanzania program staff and revised by the evaluation team. The survey consisted of 47 questions in English and was distributed to partner organizations via email during the first week of the study. The purpose of the survey was to identify the different ways in which the CHF card component is being implemented by the organizations throughout various districts and to generate information about potential problems and successes related to program implementation.

To gather information from program beneficiaries (children and parents/caretakers), the GWU team used both semi-structured, one-on-one interviews and focus group discussions. Parent/caretaker interviews comprised a series of 26 open- and closed-ended questions designed to collect information on: usage of CHF cards; household access to health services;

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1 Results from the pilot interviews are still considered valuable and are included in this evaluation report.
perceived quality of services; satisfaction with CHF services; perceived benefits of the CHF card; and perceived support from village volunteers and/or MVCC members. Interviews guides for children aged 13 -18 years were structured around similar topics, with children under 15 years receiving a modified set of questions. A small number of children ages 11-12 years also participated through focus group discussions. Generally, focus groups were used among both beneficiary groups to provide a comfortable forum in which people felt comfortable sharing honest opinions about actual usage of the CHF card, its value, and challenges to its use.

Informant interviews for health care providers consisted of a set of ten questions seeking information on the range of health care services offered at the provider’s facility; management of the CHF scheme at their facility; and providers’ perceived value of the CHF card to most vulnerable children. Informant interview with MVCC/village volunteers were designed to generate information on their roles in supporting children, as well as their own perceptions about card value. Finally, information from government officials was gathered through informal group interviews (one to four people) using a pre-established questionnaire that focused on the structure of CHF in their respective district. For all interviews and focus group discussions, participants were informed about the study purpose and the nature of the questions and asked for verbal consent.

C. Data Collection

Participants were pre-selected by partner organizations prior to the arrival of the evaluation team, with the assistance of MVCCs and village volunteers. The GWU team provided a list of priority participant groups to Pact staff, who then informed partner organizations in each district and ward. A discussion of the limitations of the participant selection is included later in this report.

**Table 1. Study Participants Overview**

<table>
<thead>
<tr>
<th></th>
<th>Interviews</th>
<th>Focus Group Discussions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Parents/Caretakers</td>
<td>27</td>
<td>8</td>
<td>82</td>
</tr>
<tr>
<td>Children</td>
<td>28</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>MVCC/VV</td>
<td>4</td>
<td>4</td>
<td>43</td>
</tr>
<tr>
<td>Health Providers</td>
<td>12</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Government Rep.</td>
<td>3</td>
<td>21</td>
<td>0</td>
</tr>
</tbody>
</table>

Data was collected from nearly 230 parents/caretakers and children through a total of 15 focus group discussions and 85 one-on-one interviews. In addition, 91 MVCC members and village volunteers were included in the study, as well as 27 health care providers and 24 government representatives. A total of 71 surveys were distributed to Pact partner organizations during the first week of the study, with a response rate of 32.4% (as of the time of writing this report). Information about study participants is detailed in Table 1.
D. Ethical Issues

The participation of children was a critical component of the study design given that they are the primary target population of the Jali Watoto and Global Fund projects. Considering the obstacles faced by orphans and vulnerable children relative to biological children living in the same household, it was important that information about access to and use of the CHF card was garnered directly from most vulnerable children themselves. However, the involvement of children, particularly children identified in their communities as most vulnerable, posed a considerable challenge to the study’s ethical design. To ensure the study was aligned with current ethical protocol, children were asked to participate in the study only when the information they could provide could not otherwise be gathered from other participants.

To alleviate fear or discomfort about children’s participation by community members, parents/caretakers, and children themselves, the evaluation team worked with Pact program staff and partner organizations to structure interviews so that adult stakeholders were approached prior to child interviews. Wherever possible, parents/caretakers were asked for their verbal consent for children’s participation prior to the interviews. In addition, at the start of each interview, children themselves were informed about what would be taking place during the interview or focus group and advised that they could refuse to answer any questions or withdraw from the interview/discussion at any time.

E. Cautions and Limitations

One primary limitation of the study findings is the quality of translation services that was available to the evaluation team. Instruments used to gather data from stakeholders were not translated into the local language prior to conducting the interviews. Instead, questions were read to participants in English and then translated into Kiswahili at the interview/discussion site. Additionally, some of the translators had low English competency and in some cases, struggled to understand the questions posed by the evaluation team. Consequently, it is possible that translators translated study questions to participants differently from one another and that translators did not accurately translate all that participants said. If study participants were each administered somewhat different questions, the study’s reliability would be decreased. Moreover, if participants were asked different questions than those designed, the validity may have also been compromised.

Additionally, in three of the five study sites, the evaluation team had to rely on staff from the partner organizations to serve as translators. This is a potential limitation because the staff had keen knowledge as to how the program was supposed to be running and had a vested interest in the outcome of the study and how the results reflected upon their own work. In an effort to modify the effects of this situation, the research team discussed with translators their responsibilities as a translator and urged them to provide only direct translation, free of any probing or other “assistance” with questions unsolicited by the interviewer. However, in multiple instances, translators from partner organization staff had to be reminded to follow a more rigid translation process. Given that partner organization staff also served as the gatekeepers to the study participants, it was necessary
for the evaluation team to minimize translators’ influence on participant responses, meanwhile keeping partner staff engaged and positive about the overall study.

Another limitation, and perhaps the most significant, is the selection method of program beneficiaries for participation in the study. Considering the time and financial constraints of this evaluation, random sampling of program beneficiaries (i.e., children, parents and caretakers) was not possible. All of the study participants were pre-selected through convenience sampling at the discretion of Pact’s partner organizations directly or the MVCC members/village volunteers. Participants then self-selected by coming to the interview/discussion location. This process has implications for the representativeness of the study sample relative to all beneficiaries of the CHF card program component for the following reasons. First, considering that Pact partner organizations are receiving funding for the CHF card component, as mentioned, they have an interest in the findings of the study. As a result, decisions about which program beneficiaries partner organizations chose to inform could potentially have been influenced by their desire to select participants that would offer positive responses in questions reflecting their work. Additionally, in the case that MVCC members/village volunteers were charged with informing beneficiaries about participating in the study, they may have been limited in the amount of time they had to travel to reach certain beneficiaries to request their participation in the study, and thus did not inform all beneficiaries. In some cases, interviews were conducted at or near health facilities, and thus the self-selected participants were potentially those individuals with relatively better access to health facilities, which could skew the data about potential barriers and use of the health services.

Another limitation on the study resulted from the involvement of children. Given that children’s participation was deemed critical, efforts were made in the evaluation design and implementation to make the study site a safe space for children. However, it is necessary to consider the implications of children’s possible discomfort in self-disclosure in the study setting due to their developmental stage, this is particularly relevant considering that the study sites did not always guarantee absolute privacy for participants and that some interviews with children were conducted in group settings.

Finally, the study was limited in the geographic range that was covered. While Pact is implementing the CHF card activity throughout forty-six districts, the evaluation was limited to five districts. Given the variability of CHF in each district, the generalizability of the study findings to all sites covered by the Pact program is thus limited. For this reason, study findings will be applied to specific districts and only where appropriate will findings be applied to program beneficiaries on the whole, such as where it appears that trends hold true across multiple districts.

VI. FINDINGS

A. Differences in Districts: Project Implementation and CHF Card Use
Over the course of the study, the evaluation team found that implementation of the CHF card component by local partners varied significantly from district to district, as did government CHF implementation. Five primary differences in the government’s management of CHF were identified: first, which household members the card covered; second, how many total people the card covered; third, what services could be accessed; fourth, the maximum cost of services that could be accessed per visit; and finally, what information was included on the card itself.

According to partner surveys, which represent organizations from 20 districts, rules about who can use the card vary. In some districts, only one MVC in the household is covered (i.e., Morogoro Urban, Arusha, Royra), while in other districts more than one child in the household is covered, but adults are excluded (Musoma Urban, Serengeti, Kuhoma, and Bunda). There were also districts in which all members in the household (up to ten) are covered, regardless of age (Geita, Mbozi). In one case (Karagwe), CHF cards are offered at different costs, according to how many people are covered by the card. Although rare, Pact program beneficiaries in some districts are sharing cards between households if individual households do not meet the maximum limit on persons covered (Kahama, Biharamulo, Igunga and Nzega).

In five of the six districts visited, a maximum of ten people can use the CHF card to access health services, according to government representatives. Morogoro Urban District was the exception, due to the fact that the CHF program had not yet been officially rolled out although government interviewees expected this to happen within the next six months. In this district, only Pact program beneficiaries can access services with the card. Only one child – the one identified as most vulnerable – is covered under each card.

The type of health facility that accepts CHF cards also varied from one district to the next. Overall, cardholders can receive services from government owned health care centers and dispensaries, in some cases at district hospitals, in Morogoro Urban at a Regional Hospital, and in Rorya at private facilities. In Igunga, cardholders can also use private facilities, provided they have a referral. In Nzega and Igunga, all health facilities within the district accept CHF cards, including district hospitals when the client has a referral. Iramba District hospitals also accept CHF cardholders, but require a 1,000 TSH fee in addition to the referral. In Morogoro Urban District, Pact has an agreement with the Regional Hospital, which is the only facility in the district that accepts CHF cards.

With the exception of Iramba, where in-patient services are not covered by CHF, stakeholders from each district generally agree that all health services are free with the CHF card. However, health providers during a group interview in Morogoro Rural agreed that all services are free at the health dispensary and health center, but disagreed among

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2 Results from partner surveys in Geita show a discord between how many individuals are covered under one card, whereby one partner reports that a total of nine individuals are covered and another partner reports that up to ten household members are covered.

3 Application for card use at one private facility is currently pending approval in Iramba, according to interviews with government representatives.
themselves about whether all services are covered at the district hospital level. The composition of the cards themselves also differs between districts. In Nzega, Iramba, and Morogoro Rural, cards do not have any photos of the cardholder(s). In both Nzega and Iramba, caretakers state that they were often required to bring receipts with them to health facilities and were turned away if they did not have them. In Iramba, photos of beneficiaries for the CHF cards are taken by the local implementing partner, but had not yet been distributed. An important caveat to note is that for 1,500 TSH, the purchase of photos is likely beyond the means of most if not all most vulnerable children households. Lastly, in both Nzega and Igunga, CHF cards cover a maximum of 30,000 TSH per visit to a health facility, whereas in all other districts visited, no limits are set on how much is covered.

See Appendix E for a summary overview of card use in different districts, according to different program stakeholders.

B. Usage of Card

One of the primary objectives of the evaluation study is to gauge the extent to which program beneficiaries are actually using their CHF cards to seek health care services. Through interviews and focus groups with children and parents/caretakers, the study concludes that the majority of Pact’s program beneficiaries involved in the study (73.7% of children and 65.5% of parents/caretakers in both interviews and focus group discussions) have used their card (for themselves or someone in their household) at least one time since receiving it (see Table 2 and 3). Results of study participants who responded “yes” to this question are similar across beneficiary type and data collection method: 82.9% and 81.3% of parents/caretakers and children interviewed in one-on-one interviews, report using the card, respectively; 58.3% and 60.7% of parents/caretakers and children in focus groups report using the card, respectively. The gap in “yes” responses between interviews and focus groups can largely be attributed to results from Morogoro Rural. Card use was reported to be lowest in Morogoro Urban, whereby 60.0% of all children and 54.5% of all parents/caretakers reported that the card had ever been used. This may be related to the fact that in Morogoro Urban, only one child is allowed to use the card.

Table 2: Card Usage (by household member) as Reported by Parents & Caretakers

<table>
<thead>
<tr>
<th>District</th>
<th>Interview</th>
<th></th>
<th></th>
<th>FGD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Y</td>
<td>Total</td>
<td>% Yes</td>
<td>N</td>
</tr>
</tbody>
</table>

4 A total of two children in the study had missing data for the question of ever using CHF card.
5 Interview questions for children asked whether the individual child had ever personally used the card, while parents/caretakers were asked whether anyone in their household had used the card.
6 In Morogoro Rural, there were sizeable differences between focus groups and interviews with children and parents/caretakers, whereby a greater proportion of respondents in interviews reported ever having used their card as compared to focus groups.
7 It is also important to note that in an additional two focus groups in Morogoro Urban, exact numbers on use were not collected from parents/caretakers (as questions were being piloted), but women in these two groups did report using the card.
Table 3: Card Usage (by child) as Reported by Children

<table>
<thead>
<tr>
<th>District</th>
<th>Interview N</th>
<th>Y</th>
<th>Total</th>
<th>% Yes</th>
<th>FGD N</th>
<th>Y</th>
<th>Total</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morogoro Urban</td>
<td>7</td>
<td>13</td>
<td>20</td>
<td>65.0%</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>50.0%</td>
</tr>
<tr>
<td>Morogoro Rural</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>16.7%</td>
</tr>
<tr>
<td>Iramba</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
</tr>
<tr>
<td>Nzega</td>
<td>0</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Igungua</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9</td>
<td>39</td>
<td>48</td>
<td>81.3%</td>
<td>11</td>
<td>17</td>
<td>28</td>
<td>60.7%</td>
</tr>
</tbody>
</table>

When reviewing the data, it is necessary to understand the context within which individuals are making decisions about use. Internal factors associated with card use, including perceived coverage, benefits, and barriers will be discussed in detail below. Possible external factors that may influence usage differently in different districts include different limitations regarding number of people supported by the card; where the card can be used; what types of services are/are not covered by the card, including monetary limits; whether the card can be shared between households; and the duration of time that people have had their cards in respective districts.

The majority of parents/caretakers who report having used the card cite that it was used for various treatment measures, rather than prevention. Reasons for seeking care cited by parents/caretakers include, but are not limited to, treatment of malaria, tuberculosis, typhoid, ear infection, leprosy, asthma, fever, coughing, diarrhea, hepatitis, respiratory disease and chest pain. Of those participants that seek services at a facility that accepts CHF cards, in most instances, people seek those services most nearby to their home, unless there is a need for referral.

This study does not assess the frequency with which people use their card relative to the number of people in each household eligible to use it. Measuring frequency was complicated by participants’ difficulty in remembering the exact number of times the card was used. An additional focus group, with parents/caretakers was conducted in Iramba that is not reflected in this data because information was not collected on the exact number of participants that report using/not using the CHF card. However, the majority of caretakers in this focus group report that their children had used the card. A total of two children in the study had missing data for the question of ever using CHF card.
was used, as well as variations in coverage (number in household covered) across districts. The study did however attempt to measure missed opportunities for use by asking children and parents/caretakers if they had ever not used the card at times of sickness. Eight of 28 parents/caretakers and three of 33 children responding to this question report that the card was not used during times of sickness. Barriers to card usage, as described below, are likely to affect non-use. However, non-use during times of sickness may also be the result of individuals’ own perceptions about how seriousness of the sickness and whether the health facility would be able to adequately address the sickness/need.

While non-use of the card was less prevalent, it is necessary to consider the reasons cited for why people did not use their card, particularly in light of the fact that frequency of card use is undetermined. The most common reason cited for non-use by both children and parents/caretakers is that the child or household members did not get sick during the card coverage period, and thus, did not perceive a need for health care services. Out of the six caretakers responding “no” to ever having used the card (in one-on-one interviews), only one cited that they or someone in their household had been sick, but selected not to use the card.\(^{10}\) Similar results were found among children, whereby out of nine children who had not used their card, none reported having been sick and not using the card, with two non-responses to this question. Non-use of the card due to absence of sickness was also reflected in focus group discussions with caretakers/parents, as well as children.

C. Perceived Coverage

Beneficiaries’ perception of coverage is important in understanding whether they are using the card to the extent that is permitted under the CHF scheme, and thus whether they are getting full advantage of the service, or, whether information and communication on the part of either Pact staff, Pact partner organizations, MVCC/village volunteers, health providers, and/or government could be enhanced so that beneficiaries may better understand what is covered, and ultimately better utilize their card.

Generally, interviews and focus groups with beneficiaries suggest a common understanding that the CHF card is used to receive free services at a health facility. Beyond this principle, there is a varying degree of confusion related to the specifics about the coverage provided. This confusion is evident not only among program beneficiaries, but also arose as discrepancies between interpretations of coverage by health care providers and government representatives. Generally, misunderstanding about coverage may lead to missing out on services that are supposed to be free. While correlations between perception of use and actual use are not appropriate for this study, we can infer that the existing confusions in the program areas may have an impact on the rates of use. Understanding will be discussed further in the Barriers section.

D. CHF Card Benefits

\(^{10}\) One respondent, who said they had not ever used the card, did not respond to the question of whether they or anyone in their household had been sick but did not use the card.
Another main objective of this evaluation is to determine the level of demand for CHF cards on the part of the most vulnerable children and the families with whom Pact works. The team set out to uncover this information through designing questions relating to perceived and actual benefits of the CHF cards for the targeted beneficiaries. Individual interviews and focus group discussions with various stakeholders, as well as partner organization surveys in multiple districts, yielded valuable information pertaining to the benefits of Pact’s CHF card program.

Data compiled from each of the five districts visited during the evaluation indicate that opinions of the card vary district by district. Given the inclusion of a diverse array of regions and populations in the study, as well as the various ways that district governments and partner organizations are implementing the CHF card program, it is natural for the perceptions of the card benefits to differ. However, there are still many noteworthy commonalities between districts and stakeholders in terms of general card benefits, which are discussed below.

**Free Health Care for Most Vulnerable Children (and in some districts, families as well)**

A constant theme that arose throughout the evaluation was beneficiaries’ positive perspective of the CHF card in reaching its primary goal – to enable most vulnerable children to access health care services for free. When asked what they liked about having a CHF card, as compared to a time when they did not have a card, the majority of parents'/caretakers’ answers included some mention of receiving free services and treatment for themselves or the children they care for who become ill. A majority of caretakers in every district gave favorable responses to questions concerning the benefit of the card, asserting that they are happy to have a card that enables them to get treatment for free, given that a families’ inability to pay is one of the greatest barriers to accessing health care services.

"**Even though one child is considered most vulnerable, it is good that other members of the household can access free health care services also.**”
- Caretaker, Morogoro Rural District

Individual and group’s opinions of the cards were very favorable, even when they had not used the cards themselves, but had heard of the benefits through other friends and community members. In Morogoro Urban and Morogoro Rural, several female caretakers in two focus groups had never used the card, but agreed that the best benefit of the card was that their children (and themselves as well in Morogoro Rural) could receive health services for free, and asserted that those children would otherwise not be able to afford health care. Caretakers shared stories of having to search many days for money in order to take their child to the clinic before they had a CHF card, and this was a great stress on their household.
Throughout the five districts that were visited, government officials, health care providers and MVCCs / village volunteers also cited free access to health care for most vulnerable children as one of the greatest benefits to Pact’s CHF card program. Given their direct access to the children, MVCC members and village volunteers had an especially positive opinion of the card, and stated that the cards had greatly helped the children in their communities. Several health providers interviewed also stated that before health cards, people would often “wait until their condition was very bad” before seeking health services.

Responses from certain questions on the partner organization surveys also provided further insights about the perceived and actual benefits of the CHF card program. When asked if cardholders were required to select one health provider during the CHF card’s validity, 18 out of 23 partner organizations responded no, which implies the benefit of flexibility for beneficiaries in selecting which dispensary, health center or hospital they attend. In a question asked about whether referrals to other providers were covered under the CHF card, 14 organizations responded yes, that cardholders may use the card at a referral hospital, and 13 organizations responded that beneficiaries were made aware of the referral services when they received the card. This information also reveals the ability of cardholders to use their card at a more advanced health facility in their district if they cannot be treated at a basic dispensary or clinic. In terms of additional benefits that CHF card program participants receive, 18 organizations provide mosquito nets to those with a CHF card, and 14 organizations responded that they feel that there are no health services that would be more useful than a CHF card to most vulnerable children and their caretakers.
Access to Free Medicines

In conjunction with satisfaction about their ability to access health care services for free, program beneficiaries are also generally pleased with the benefit of free medicines. When asked about why they used their CHF card, participants most commonly cite seeking services for malaria. Of those respondents who cite seeking care for malaria, the majority report also receiving free malaria medication treatment. In Morogoro Urban, where beneficiaries have access to the district hospital, health providers noted that if a particular medication is not available in the hospital, they will ensure that an alternative or generic is issued, and always for no cost to the cardholder. Drugs in other districts have varying degrees of availability, depending upon whether the beneficiaries live closest to a dispensary, health center or hospital, since the smaller facilities were less likely to have a constant supply of medicines at all times. However, even in the most basic dispensaries and clinics, the drugs in the medical stock, albeit limited, are provided to those with cards for no cost. It is important to mention that several respondents cite that before having a CHF card, they would usually delay seeking treatment/medication until they could find money to purchase drugs at a pharmacy.

"CHF is very supportive because even if you don't have cash, you can still get medicine.”
– Child, Igunga District

"Before [I had the card], it was difficult to go to the dispensary when I did not have the money. Now, even if I have a cough, I go.”
– Caretaker, Iramba District

Improved Health of Child (and family in some cases)

From the respondents’ perspective, another benefit of the CHF cards is that the health of the child (and where applicable, the family) has improved since obtaining a card. In interviews with caretakers across all districts, 89% of respondents gave positive answers to the question of whether or not they think their family's health had improved (see Figure 2). One female caretaker in Iramba district noted that before the CHF card program, “more people were lost” because of delayed medical care; now those people with cards visit the clinic more often. In focus group discussions with MVCC members and village volunteers, the improvement of children’s health was also raised as a benefit to the CHF card program. One group of MVCC members in Iramba stated that the CHF card program had “decreased the number of deaths” in their community, as well as allowed children to attend school more often since they were sick less frequently.

“Before the card, my child's health was a problem. Now it cannot be a problem.”
– Caretaker from Morogoro Urban District

Tying into this theme, several caretakers answered that they were less fearful of health emergencies since being issued a card, given their ability to go to a health center or hospital for free. In several cases, respondents who had never used their CHF card cite the benefit of a child’s health improvement, often from witnessing the benefits
provided to neighbors and friends who had used their cards. Finally, 57% of respondents in the caretaker interviews reported that they went to the health facility more often since they were issued a CHF card, either for themselves or for their children. One caretaker in Iramba stated that she goes to the health clinic “almost every day... well not every day, but many times” and receives services with the card.

**Good Quality of Care through the CHF Card Program**

To further gauge the contentment of beneficiaries with the CHF cards, questions were asked during interviews and focus group discussions about their satisfaction with the CHF card services. In interviews with caretakers, 71% said they felt respected by the health provider when they received care with the CHF card. Interviews with children also uncovered a general happiness with the doctors and nurses that treated them, however, there were still specific cases where children stated dissatisfaction.

In Morogoro Urban and Igunga Districts, interviewees mentioned that with the CHF card, they no longer had to wait in a long line at the health facility. Also in Morogoro Urban, children and caretakers both reported that doctors and health providers at the Regional Hospital treated children with a CHF card better than those children without a card. MVCC members and village volunteers also commonly reported that children were receiving "good quality care" with the CHF card, and many had witnessed this when they accompanied the children to the clinic or hospital.

**Perceived Value**

To determine their worth of the card, beneficiaries were asked if there were any other health services that may be more useful than having a CHF card. This question sparked some confusion given that it may have been difficult to translate and maintain its intended meaning. While some participants stated that there was nothing they would rather have than a CHF card for their children or themselves, others offered suggestions such as nutrition support, better shelter and mosquito nets. It is difficult to infer from these responses whether those people would rather have these items for their children or themselves than a CHF card, or if their suggestions were in addition to a CHF card. However, given the high number of people who responded that they, in fact, do use their cards when they are ill, an inference can be made to the positive worth of the card to the beneficiaries. Fourteen out of twenty-three partner organizations also responded that they feel that there are no health services that would be more useful than a CHF card to most vulnerable children and their caretakers.

"The service is excellent, from the reception to the doctor.”
– Child, Morogoro Rural District

"I feel good because I am sure I can get help if I get sick.”
– Child, Morogoro Urban District
Another question asked to establish what value beneficiaries placed on the CHF card was whether interviewees would be willing and/or able to buy a CHF card if it was not provided to them for free. Of the caretakers interviewed, 66% responded that they would in fact, buy the card if it were not free, which includes both a respondents’ willingness and ability to buy the card. A few interviewees said that they would buy a card depending upon how much it cost, although they did not give a specific amount that they would be willing to spend.

**Figure 2. Benefits of CHF card as Cited in Interviews with Caretakers**

![Bar chart showing benefits of CHF card as cited in interviews](image)

D. **Barriers to Usage**

Despite a number of significant benefits to using the CHF card, there remain real barriers to its usage. It is clear that barriers vary widely between districts and even between individuals in the same district. Nonetheless, there are several important constraints that were cited many times, which are discussed below (also see **Figure 3**).

**Wait Time**

The wait time to see a physician is the most often cited barrier according to interviews with children and caretakers. Respondents report lengthy wait times at health facilities. One respondent who was interviewed at a health center mentioned that he had arrived at 1 am the night before and had just seen a doctor that afternoon.

Caretakers and health care providers explain that the lines at health centers are informally triaged so that emergency cases would not need to wait as long as patients with more routine problems. Morogoro Urban has established a parallel reception system for participants in CHF and NHIF, which health providers report to have much shorter wait times. Nonetheless, long lines are a significant barrier in the majority of wards visited and
prove an especially difficult challenge to poor, single-parent, or child-headed households who may not be able to forgo a full day’s work to seek care.

**Figure 3. Barriers as Cited in Interviews with Caretakers and Children**

![Graph showing barriers as cited by caretakers and children]

*Question only asked of female respondents.*

**Distance to Health Facility and Cost of Transportation**

A primary constraint to the use of CHF cards is the distance between health facilities and individual cardholders’ homes. Though several respondents note that they live in a village served by a local dispensary or health center that was less than one kilometer away, in the vast majority of cases, distance is a significant barrier. Partner organizations report that their clients who live furthest from the health facility are situated 21 km away, on average. Limited coverage of CHF can exacerbate this problem as in Igunga District, where some caretakers reported living very close to a private hospital, but had to travel long distances to reach a public facility that accepts the card. If the closest health center is not equipped to provide the services required and must refer the patient to another facility that is farther away, distance becomes an even larger barrier and frequently prevents beneficiaries from receiving the services they need. **Figure 4** shows the primary modes of transportation to health facilities, as cited in partner organization surveys.

“I stay a little bit far, so the distance to the hospital is sometimes a problem. If the condition is severe, people must carry you to the hospital.”

- Caretaker, Morogoro Rural District
Long distances are particularly problematic for those who have no choice but to walk, even in cases of extreme illness or emergencies. For many families that support most vulnerable children, paying for a taxi or even hiring a bike is outside their reach. Thus, as illustrated in the above graph, when asked to list common modes of transportation in their district, most partner organizations cite walking as their first response.

To cope with this significant barrier, one MVCC in Iramba reports contributing community resources to pay for a taxi for a particularly sick child and another MVCC in Nzega recounts that they had previously taken children to the health center themselves on a bicycle. Some health centers have ambulatory services, but vehicle use is typically prioritized for the most extreme emergency cases and, in some situations, the patient must pay for its use or contribute for fuel.

Long distances to health centers and the high cost of transportation decrease the utility of CHF cards in remote communities, because distance serves as a significant barrier to consistently seeking services for preventative care and mild illness, and makes accessing health care difficult and dangerous even in the most extreme emergencies.

**Quality of Services and Drug Availability**

In response to questions about quality of services, few respondents spoke negatively about the health providers and facilities. When asked if they felt respected by providers, only four of thirty-seven caretakers said “no.” Though these responses seem to imply that quality of services is not a barrier to use of the card, some aspects of quality do seem to affect card usage. One of these factors is the capacity of health providers to supply the requested care with the resources available to them. Staff and equipment shortages contribute to long wait
times at health centers, a frequently cited barrier, and reduce the ability of the health provider to meet the patient’s need once he or she is seen.

Though district hospitals are well-equipped to deal with a range of health problems, dispensaries and health centers are much more limited. A health provider in Morogoro Rural explains that his staff must refer patients for even relatively simple services like setting a bone. In these cases, the patients may be discouraged from seeking care, unsure about whether or not the referral is covered on their CHF cards, or unable to travel a long distance and ultimately not access services.

In addition to having limited staff and equipment, many health facilities are plagued by chronic drug shortages. Caretakers and children, after being asked about several specific problems and the extent to which they are barriers to usage, were asked to name any other problems associated with using their CHF cards. One of the most frequent responses was drug shortages. In cases where the health facility did not have the necessary drugs, providers could either choose to prescribe a similar drug that was in stock or to recommend that the patient purchase the drugs at a pharmacy. When told to purchase drugs at a pharmacy, some caretakers say that due to lack of money they were forced to go without. Another respondent explains how she is more likely to go straight to the pharmacy the next time anyone in her family became sick.

Thus, although children and caretakers did not often cite quality of services as a barrier, it is clear that aspects of quality did affect beneficiaries’ likelihood of regularly seeking services at a formal health facility.

**Verification of Identity**

For under-resourced health centers, verifying that the people who purchased or were given the CHF card are the only ones to use it is an important priority. Yet, some verification efforts are themselves barriers to the use of the card. These measures make using the card more difficult and sometimes even lead to refusal of services to those who are unable to provide acceptable forms of proof.

The two most common ways for health providers to prove the user’s identity are by demanding photos of the cardholder and by asking to see receipts. Photos are either put in the child’s file at the hospital, on the card directly, or both. A health provider in Morogoro Rural showed a cardholder’s file at the health center, which also had photos of all the family members who could use the card. For people who buy the cards themselves, providing these photos is a barrier as each photo costs approximately 1,500TSH (just over USD$1). Beneficiaries of Pact’s program should receive a photo for free, but in practice the photos were often delayed and could still cause difficulties for card usage.

Another complicating issue is that frequently the cards have a photo of one child, but do not have a photo of every person eligible to use the card. In fact, 81% of Pact’s partner organizations who responded to the survey said that they require only the photo of one most vulnerable child on the card. Because others covered by the card (up to nine people)
are not provided with a card by Pact’s partner organizations and purchasing a photo remains a barrier, confirming a cardholder’s identity remains an important barrier to use for many.

Receipts are another way for health providers to verify that the person trying to use the card is the rightful owner. Unfortunately, for most vulnerable children whose cards have been purchased by an organization and then subsequently distributed to them, showing a receipt is impossible. In Iramba District, MVCCs and caretakers explain that this is a key constraint for the children in their community and report several instances where children had been refused services because they were unable to show a receipt.

Although it is reasonable that health providers take steps to ensure that cards are being used correctly, the requests for receipts or photos do not seem to be universally applied and often are a result of misinformed health providers. Thus, cardholders never know exactly what to expect when it comes time to seek care. Some health providers report providing services for people they knew had the card, regardless of what documentation those patients brought, while seeking more proof from patients with whom they were less familiar. To the extent that the failure to produce this verification keeps the most vulnerable children from receiving services, which does occur according to interviews, the demand for photos or receipts is a significant barrier to use.

Understanding

As mentioned earlier, understanding of services is frequently a problem and many Tanzanians, even in the districts where CHF is operational, have little understanding about how the scheme works or how it could be useful to them. Beneficiaries of Pact’s project who do not understand the benefits of their card or are confused about how to access services face a major barrier in effectively using the card.

One common confusion among parents/caretakers is related to which household members can use the card and the total number of members covered under each card (note that children were exclusively asked about their own card use, not that of those in their household). In Morogoro Rural and Iramba, where adults are permitted to use the card so long as the total number of household members does not exceed ten, some parents/caretakers are not aware or are unsure whether adults are covered. In Igunga, some adults report that they cannot use the card, but this may be attributed to the fact that households share cards in this district and so the ten person card limit is reached by sharing cards, rather than because there is an explicit policy against adults using the card. Finally, in Igunga and Morogoro Rural, some parents/caretakers report that six and five household members are covered under the card respectively, rather than the correct number of ten.

Though less widespread, there is also confusion among some parents/caretakers and children about where the card can be used and what the protocols are for obtaining and using referrals. In Morogoro Rural, parents/caretakers in one focus group believe that the card can be used strictly at Tawa Health Center and not at local health dispensaries. In
Morogoro Urban, despite being limited to a just a few cases, women describe past experiences of trying to use the card outside of the Regional Hospital and being denied. In Iramba, there is misunderstanding by some children who believe they cannot use the card at the district hospital. Confusion about referral policies extends from program beneficiaries, to the MVCC, even to the health providers. Although not as prevalent as other misinformation, confusion about referrals is problematic in that people seeking services at facilities that do not accept cards not only wastes time, but also may frighten cardholders into thinking they will have to pay at any facility, ultimately dissuading them from seeking services the next time they need care.

Sometimes I go to the hospital with the card and the health provider will tell me, ‘I don’t know anything about this card.’

– Child, Iramba District

Some of the plausible causes for this confusion are thus explored, based on knowledge about where most vulnerable children households receive their information. According to the partner surveys, information channels to most vulnerable children households include via MVCC/village volunteers, at time of distribution or at monitoring visits, at ward public meetings, via debates, posters, in contracts signed with wards, and at community meetings/village assemblies.

The study finds possible breakdown of information flow from MVCC/village volunteers and cardholders. In some areas, MVCC/village volunteers struggle to make regular visits to all beneficiaries and thus, may not have the time to provide proper information to all beneficiaries. In some cases, MVCC/village volunteers charged with educating beneficiaries are not equipped with the accurate information themselves. This presented as a problem in Morogoro Rural where some MVCC report confusion about the coverage of referrals and in Nzega, for instance where one village volunteer questions whether CHF is still functional. Moreover, if MVCC/village volunteers do not accurately perceive the need for education, opportunities may be missed to provide vital information to beneficiaries. It was found that despite confusion among beneficiaries about coverage in Nzega and Iramba, MVCC/village volunteer believe that beneficiaries understand card coverage.

Inaccuracies within information disseminated to beneficiaries can be generated in multiple ways. The study finds that some partner organizations have incomplete or flawed information regarding the limits of the card. For instance partner surveys in Geita differ from one another on how coverage is interpreted and in Igunga; Pact’s partner interprets coverage differently from that of the government. Mixed messaging may also descend from higher levels; differences of interpretation of the rules existed between government entities within districts, as well as between government and health care providers. For instance, in Morogoro Rural, interviews with government officials yielded conflicting information on the total number of members covered by the card. In Iramba, providers interviewed believe that CHF cards not purchased by the partner organization only cover six individuals, while those covered by the implementing partner cover ten. In Morogoro Rural, there was confusion among health care providers as to whether services at the district hospital should receive full coverage under the card.
Misunderstandings among beneficiaries can make them less likely to seek services when they are sick or in need of preventative care. When health providers do not understand the CHF system or the benefits covered under the card, they could refuse services to a cardholder or charge for services inappropriately. Poor information among MVCCs and village volunteers perpetuates the cycle of confusion and can spread misinformation. A lack of understanding of the card and its benefits among all of these stakeholder groups is a significant barrier to the program’s success.

Stigma and Discrimination

Though not a universally cited problem, some beneficiaries of the CHF card report feeling stigmatized by members of their community or discriminated against by health providers. Both of these situations discourage use of the card. Though they were not mentioned as much as some of the other barriers discussed here, it is clear that in the communities where stigma is a problem and in the health facilities that discriminate between cardholders and paying patients, these two forces are important barriers to consider. “Social stigma” was not a term that the respondents understood clearly, but as a caretaker in Iramba explained, “some neighbors feel envy at the children who can use the card.”

Other interview participants mentioned jealousy within the community or disparities between households. In Morogoro Urban, a limited number of cards were distributed evenly amongst vulnerable families to avoid stigmatizing any one family by giving them many cards, even though the CHF cards in Morogoro Urban cover only one child. This approach may have led to stigmatization, as equally vulnerable children within the same community, and even within the same family, were receiving different levels of health care.

Within health care facilities, some respondents report that they were treated differently than patients who did not have cards and paid for services. A village volunteer in Nzega remarked that some health providers would tell cardholders that they were out of drugs, yet provide drugs for those patients who paid. Other interviewees report that those who pay are treated more quickly and in a preferential way compared to those who do not pay. However, it is worth noting that Morogoro’s district hospital has a separate reception area for CHF and NHIF cardholders, and subsequently is able to offer shorter wait times to those with CHF cards.

Expiration of Card

For families who receive free CHF cards from Pact, the expiration of the card is the ultimate barrier. Between receiving funding, purchasing the cards, and distributing the new cards, card renewal can be a long process that has left families temporarily without coverage. In Igunga, some caretakers report that their card had expired and that they were no longer able to access free services as a result. In Iramba, the implementing partner chose to pay for all five years of the card’s cost at once to avoid gaps in coverage during the renewal process. However, this option created its own barrier, as health providers began to
question the card’s validity after the expiration date that was preprinted on the card, even though it was only one year into the five year period. Interview questions concerning the cards’ expiration and renewal often elicited confused and concerned responses, revealing that those families whose cards have expired are often unsure of how they would respond if a medical emergency arose.

E. Advocacy & Sustainability

At the outset of this evaluation, Pact expressed interest in knowing which advocacy issues could be taken up with government that would heighten the value of the card, and ultimately the potential for improved health of most vulnerable children. In fact, the government’s commitment to the CHF program and health care in Tanzania is a critical component of program sustainability for Pact. If the economic strengthening component of the programs is effective and the participants’ experience with CHF has been positive, they may choose to purchase their own cards after the project ends to continue providing health care for their families.

The sustainability of the Global Fund and Jali Watoto projects is an important concern for Pact and for all stakeholders who have an interest in ensuring that benefits of the project endure beyond the projects’ end date. If CHF is not generally a sustainable model, Pact may opt to invest in other interventions for improving health care for children. Therefore, this evaluation attempts to look beyond the immediate effects of the CHF card on the health of most vulnerable children, considering the long-term sustainability of CHF more broadly. Although there are some challenges within the health system that lie beyond the scope of both projects, the evaluation finds that Pact has made attempts to integrate sustainability in its project design and that, to a certain extent, the government has bought into the CHF program.

The sustainability of CHF card benefits for project beneficiaries is largely contingent on four factors: one, the government’s commitment to promoting CHF card use and to strengthening the health sector in general; two, existing and projected demand for CHF cards, particularly among most vulnerable children and households; three, the existing health structures and how the program is strengthening them; and four, economic strengthening of caregivers.

Government Commitment to Strengthening Health system

In group interviews with government representatives, there were mixed responses to questions regarding the sustainability of the project and whether there are any plans to continue to support most vulnerable children without external funding. In Morogoro Urban District, the Acting Municipal Director stated that new donor funds would be necessary to renew cards for existing beneficiaries, suggesting that financial support for most
vulnerable children would end with the project. In Igunga District, the District Medical Officer (DMO) believes that “CHF is the only way to support the poor,” indicating support for the program, but also reports that there are not enough resources to continue providing free CHF cards because “the government cannot support every person in the country.”

Although no government interviewee disclosed any future plans to continue support for most vulnerable children, several state that coverage for CHF cardholders would be extended in some districts and that strengthening MVCCs and health committees with trainings was a priority. In Morogoro Rural, for example, with the formal initiation of CHF in the district the government intends to extend CHF coverage to all government health facilities within the next six months to improve access to health services and increase incentives to join the scheme. In Morogoro Rural and in Iramba Districts, government authorities are exploring ways to integrate private facilities into the CHF scheme. In general, government interviewees consider CHF to be a cost-sharing mechanism and are interested in increasing incentives for people. However, when asked what plans they had for supporting most vulnerable children when external support ended, none of the government interviewees indicated that alternative measures to financing CHF cards are being considered for most vulnerable children and households.

**Demand for CHF cards**

The continued use of CHF cards after the projects’ end is closely correlated to whether people value them enough to purchase them, and if so, if they are able to afford the cards. Demand for the cards, a proxy for how much they are valued, was reported to be increasing in several districts such as Iramba since the free CHF cards were introduced. Moreover, our evaluation suggests that the distribution of free CHF cards may be generating demand for the cards among most vulnerable children households and their neighbors. In the words of a local partner organization director in Morogoro Urban District, “the CHF card is a catalyst,” as more people see the benefits of the card, more will join. Moreover, in interviews with caretakers, only 9 of 37 said they would not be willing or able to buy the CHF card if it were not free. Twenty-one said they would be willing while seven said it would depend on the cost.

Demand for the cards is closely tied to how accessible health facilities are located to cardholders and what health services are available. Those living far away from a government health facility have to pay transport and opportunity costs, especially as follow-up visits may be necessary, and these may outweigh whatever benefits they gain from having the card. Similarly, the fact that CHF cards are often only accepted at government facilities puts card holders at a disadvantage in cases where medicine or medical treatment needed is not available. In Iramba, health providers stated that many community members asked why they should pay 5,000 TSH for the card if they cannot get all health services they need. Similarly in Morogoro Rural, health providers suggested that "if all the services were available here, possibly everyone would have contributed [to buy CHF cards]."
The quality of health services at government facilities is, in turn, correlated to demand for the cards since as more people join the scheme, the more financial resources health facilities have to buy medicine and equipment. Moreover, the more people join CHF, the more government is able to support MVCs through cross-subsidization (i.e., the healthy and better off indirectly supporting treatment of more vulnerable). This logic was understood and explained to us by government authorities in Igunga as well as by health facility personnel in Morogoro Rural. At present, CHF members are few in proportion to the total population but this may change if the government follows-through on its commitment to building dispensaries in every village by 2010, as we were informed by representatives in Morogoro Urban and Igunga.

**Strengthening Existing Health Structures in Tanzania**

**MVCCs and Volunteers**

In the case of MVCCs, local partners provide training and mentoring as support. Volunteers are also provided with training as well as a small wage for motivational purposes. Although volunteers and MVCCs play a similar role in both programs, a primary difference is that MVCCs are a government entity, while volunteers have been hired by Pact to support project activities. Program officers interviewed state that some MVCCs are not very active compared to village volunteers; one reason for this may be that volunteers receive compensation and that partner organizations have more control over who is selected to be a volunteer.

In general, the level of engagement of MVCCs varied among those we spoke to during focus group discussions. In Morogoro Urban, for example, MVCC members are well aware of their responsibilities and are vocal advocates for most vulnerable children living in their area. Moreover, members state that MVCCs collect financial and in-kind support from the community to support children. In contrast, MVCC members in Iramba report visiting children once a month, on average, and met as a group once every three months. In Iramba, as well as in other districts, no additional support was garnered from the community to support most vulnerable children.

The government supports MVCCs with training and responses to questions asked during interviews suggest that they are interested in building their capacity and strengthening their role at the village level. In Nzega, government officials stated that there was money in next year’s budget for training MVCCs. In Iramba, government officials claim that seed money had been provided to MVCCs for family livelihood training. One government official in Iramba was particularly adamant about having the community take responsibility for their own development, and suggested that one way for doing this would be to have MVCCs own their own account which they could use to support children in their community.

**Health Facilities**

The current system of channeling CHF revenue from health facilities to district-level government who then re-distributes back to health facilities (in the form of medicine and supplies), has left many health providers unhappy with the lack of transparency in the
transfer of funds. In Morogoro Rural, health providers express frustration that they do not know how the money collected is being spent and believe that if people knew how it was being used, more might be willing to join. In Nzega and Iramba as well, health providers state that having their own account would allow them to better know how the money they collect with CHF cards is being used. If they had their own account, one health provider in Iramba suggests, they could buy their own medicine and supplies and not have to wait every three months for government shipments. Government officials indicate that the idea of individual facility accounts is something currently being considered by the MOH, although officials in Igunga expressed concern that health facilities lack the capacity to manage finances.

Economic Strengthening

The need for more economic strengthening is a theme that came up, in one form or another, during interviews and focus groups with MVCCs and health providers. In Iramba, for example, one health provider believed that "the best thing [to do] would be if Pact could think of something sustainable... people making their own income would be better – or else they just remain poor." Moreover, in light of probable increases in the cost of CHF cards (due to the rising cost of drugs) mentioned in interviews with health providers in Nzega and Morogoro Rural Districts, and the systemic poverty of most vulnerable children households everywhere, economic strengthening is integral if beneficiaries are ever going to be able to buy CHF cards on their own.

Currently, Pact is addressing this need through income-generating activities initiated by local partners and through the WORTH program, which is currently being implemented in two regions in Jali Watoto with plans for it to be expanded to cover all 22 districts. In the Global Fund program, two districts are currently introducing WORTH with plans for it to be expanded to three more districts. A prime example of an economic strengthening activity is local partner JIDA's distribution of livestock to most vulnerable children households. The first offspring of these livestock are redistributed to other households so that the benefits are multiplied. The livestock generate income for households, while also building self-esteem for households who otherwise own very little. In the words of JIDA's Director, "...ownership itself is something. If a most vulnerable child has goats, they have respect."

E.  Cross-cutting Themes

Through analysis of data compiled from interviews, focus groups and partner surveys, several key themes within the CHF card program can be identified. Many of these, such as card benefits and barriers, stood alone in the analysis, and have been discussed in the preceding sections. Other themes arose time and again throughout the study process and deserve particular attention given their cross-cutting nature.

The first cross-cutting theme that must be addressed is the variance in the CHF card structure in each district throughout Tanzania, and the impact this has upon Pact’s CHF card program. Through information gathered in the five districts visited, as well as through partner surveys from other districts, it becomes apparent that the CHF configuration differs greatly from district to district and region to region. Differences exist in coverage and
enrollment, operation, use and management of funds, and sustainability. Some of these differences have been raised in detail in earlier sections of the report, though one prime example is our finding that CHF is only implemented in rural areas, and urban areas instead utilize “Tiba Kwa Kadi” or TIKA, where only one child per household can use a health card.

Such radical variations in the CHF structure in different districts plays a major role in Pact’s CHF card program implementation. First, to designate a target number of most vulnerable children and their families that each partner organization should reach, Pact must gather information on how many people can use a single health card in a particular district. Moreover, Pact needs to be aware of the structure of the CHF card program before designating funding to local organizations for the purchase and dissemination of CHF cards. For example, additional funding may be needed for partner organizations to purchase photographs in those districts that require photo identification. Finally, the differences in where the card can be used and the limitations in services rendered with a CHF card also impacts Pact’s CHF programming. In order for the program to be successful, the CHF card must be perceived as valuable to the beneficiaries, otherwise the card will not likely be used.

Another noteworthy cross-cutting theme is the understanding of the CHF card and the card program by all stakeholders. As discussed above, variances in understanding of the card were apparent in interviews and focus groups with all parties, including caretakers, children, health providers, MVCC members, village volunteers and even government members. This issue has a deep impact upon Pact’s program implementation given that a lack of information, or a wealth of incorrect information, can be harmful to the people that Pact is aiming to help. Further details of the perception of the coverage of the card was provided in the findings section of this report, and is pertinent to both actual usage of the card, as well as perceived benefits and barriers to card usage. Misunderstanding of the card by beneficiaries can lead to the lack of sustainability of the program itself since the eventual purchase of cards, even by the most vulnerable members of the community as well as others, is critical to the continuation of the program.

CONCLUSION

Over the course of this evaluation, a broad range of issues were examined through multiple lenses for the purpose of studying how and if CHF cards are being used and in what ways Pact implementation could be improved to support the benefits accrued to most vulnerable children. In the context of Tanzania’s endemic poverty and weak health infrastructure, CHF cards are found to be a desirable means for improving access to health services under the Jali Watoto and Global Fund OVC programs. However, internal barriers related to implementation and external barriers, such as the existing government CHF framework, continue to undermine the potential value of free CHF cards. Ultimately, CHF cards are not a magic bullet and could be strengthened if provided in conjunction with Pact’s other components, such as economic strengthening and education, to ensure sustainability. Moreover, the geographic breadth of the two programs and the significant variance found in CHF program implementation in the districts visited suggests that while Pact’s decentralized approach has advantages, continued capacity building of stakeholders and a
standardized monitoring and evaluation system would help ensure uniform quality across all project sites.

IV. RECOMMENDATIONS

A. Implementation

Improve information sharing and dissemination among partners

Local partners are one of the most critical elements to implementation of Pact’s CHF card program. Since they have a direct connection to the beneficiaries, as well as a close tie to the MVCCs, village volunteers, health providers, and even government officials, they can serve as a powerful linkage between all stakeholders involved in the program. With the right tools and knowledge, they have the potential to ensure that the most vulnerable children and their families are well informed and best supported throughout each district. However, as described in the findings section of this report, there are vast discrepancies in the ways in which partner organizations are implementing their programs and disseminating information, which has an effect upon the use of CHF cards by beneficiaries.

Guidelines for partner organization’s implementation of the CHF card program should be more unified amongst districts, as well as between the Jali Watoto and Global Fund program. We recommend for a toolkit to be designed for Pact partner organizations that are involved with the CHF card program, similar to the Guidelines for Service Providers in Villages and Streets, designed for the Jali Watoto program, but with more detail regarding the CHF card component. Such a toolkit may include: requirements for distributing cards to families or health providers; recommendations for card renewal processes; measures for distributing photos to children and families (or health care facilities); and sample monitoring and evaluation techniques and forms.

Exchange visits should take place between partner organizations to share lessons learned and various CHF implementation techniques. Through monitoring the activities of partner organizations and direct interaction, Pact Program Officers are able to identify which organizations in their region are executing the CHF card program component most effectively. Those high-performing organizations, as well as organizations that are more nascent or have not had as much success with CHF, may participate in exchange visits for several days to share experiences and lessons learned. Organizations can discuss implementation techniques, monitoring and evaluation systems, and challenges they have faced with CHF. Exchange visits do not need to be limited to a single program, as particular partners within Jali Watoto or Global Fund may still be able to learn from one another.

Building the Capacity of Other Stakeholders

A key component of Pact’s work globally is capacity building of local stakeholders. In the Jali Watoto and Global Fund programs, three stakeholder groups critical to the project’s success are village volunteers, MVCCs, and health providers. These groups are often the beneficiaries’ closest contact with the project and will be the first to respond should...
problems with the card’s usage arise. As such, they must be both educated and empowered to supply their key support role. However, findings show that some MVCCs, village volunteers, and health providers still lack critical competencies for serving their communities and lack a solid understanding of the CHF program.

**Increase training for village volunteers and the MVCCs to ensure they understand their role and the CHF card system.** Village volunteers and MVCCs, when empowered to fulfill their roles as service providers to and advocates for vulnerable children in their community, can be a powerful and sustainable component of the program. In order to fulfill that role, they must have adequate training and support from Pact and its partners. Education about CHF should be a central part of that training as MVCCs and village volunteers did not universally understand the CHF scheme, its benefits, or how to access them. Support for these two critical groups could take the form of formal trainings, mentorships from Pact or partner staff, or exchange visits with successful volunteers and MVCCs in other districts.

**Educate health providers about how the CHF card system works and how best to support cardholders in accessing services.** Confusion among health providers about how to implement CHF, what services are covered, and how referrals are handled is particularly destructive to the program’s success since it leaves beneficiaries without an informed authority to direct their health services and card usage. Unless health providers are educated advocates for cardholders, usage rates and the quality of services will suffer and health providers may refuse services to someone who could be benefiting from the card. Pact should mobilize partner organization staff or village volunteers and MVCC members to travel to health centers and dispensaries to sensitize the staff about CHF and working with cardholders.

**F. New Directions / Innovative Approaches**

While some existing aspects of implementation can be modified for greater effect, Pact may also consider undertaking some new approaches to program implementation. The following recommendations are offered to Pact with the idea that Pact has the opportunity and capacity to grow the positive impact of the CHF card through targeted new approaches.

**Consider a subsidization plan for CHF cards.** As Pact reallocates funding, with the potential for an overall decreased lump sum for CHF cards, it is recommended that Pact explore the introduction of a partial subsidization of CHF cards. Subsidies could be offered to program beneficiaries after their first card (fully funded by Pact) expires, at a rate relative to the rate of user fees and considering the capacities of different beneficiaries. This would not only allow Pact to stretch funding further, but would also leverage the commitment of most vulnerable households in supporting themselves. Ultimately, this could allow people the opportunity to evaluate whether CHF was worthwhile and help to

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11 While further research would need to be conducted to inform implementation of this recommendation, cursory research suggests that subsidization of insurance for the poor in other sub-Saharan African countries by the Dutch NGO PharmAccess is being provided at 85-90% of the cost of buy-in to the scheme.
increase sustainability by setting people on track towards covering an increased share of the card cost on their own.

**Develop information communication materials to be posted at health facilities.** Clear documentation of rules about CHF card usage would contribute to increased knowledge among cardholders as to what they were entitled to wit their cards. It is hoped that with more information, cardholders would seek care more freely and have greater efficacy in advocating for their health care rights. It is recommended that Pact develop information communication materials and work with the local and district-level governments to post this information at all facilities where the CHF card is accepted. This may also contribute to an increased understanding by health care providers who have confusion over what the CHF card covers.

C. **Advocacy**

In the decentralized context of Tanzania, where significant responsibility has been delegated to local government structures, CSOs are in a position to influence policy-making and inform government operations. Already, Pact’s local partners work with local government authorities in the identification of most vulnerable children and, through their collaboration with MVCCs, in community mobilization and outreach. However, MVCCs and volunteers have a marginal role in local decision-making and, as these findings reveal, are in many cases poorly informed and lack the organizational capacity to effectively advocate for the most vulnerable children they support. Yet, as community-selected and highly motivated (especially in the case of volunteers) individuals, well-informed of the needs of the children they support, MVCCs and volunteers could play a stronger role in providing feedback to the local government on the CHF program’s effectiveness and in mobilizing the community to support most vulnerable children and CHF. Pact can, in turn, take on the role of catalysts for more civic engagement on the part of CSOs, MVCC members, and volunteers. The following are our recommendations:

**Invite government authorities to attend MVCC, volunteer and local partner trainings** and speak on issues related to CHF card use and implementation, allowing for a question and answer period following the training. In addition, if targeting more senior level authorities, we recommend that Pact and its partners invite government officials as guests of honor to attend a closing ceremony. Their attendance would facilitate information-sharing between MVCCs and local government authorities, encourage buy-in to the program, and build trust between the government and community stakeholders. Opportunities to increase interaction between civil society actors and the government should not be lost since this can build the foundation for future cooperation.

**Form an MVCC advisory committee composed of key stakeholders,** including MVCC members, volunteers, caretakers, and health providers, that would meet regularly to provide input on policies and implementation. Pact’s Learning Groups, held in July of 2008, were successful in developing linkages between these stakeholders and are a step towards creating a more sustainable, government-organized advisory group. Pact’s partners, who already have good relationships with ward and local authorities, can be instrumental in advocating for this to happen.
Create Public Expenditure Tracking Systems (PETS) to increase information flow between the government, communities, and other stakeholders would increase accountability and respond to strong demands we heard among several health providers for more transparency in the management of CHF. PETS, which has already been implemented by Pact under another Program in Tanzania, could have a deep impact on the Tanzania health system if applied in conjunction with the CHF card program. Currently, money collected through CHF at health facilities is routed to the district level health department. Health providers are not given information or invited to provide feedback on how CHF money is redistributed among health facilities or how it is spent. If health providers and communities could monitor how CHF funds were being used and were given the opportunity to discuss spending priorities, the benefits of CHF membership would be more evident and the link between CHF and better quality health services more tangible.

D. Future Research

Although this evaluation of CHF card implementation, under Pact Tanzania’s OVC programs, was conducted to provide readers with a broad understanding of issues related to CHF card use, project implementation, and sustainability, there remain areas of research that the evaluation team did not explore due to time and budget constraints.

Cost-benefit analysis

One of the suggested areas of future research is to conduct a cost-benefit analysis of CHF cards under Pact’s two social sector programs. Although we know that beneficiaries largely value the cards for the free access to health services they enjoy, it remains uncertain whether Pact could have a greater impact on the health of most vulnerable children through other, more cost-efficient means. A cost-benefit analysis, which would involve extensive interviews with card holders, would find the monetary value of the benefits of and costs to owning and using a CHF card. By measuring how much benefit is being generated for children and caregivers and at what cost, it would be possible to compare health services based on quantifiable data. Measuring benefits and costs in this way would, in turn, provide information on why CHF cards may be more effective in some districts than others. Armed with this knowledge, Pact could make informed decisions on where to expand CHF card activities and where to pursue other health strategies. For example, if the cost of transportation to the nearest health facility (both actual and opportunity) is very high in one district, to the point that they outweigh all perceived and actual benefits of owning a CHF card, it is likely that Pact’s impact on improving health will be minimal there.

Understanding of people’s willingness to pay for CHF cards

Willingness-to-pay (WTP) surveys have been used in the past to gauge demand for membership in social insurance schemes. Examples exist from China, India, and in countries in West Africa. These surveys have been used to determine the price of insurance schemes, but could be utilized if Pact pursues partial subsidization of CHF cards. One approach of WTP is “bidding.” In this scenario, the interviewer explains the insurance scheme to study participants and participants are asked if they are willing to pay a certain amount for their household to be included in the social insurance plan. Starting prices can
be selected randomly at each interview within a specific range of prices, relative to the actual price of the scheme. If participants respond ‘no,’ the interviewer reduces the asking price by incremental amounts, continuing to do so until the participant responds ‘yes.’ Alternatively, if the participant initially responds ‘yes,’ the interview raises the asking price in pre-determined increments until the participant responds ‘no.’

Economic strengthening and health seeking behavior

A third suggestion for further research is assessing the effect of economic strengthening on health seeking behavior, specifically whether resources generated through income generating activities are ultimately applied to health services. Several of Pact’s partner organizations are implementing income generating activities for most vulnerable households, with the goal of enabling these households to provide for their own needs, including their health needs, in the future. While successful efforts in income generation can generally yield important gains at the household level, in particular for most vulnerable households, future research would be useful in informing whether these activities generate resources that people apply specifically to health services. Whether income generation activities can be introduced as a way to mobilize health resources could help Pact gain better insight into how to integrate a capacity building component into their health interventions.

Alternative methods to pool funding from private and public sources

Particular districts in Tanzania may be conducive to alternative sources of funding CHF cards rather than strictly relying on a household’s purchase of the card. One mode of funding could be through public private partnerships, depending upon the capacity of the private sector in a district. Private companies have a vested interest in the health of the communities where they operate, thus could be enticed to partially fund CHF cards even for vulnerable members of a community who are not able to work, as well as their own employees. Additionally, private entities may not be the only outlet for alternative means of funding; Associations, Religious Groups, and Village Councils could also raise funds from members to support the purchase of cards for MVCs in their community. Finding alternative funding sources is critical to the sustainability of the CHF program, and would enable communities to depend less on outside assistance and international NGOs.
References


Appendices
Appendix A

Research Methodology

<table>
<thead>
<tr>
<th>Method</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-on-one semi-structured</td>
<td>• Beneficiaries (children &amp; parents)</td>
</tr>
<tr>
<td>interviews</td>
<td></td>
</tr>
<tr>
<td>Focus Group Discussions</td>
<td>• Beneficiaries (children &amp; parents)</td>
</tr>
<tr>
<td></td>
<td>• MVCC/Village Volunteers</td>
</tr>
<tr>
<td>Key Informant Interviews</td>
<td>• Government representatives</td>
</tr>
<tr>
<td></td>
<td>• Health providers</td>
</tr>
<tr>
<td></td>
<td>• MVCC/Village Volunteers</td>
</tr>
<tr>
<td>Partner Organization Survey</td>
<td>• Pact partner organizations in JW and GF program (71 surveys)</td>
</tr>
</tbody>
</table>
Appendix B

Study Objective Framework
### Objective 1: To identify the different ways in which the CHF scheme is being administered by the Government of Tanzania in various districts throughout the country.

1. Gather information from government representatives at the district and local level, primarily: who can use card; where can card be used; what services are covered under card
   - Key informant interviews with government in each of five districts
   - GWU team; Pact partner organizations

2. Gather information from Pact partner organizations to understand how they are implementing the CHF card program
   - Partner organization survey
   - GWU team; Pact program officers; Partner organizations

3. Gather information from Pact program officers and other staff regarding impressions of differences in program implementation
   - Informal discussions
   - GWU team; Pact program officers

### Objective 2: To document the benefits of and barriers to using CHF cards, as experienced by most vulnerable children households.

1. Document intended use of CHF cards by GoT, in terms of ability to positively impact health
   - Literature research
   - Key informant interviews with government representatives
   - GWU team; government officials

2. Understand the extent to which families are using (or not using) their CHF cards
   - Interviews with children/parents/caretakers
   - Focus group discussions with children and parents/caretakers
   - GWU team; partner organizations; parents/caretakers; children

3. Identify the benefits (regarding health and well-being) and barriers of CHF card?
   - What are the perceived benefits by beneficiaries? By other stakeholders?
   - Interviews with children/parents/caretakers
   - Focus group discussions with children and parents/caretakers
   - Key informant interviews with health care providers
   - Focus group discussions with MVCC and village volunteers
   - GWU team; parents/caretakers; children; health care providers; MVCC and village volunteers
beneficiaries? By other stakeholders?

- What are the perceived internal barriers (directly related to project implementation) by beneficiaries? By other stakeholders?

**Objective 3:** To evaluate the impact of project implementation on the use of CHF cards by beneficiaries.

1. Compare implementation approaches by partner organizations across districts
   - Partner Organization Survey
   - Discussions with Pact staff
   - GWU team; partner organizations; Pact program officers

2. Identify the benefits and barriers related to project implementation. (same as above)
   - Interviews with children/parents/caretakers
   - Focus group discussions with children and parents/caretakers
   - GWU team; partner organizations; parents/caretakers; children; translators

**Objective 4:** To determine the level of demand for CHF cards on the part of the most vulnerable children and households with whom Pact works.

1. Explore people’s willingness to purchase the CHF card on their own
   - Interviews with parents/caretakers
   - GWU team; partner organizations; translators

2. Identify other health services that people would prefer to the CHF card
   - Interviews with children/parents/caretakers
   - Focus group discussions with children and parents/caretakers
   - Focus group discussions with MVCC and village volunteers
   - GWU team; parents/caretakers; children; MVCC and village volunteers; partner organizations; translators

**Objective 5:** To identify advocacy issues for partners to take up with local district health care administrators, as well as with the Ministry of Health for overall improved health of most vulnerable children.

1. Identify the benefits and barriers related to external (to the project) causes
   - Interviews with children/parents/caretakers
   - Focus group discussions with children and parents/caretakers
   - Key informant interviews with health providers and government representatives
   - GWU team; parents/caretakers/children; health providers; government; partner organizations; translators
Appendix C

Survey Tools

a. Questions for Caretakers (including parents, grandparents, relatives, child heads of household and other caretakers)
b. Questions for Children (13 - 18 years old)
c. Focus Group for Children (13-18 years old)
d. Questions for Village Volunteers
e. Questions for MVC Committees
f. Questions for Government Officials
### a. Questions for Caretakers (including parents, grandparents, relatives, child heads of household and other caretakers)

<table>
<thead>
<tr>
<th>Date:</th>
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<tbody>
<tr>
<td>District/Region:</td>
</tr>
<tr>
<td>Names of Interviewers:</td>
</tr>
</tbody>
</table>

#### General Information

- **Interviewee ID:**
- **Gender:**  
  - Male
  - Female

#### Usage of the CHF Card

1. In what year were you born?

2. Can you tell us what a CHF card is?

3. Who in your household can use the CHF card? Who cannot use the CHF card?

#### Usage of the CHF Card

4. Do you know what you need to do when it comes time to renew the card? *(Have them describe the process)*

5. What free health services can you get with your CHF card? Please say **Yes** / **No** / **I don’t know** for each of these services:
   - Drugs/Medications ______
   - Family Planning ______
   - VCT ______
   - Immunization ______
   - Prenatal care ______
   - Are there others? ______

6. What free health services can you **not** get with your CHF card? Please list:
7.  Where do you go to use your CHF card?  

8.  Is this the same place where you normally go when you are sick?  
   - Yes  
   - No  

9.  Have you received any kind of medication with your CHF card?  
   - No  
   - Yes  

   **Where do you get the medication?**  
   - The health provider at this facility provides it to me.  
   - At a pharmacy  
   - Other: ____________________________  

10. Have there been times when you were sick and did not use your CHF card? Why and please describe.  

### Accessibility of Services  

11. How far do you live from the nearest health facility that accepts a CHF card?  
   _____ km  

12. How much does it cost you to get to that health facility?  

13. Now I am going to read you a list of some of the possible problems that might make using your CHF card difficult. For each one that I read to you, please tell me if you think these problems have a **large**, **small**, or **no effect** on your decision to seek services.  

   a. Cost of transportation to a health facility that accepts CHF cards  
      - Large  
      - Small  
      - No effect  

   b. The time it takes to get to a facility that accepts CHF cards  
      - Large  
      - Small  
      - No effect  

   c. Taking time away from work or duties around the house  
      - Large  
      - Small  
      - No effect  

   d. Time you spend waiting before seeing a provider  
      - Large  
      - Small  
      - No effect  

   e. Availability of female health providers  
      - Large  
      - Small  
      - No effect  

14. Are there any other problems that you can think of that make it difficult to use your CHF card?  

15. When you go to a health facility that accepts CHF cards, do you  
   - Yes  
   - If yes, what do you pay for:
<table>
<thead>
<tr>
<th><strong>Satisfaction with Services/Quality</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Are you satisfied with CHF card services?</td>
</tr>
<tr>
<td>17. When you or someone in your family goes to the health centre where you can use your CHF card, do you feel respected by the provider?</td>
</tr>
<tr>
<td><strong>Probe Questions:</strong></td>
</tr>
<tr>
<td>Do you feel comfortable asking questions to the staff at the health centre/dispensary?</td>
</tr>
<tr>
<td>Do you feel they spend enough time with you?</td>
</tr>
<tr>
<td>18. What is your opinion of the providers who accept CHF cards?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Benefits of Cards</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Please share with me the things that you like about having a CHF card compared to when you did not have a CHF card?</td>
</tr>
<tr>
<td><strong>Probes Questions:</strong></td>
</tr>
<tr>
<td>Do you feel that you can go to the health center more often / whenever you need?</td>
</tr>
<tr>
<td>Do you feel that you have better access to medicines?</td>
</tr>
<tr>
<td>Are you less fearful about what would happen if you or someone in your family has a health emergency?</td>
</tr>
</tbody>
</table>
| 20. Do you think that having a health card has improved your health?  
Improved your children’s health? |
| 21. Do you think that there are other health services that would be more helpful to you and your family than having a health card? |

<table>
<thead>
<tr>
<th><strong>Program Questions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Do you receive visits by village volunteers (or MVC committee)? How often?</td>
</tr>
<tr>
<td>23. What kind of support does the village volunteer (or MVC committee) provide to you? Have these services been useful to you? Please explain.</td>
</tr>
</tbody>
</table>
24. How do you communicate your needs to the village volunteers?

25. Do volunteers ever come with you to the health facility?

26. If the CHF card was not free, would you spend your own money to buy a CHF card?

Those are all the questions that I have for you today. Is there anything else that you would like to share with me about your experience with the CHF card or about anything else we talked about today?

Thank you very much for taking the time to talk with me today. Your participation has been very helpful.
# b. Questions for Children (13 - 18 years old)

<table>
<thead>
<tr>
<th>Date:</th>
<th>District/Region:</th>
</tr>
</thead>
</table>

Names of Interviewers:

**General Information**

<table>
<thead>
<tr>
<th>Interviewee ID:</th>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

13. How old are you?  
_Probe: How old were you at your last birthday?

<table>
<thead>
<tr>
<th>Year:</th>
<th></th>
</tr>
</thead>
</table>

**Usage of the CHF Card**

Ok, now I am going to ask you some questions about the kind of health services you use and about CHF cards. I want to remind you that your responses will be used to help us understand if the CHF cards are helpful to you. So, it will be most helpful if you answer the questions as honestly as you can.

14. Do you have a CHF (health services) card?  

15. Do you know what a CHF card is? Can you describe to me what you think it is?

If no awareness or knowledge of CHF card after probe, skip to #4

16. Who in your family is responsible for the CHF card?  

- [ ] A sibling  
- [ ] Mother  
- [ ] Father  
- [ ] Grandparent  
- [ ] Caretaker: name: _______________  
- [ ] Other

17. Where do you go when you are sick?  

- [ ] Health centre  
- [ ] Dispensary  
- [ ] Private provider  
- [ ] Public hospital  
- [ ] Private hospital  
- [ ] Traditional healer  
- [ ] Other: __________

18. Have you ever used your CHF health card?  

- [ ] No  
- [ ] Yes

19. Why did you use your card?  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
**Probe: What kind of services did you use?**

<table>
<thead>
<tr>
<th>20. Could you tell me about any times when you went to see a doctor or nurse, but did not use your CHF card? Please describe the situation and tell me why you did not use your card.</th>
<th>Describe:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Did someone have to pay for this?</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Yes → Who paid? __________</td>
<td></td>
</tr>
<tr>
<td>☐ No</td>
<td></td>
</tr>
</tbody>
</table>

| 21. Have there been any times where you were sick or needed medicine, but did not go to see a doctor or nurse? If yes, please describe the situation and tell me the reason you did not go to see the doctor or nurse. | |

**Accessibility of Services**

<table>
<thead>
<tr>
<th>22. When you go to the health facility, does someone in your household usually accompany you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A sibling</td>
</tr>
<tr>
<td>☐ Mother</td>
</tr>
<tr>
<td>☐ Father</td>
</tr>
<tr>
<td>☐ Grandparent</td>
</tr>
<tr>
<td>☐ Caretaker: name: _______________</td>
</tr>
<tr>
<td>☐ Village volunteer or MVCC member</td>
</tr>
<tr>
<td>☐ Go alone</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
</tbody>
</table>

**Probe: What about someone that does not live in your household? (note under other)**

**For 15-18 yr. olds:**

*Now I am going to read you a list of some of the possible problems that might make using your CHF card difficult. For each one that I read to you, please tell me if you think these problems have a large or small effect on your decision to go to the doctor or nurse at a place that accepts CHF cards, or if you think that they do not have any effect. The first one is…*

<table>
<thead>
<tr>
<th>23. Cost of transportation to a health facility that accepts CHF cards.</th>
<th>☐ Large ☐ Small ☐ No effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Distance to a facility that accepts CHF cards.</td>
<td>☐ Large ☐ Small ☐ No effect</td>
</tr>
<tr>
<td></td>
<td>How far away do you live from the health facility that accepts CHF cards (km)? __________</td>
</tr>
<tr>
<td>25. Time you have to spend waiting before being seen at a facility that accepts CHF cards.</td>
<td>☐ Large ☐ Small ☐ No effect</td>
</tr>
<tr>
<td>26. There is no one to go with you to a facility that accepts CHF cards and you did not want to go alone.</td>
<td>☐ Large ☐ Small ☐ No effect</td>
</tr>
</tbody>
</table>
27. (For female respondents) Availability of female health providers at the facility that accepts CHF cards.

<table>
<thead>
<tr>
<th></th>
<th>Large</th>
<th>Small</th>
<th>No effect</th>
</tr>
</thead>
</table>

28. Are there any other problems that you can think of that make it difficult to use your CHF card?

29. When you go to a health facility that accepts CHF cards, have you or the person that took you to the facility ever had to pay any costs even when you have your CHF card?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Explain:</th>
</tr>
</thead>
</table>

(Probe for what type of services they had to pay for and what type of services were given for free with the card.)

**For under 15yrs.**

30. Are there any things that make it difficult to go to see the doctor or nurse/the health services? Please explain:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Explain:</th>
</tr>
</thead>
</table>

**Satisfaction with Services/Quality**

Now I am going to ask you about what you think about the quality of services you receive with your CHF card.

31. When you use your CHF card, are you happy with the services that you receive? Please describe.

32. When you go to the health facility where you can use your CHF card, how long do you typically have to wait before the health provider sees you?

33. When you go to the health facility where you can use your CHF card, are the providers nice to you?

*Probe Questions:*

*Do you feel comfortable asking questions to the staff at the health centre/dispensary?*

*Do you feel they spend enough time with you?*
If you have questions, do the staff at the health centre/dispensary try to answer your questions?

Do you feel that you are treated differently than people that do not have CHF cards?

34.

Benefits of Cards

The next questions have to do with what you think the value of the CHF card is and whether the services you receive with your card are important to you.

For 15-18 year olds:

35. Do you currently take any kind of medication?
   
   Probe: Is the medication covered by the CHF card?

   - [ ] No, I do not take any medication.
   - [ ] Yes, I take medication that is covered under the CHF card.
   - [ ] Yes, I take medication that is NOT covered by the CHF card.

   Is the medication available?
   - [ ] Yes, it is always available.
   - [ ] No, it is never available
   - [ ] It is sometimes available → Describe:

36. Please describe to me your opinion of the overall experience of going to see the doctor or nurse when you use your CHF card?

37. What do you like about having a CHF card?

   Probe: Has anything about your health changed since you got the card?

38. Do you think that there are other health services that would be more helpful to you than having a health card?

Program Questions

Next I am going to ask you a few questions about the MVCC/village volunteers that are working in your community. The first question is...

39. Do you know who the MVCC/village volunteers in your community are?
   Can you explain to me how they help you and the people in your
household?

**Probes:**

*Do you know how often the MVCC/village volunteers visit your home?*

*What kind of things does the MVCC/village volunteer do for you? Has this been useful to you? Please explain.*

*Do you ever talk to the MVCC/village volunteers about certain needs that you have?*

Those are all the questions that I have for you today. Is there anything else that you would like to share with me about your experience with the CHF card or about anything else we talked about today? Do you have any questions for me?

Thank you very much for taking the time to talk with me today. Your participation has been very helpful.
### Focus Group for Children (13-18 years old)

**Date:**

**District/Region:**

**Names of Interviewers:**

### General Information

**Interview ID number:**

1. What do you do when you are sick?

2. Do you know what a CHF (health services) card is?

3. Have you ever used your CHF (health services) card?
   
   **Prompt: How many times?**

4. When you go to a health provider, does anyone go with you? Who?

5. How do the health providers help you?

6. Are the health providers nice to you?
   
   **Prompt: Did they spend enough time with you?**

   **Did you feel comfortable asking questions?**

   **Do you think they treated you any differently than other kids who don't have CHF (health services) cards?**

7. Did they make you feel better?

8. Do you have any brothers and sisters? Do they have health cards? Do they use the same card you do?

9. Have you ever been sick and not gone to the health provider? Why?

10. What makes it hard to go to the health provider?
   
   **Prompt: Does it take a long time to get to the hospital?**

   **Do you always have someone to go with you?**
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Do you have to wait a long time once you get there?</td>
<td></td>
</tr>
<tr>
<td>11. How do your village volunteers/MVCC members help you?</td>
<td></td>
</tr>
<tr>
<td><strong><strong>Prompt: Do you know who they are?</strong></strong></td>
<td></td>
</tr>
<tr>
<td>Do they visit you in your home? How often?</td>
<td></td>
</tr>
<tr>
<td>Do they ever go with you to the health provider?</td>
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</tr>
<tr>
<td>What kind of services do they provide you?</td>
<td></td>
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<tr>
<td>Do you ever tell them about problems you are having? How?</td>
<td></td>
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<tr>
<td>12. If you remember a time before you had your CHF (health services) card, what did you do when you were sick?</td>
<td></td>
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</table>
## d. Questions for Village Volunteers

<table>
<thead>
<tr>
<th>Date:</th>
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<tr>
<td>District/Region:</td>
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<tr>
<td>Names of Interviewers:</td>
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### General Information

**Interview ID number:**

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
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</table>

1. What kind of training did you receive from Pact or a partner organization? Was it useful?

2. Did Pact provide you with a book of guidelines for your work?

3. Do you use it?

4. Is it helpful?

5. What is the needs assessment tool that you use? Where did you learn how to use it?

6. When you did the needs assessment, what kinds of needs were you looking for among MVCs?

7. What kinds of services do you personally provide for MVCs and their families?

8. How often do you visit MVCs in their homes? What other ways do you have of communicating with them and their families?

9. Who is responsible for educating the families about their CHF (health...
<p>| | |</p>
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<tbody>
<tr>
<td><strong>services) card and how to use it?</strong></td>
<td></td>
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<tr>
<td><strong>Probe:</strong> Do you have any role in educating the families about their cards or in encouraging them to use services?</td>
<td></td>
</tr>
<tr>
<td>10. Have you ever accompanied MVCs to health care services?</td>
<td></td>
</tr>
<tr>
<td>11. To your knowledge, are MVCs treated well when they go to the health center?</td>
<td></td>
</tr>
<tr>
<td>12. How do you think having a CHF (health services) card helps the families with whom you work?</td>
<td></td>
</tr>
<tr>
<td>13. Do you think the CHF program is effective at achieving its goals?</td>
<td></td>
</tr>
<tr>
<td>14. What other health interventions do you think could be more useful to MVCs and their families than the CHF (health services) card?</td>
<td></td>
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</tbody>
</table>
### e. Questions for MVC Committees

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td><strong>Date:</strong></td>
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<td><strong>District/Region:</strong></td>
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<td><strong>Names of Interviewers:</strong></td>
<td></td>
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<tr>
<td><strong>General Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Interview ID number:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Gender:**  
  - [ ] Male  
  - [ ] Female                                                                                                                                                          |        |
| 13. How is your committee made aware of which community members / MVCs need support?                                                                                                                                                  |        |
| 14. Do you believe that the MVCs in your community were correctly identified?  
  *Probe: Are there MVCs the District Council missed?*                                                   |        |
| 15. Is the community able to support MVCs without outside assistance?                                                                                                                                                                |        |
| 16. How does knowing that an international organization is involved in supporting the MVCs in your community affect your communities’ willingness to support them?                                           |        |
| 17. What are you providing for MVCs in your community?                                                                                                                                                                      |        |
| 18. Where are you getting resources from the community to support MVCs?  
  *Probe: Are there individuals/groups who give financially?*  
  *Are there individuals/groups who give in-kind support?*                                                                                                      |        |
| 19. Why do you think those who supply resources for you choose to do so?                                                                                                                                                   |        |
| 20. How do you support MVCs in your community without further stigmatizing them?                                                                                                                                   |        |
| 21. What has the committee’s involvement been like with Pact or their partner organization? Were you trained, educated, or consulted by Pact or one of its partners?                                   |        |
### f. Questions for Government Officials

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Date:</td>
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<tr>
<td>District/Region:</td>
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</tr>
<tr>
<td>Names / Titles of Interviewers:</td>
<td></td>
</tr>
<tr>
<td><strong>General Information</strong></td>
<td></td>
</tr>
<tr>
<td>Gender: Male/Female</td>
<td></td>
</tr>
<tr>
<td>1. Are the most vulnerable populations accessing health services in your district? What about orphans and vulnerable children?</td>
<td></td>
</tr>
<tr>
<td>2. If so, what are the programs / initiatives that are enabling this?</td>
<td></td>
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<tr>
<td>3. If not, what are the barriers that the most vulnerable populations face when accessing health care?</td>
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</tr>
<tr>
<td>4. What, in your view, is the ultimate goal of the community health fund / CHF program?</td>
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<tr>
<td>5. What kinds of services is a child able to access through the CHF?</td>
<td></td>
</tr>
<tr>
<td>6. What services are they not able to access?</td>
<td></td>
</tr>
<tr>
<td>7. How are you planning on improving this access?</td>
<td></td>
</tr>
<tr>
<td>5. Is the CHF program enabling better access to health care? Specifically for OVCs?</td>
<td></td>
</tr>
<tr>
<td>6. Do you have other recommendations about how to ensure that vulnerable and poor families are able to access health care services in relation to the CHF program? Specifically in terms of prevention, treatment, and access to services (ie, transportation).</td>
<td></td>
</tr>
<tr>
<td>7. How would you like the government to be more involved in serving the needs of the most vulnerable in your community?</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D

Project Implementation Diagram
Appendix E

Breakdown of CHF Card Use in Districts Visited
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th># of people covered by card</th>
<th>Where CHF card can be used</th>
<th>Types of services NOT covered</th>
<th>Description of CHF Card</th>
<th>Maximum cost of health services covered per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MOROGORO URBAN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>One child per card; within next 6 months, CHF should be expanded to all government facilities in the district (only project beneficiaries)</td>
<td>None</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Health Providers</td>
<td>One child per card Regional Hospital (only project beneficiaries)</td>
<td>None</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Caretakers</td>
<td>One child per card At regional hospital; some had tried using it elsewhere and had been turned away</td>
<td>None</td>
<td>Many cards do not have a photo.</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td><strong>MOROGORO RURAL</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Government</td>
<td>Up to 10 people Health dispensaries and health centers in district but NOT at the District hospital</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>No limit</td>
</tr>
<tr>
<td>Health Providers</td>
<td>---- Heath dispensaries and health centers in district but NOT at the District hospital</td>
<td>All services at dispensary and health center. However, disagreement about what services at the District/Regional Hospital are covered: some are saying no services are covered, some say certain services at Regional, for instance x-ray.</td>
<td>Faraja purchased photos</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Caretakers</td>
<td>Some said only children can use the card; one said that only up 5 people per household could use the card Some thought they could only use the card at the health center, not at the dispensary</td>
<td>None</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Stakeholder</td>
<td># of people covered by card</td>
<td>Where CHF card can be used</td>
<td>Types of services NOT covered</td>
<td>Description of CHF Card</td>
<td>Maximum cost of health services covered per visit</td>
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<tr>
<td><strong>IRAMBA</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Government</td>
<td>Up to 10 people; both adults and children</td>
<td>All government health facilities; to go to district hospital must pay 1,000 TZS and have a referral.</td>
<td>In-patient services</td>
<td>Cards do not have photos so they use lists they have.</td>
<td>No limit</td>
</tr>
<tr>
<td>Health Providers</td>
<td>Up to 10 people</td>
<td>----</td>
<td>In-patient services</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Caretakers</td>
<td>All children; some confusion about whether adults could use it</td>
<td>Dispensary, health center, and referrals to hospital</td>
<td>Inpatient services, referrals to Regional Hospital</td>
<td>no photos; pictures were taken but have not been distributed; some said they need a receipt to use services</td>
<td>----</td>
</tr>
<tr>
<td><strong>NZEGA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>Up to 10 people</td>
<td>All health facilities</td>
<td>none</td>
<td>----</td>
<td>30,000 TZS</td>
</tr>
<tr>
<td>Health Providers</td>
<td>----</td>
<td>All health facilities</td>
<td>none</td>
<td>Most don’t have a photo.</td>
<td>----</td>
</tr>
<tr>
<td>Caretakers</td>
<td>In some cases, more than 6 people</td>
<td>Dispensary, health center, and district hospital with referral</td>
<td>none</td>
<td>Only 1 name on the card; other users have their names at the health facility. Need a receipt</td>
<td>No limit</td>
</tr>
<tr>
<td>Stakeholder</td>
<td># of people covered by card</td>
<td>Where CHF card can be used</td>
<td>Types of services NOT covered</td>
<td>Description of CHF Card</td>
<td>Maximum cost of health services covered per visit</td>
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<tr>
<td>IGUNGA</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Government</td>
<td>Up to 10 people</td>
<td>Dispensary, health center, and district hospital with referral. One private facility included in coverage</td>
<td>none</td>
<td>----</td>
<td>30,000 TZS</td>
</tr>
<tr>
<td>Health Providers</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Caretakers</td>
<td>----</td>
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</table>
Appendix F

Map of Study Sites

Program Activities 2008

Key
- Global Fund OVC Program
- BONGA PETS Activity
- WORTH
- Jall Watoto Initiative and Aid Stigma Campaign

Region Name
Appendix G

Literature Review

This literature review was conducted in July – August 2008 by The George Washington University Capstone team. It covers existing literature concerning community health insurance as a risk sharing strategy, the different models used, the major players in the field, the achievements of this strategy, and its ongoing challenges. The review is not specific to the Community Health Fund, or to Tanzania, but was important in the team’s initial research on health financing; offering a strong foundation from which the CHF scheme was understood. The literature review is included in this report to provide general background on community health financing for those interested in a broad review of literature.
Community-based Health Insurance as a Risk-sharing Strategy

Literature Review

By:
Charles Guedenet
Stephanie Marienau
Beth Rogers-Witte
Christina Stellini

August 28, 2008
Ensuring that the world’s poorest people have access to quality and affordable health care has been an elusive goal for developing world governments, international organizations, and donors. Though the poor bear a much greater share of the global disease burden than do wealthy nations, the resources expended for health in low and middle income countries is comparatively low, encompassing only 11% of global health spending (Preker et al 2002). This low number is easily accounted for when one considers that developing governments often lack the necessary resources to spend on health and that poor families living in these countries also do not have an adequate income to pay for the medical services they need.

An effective public financing mechanism is the ideal when it comes to providing health services to the poor, but is not always feasible. In countries where tax collection is low, governments must make difficult choices about where to spend their resources and the price tag on health care can be daunting. Estimates of the cost of providing universal access to health services vary widely, but all are high, ranging from US$25-50 billion to over US$100 billion (Preker et al 2002). Even those developing governments that do make health care a priority, struggle to meet the scale of their country’s needs.

In the absence of government or donor-provided health services, poor families often go without necessary medical care or sacrifice immensely to pay for it. For example, when families experience a negative event that leads to economic struggles, they must make difficult choices, such as reducing their food intake or pulling a child out of school (ILO/STEP-GTZ 2006). Thus, the lack of access to affordable health care is an economic development issue that can reinforce the cycle of poverty. Individuals cannot invest in businesses or educate the next generation if their savings is wiped out every time a family member falls ill. Sickness can lead to destitution and undermine future development efforts.

Informal social networks, like families and communities, are often the only source of reliable support in attaining access to medical care. When there is a health crisis, these groups can pool money to meet an individual’s need. This type of social safety net is critical to survival in the developing world, though its drawbacks are clear. Where poverty is widespread, even a large group of individuals may struggle to mobilize enough money to continually meet each others’ needs. In these environments, more formal risk-sharing strategies can be useful in harnessing the community spirit of sharing into a sustainable plan to reliably provide quality health care. One of the most promising of these strategies is community health insurance, a scheme that groups together a community to pay a small fee regularly, which is then used to pay for the medical costs of the members of that group.

In this paper, we review the existing literature concerning community health insurance as a risk sharing strategy, the different models used, the major players in the field, the achievements of this strategy, and its ongoing challenges. To begin, this report will situate community health insurance in context with an overview of the concept of risk-sharing and a brief examination of a few common examples of this principle.

**Risk-Sharing Strategies**
A risk-sharing strategy is any group agreement that requires participants to pool their resources and compensate those who suffer a certain hardship. Risk-sharing is more common in industrialized nations than it is in the developing world, and it is still rarer in lower income brackets within poor countries (Preker et al 2001). Risk-sharing can refer to any arrangement
where the potential for hardship is spread among a group of people to reduce its impact, whether that arrangement is car insurance in Iowa or village savings and lending in Zambia.

Though risk-sharing arrangements exist all over the world, for the purposes of this paper, we will discuss risk-sharing in environments with large populations who are poor and particularly vulnerable to risks. Government-run social protection programs may be aimed at similar goals, but the risk-sharing strategies we will discuss here involve community members themselves meeting each other’s needs. Risk-sharing happens in communities, but national governments can play a critical role in assisting the process by supporting the arrangement and subsidizing user fees for the poor (Preker et al 2001).

Social networks of families and neighbors have always been crucial in providing social safety nets for members of their community who meet hardship. Cash transfers or in-kind assistance may be offered at this point, with the implied assumption that the recipient will help the giver, should that person fall on hardship (ILO/STEP-GTZ 2006). This type of community assistance is indispensable for survival in families where one illness or unforeseen hardship could lead to destitution. Formal risk-sharing simply organizes the existing process of neighborly assistance into a sustainable plan for meeting a community's needs.

According to a document produced by the International Labor Organization (ILO), poor families experience insecurity when exposed to one or several types of risks. Natural risks like drought, economic risks like crop failure, life cycle risks like a death in the family, and health risks like disease, all pose threats to individuals who lack the resources or support to sustain a setback (ILO/STEP-GTZ 2006). The same article describes the “snowball effect,” the trend that many risks, like drought and crop failure, are linked and that negative events often arrive in groups (ILO/STEP-GTZ 2006). When hardships “snowball,” an individual’s ability to meet his or her own needs is further crippled.

To help individuals mitigate the effects of hardship, several risk-sharing schemes have been developed and are gaining in popularity. As there are many varieties of risk-sharing methods, this section will provide only an overview of what exists. In a 2002 bulletin of the World Health Organization, the best-known type of risk-sharing strategy, microfinance, is divided into subcategories for discussion of the uses of each type (Preker et al 2002). According to the report, microcredit, micro savings, and micro insurance each serve different functions, but they each involve organizing a group of people to spread one another's risk and financial challenges among themselves.

Microcredit, the most common type of microfinance, provides small loans to individuals or groups to permit them to operate businesses or invest in their land, thereby taking advantage of opportunities that they may not choose without a safety net to protect them in the case that the risk does not pay off. Microcredit can be a ladder out of poverty and also serves as a safety net in times of crisis, by providing support and resources during short-term shocks or natural disasters that might otherwise leave the family destitute.

Micro savings provides a way for individuals – who would not otherwise have access to financial services or the ability to open a bank account – to save money. These savings can then be used to invest in business expansion, land acquisition, payment of a child’s education, or to meet the costs of any number of unpredictable events like a marriage or a death in the family. These savings schemes can be conducted for individuals who choose to store up a portion of their income or for groups who pool their money and save it together. Like community health insurance, micro savings can help participants pay for their medical care when they use their savings for health costs.
Micro insurance allows participants to pay small amounts into an account or a group savings scheme. This strategy is most often implemented by an NGO or civil society organization for individuals who do not qualify for traditional types of insurance, such as workers in the informal economy. Other types of micro insurance, including disability, unemployment, crop failure, fire, and theft, are also being developed. Community health insurance is closely related with micro insurance.

Some other examples of risk-sharing include emergency or solidarity funds, which are paid for through community contributions and go to support members of the community who are experiencing hardship (ILO/STEP-GTZ 2006). Like other risk-sharing strategies, this method can be used to help participants who fall ill to meet their health care costs.

Risk-sharing strategies link groups of people together to mitigate the hardship associated with certain kinds of risks. In this paper, we focus on health-related risks. The next sections will review the literature concerning various models of health insurance as a type of risk-sharing strategy and then focus in on community-based health insurance in particular.

Risk-Sharing for Health

Donors, governments and non-governmental organizations have determined in recent years that health insurance mechanisms can close the gaps of health financing and assist poor and vulnerable populations in developing countries. Research around this issue has evolved in the last decades, with the knowledge that one of the major barriers to healthy populations is individuals and communities’ inability to pay for proper health care. One notable health insurance structure is private health insurance (PHI). PHI is becoming more prevalent in both developed and developing countries – even playing a greater role in Africa today. The aim of PHI is to increase financial protection and access to health services to those able to pay. The one major shortcoming of the mechanism is that it is considered particularly inequitable unless poor people are subsidized. PHI must be regulated or else can lead to “an escalation of costs, a deterioration of public services, a reduction in the availability of preventive health care services, and widening inequalities between poor people and those who are better-off” (Joint NGO Briefing Paper 9). Even in developed nations, the public sector is generally under funded, leading to slow and inequitable service provision.

An additional insurance scheme is private micro health insurance. Approximately 35 million people are covered by micro health insurance worldwide, which are offered by private institutions such as insurance companies or microfinance institutions. As opposed to private health insurance, micro health insurance specifically targets poor populations, even though both schemes are typically for-profit. Coverage often includes primary health care and hospital care, protecting users against catastrophic health expenditures. However, a major disadvantage of this type of scheme is that it still does not reach the poorest and most vulnerable populations.

Social health insurance (SHI) provides another option for risk-sharing of health related costs. SHI may, in fact, have the greatest potential to reach the most number of people of all the health insurance schemes (Joint NGO Briefing Paper 14). Nonetheless, SHI is usually not a practical option in many low-income countries where numerous barriers exist. SHI requires strong institutional and administrative capacities, particularly within revenue collection. Within SHI, membership is mandatory and premiums are set in proportion to income. Employers, workers and the government generally share the responsibility of payments into the system.
Even though people in the informal sector and the unemployed are generally disadvantaged within the SHI structures, some countries have tested SHI schemes that extend into the informal sector. Examples include Seguro Popular de Salud (SPS) in Mexico, Universal Coverage (UC) in Thailand and the National Health Insurance Scheme (NHIS) in Ghana (Joint NGO Briefing Paper 14). In Thailand, the UC structure offers any Thai citizen that does not fall within another insurance scheme full access to health services given by a designated network of providers. This structure developed over time and included decades of investment in rural areas, in primary health care centers, and in administrative systems to register participants.

**Community-Based Health Insurance as a Risk-Sharing Strategy**

**Overview of CBHI**

Community-Based Health Insurance (CBHI) is another option for risk-sharing of health costs and one of the many forms of community financing of health care. While there exist many variations in terms of populations covered, services offered, regulation, management functions, and objectives (Schieber et al 2006), CBHI schemes can be defined generally as small-scale health insurance, based on the concepts of mutual aid and collective pooling of health risks, where members make regular payments of a small premium to a common fund. The fund pays for members’ health care needs, with the goal of reducing direct payments at the point of service (Bennett et al 2004). Decision-making and management of the schemes are the responsibility of members themselves (Partners 2004; Tabor 2005; Criel 2003; Smith and Sulzbach 2008). Always voluntary and not-for-profit, these insurance schemes take the form of local initiatives that aim to assist low-income households who would otherwise lack access to health insurance (Tabor 2005). In particular, schemes are designed to target people in the informal sector, such as home workers and small businesses in urban areas and subsistence farmers in rural areas (Criel 2005).

The majority of CBHI schemes cover only basic primary care and essential generic drugs (Ndiaye et al 2007; Partners 2004). Rather than an insurance premium based on an individual rating, as is the case with market-based insurance plans, CBHI schemes use a risk profile of the community to determine the premium. This method draws upon strong existing community and familial networks that exist in many of the target countries. It encourages a greater level of solidarity between people with higher and lower health risks. Typically, CBHI members have just one option in terms of a plan (Tabor 2005). Scheme success and sustainability depends highly on the attractiveness of the benefits package, the level of quality and decisions of health care providers, and the extent to which drugs and other supplies are available (Drouin 2007; Wiesmann and Jütting 2000).

Many actors participate in the initiation of CBHIs. These include health facilities, NGOs, trade unions, local communities themselves, local governments, and cooperatives (Jutting 2003). While any of these actors can own and run the initiative, it is believed that the greater the participation in owning and managing funds on the community’s behalf, the easier it will be to keep costs low. Community participation will also help protect against moral hazard and can pave the way for health education and sensitization of fellow members, thereby promoting healthy behavior and use of preventative services. While all schemes have a community-based dynamic, such that those who organize and benefit from them share common characteristics within a given community (Criel 2005).

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12 Weismann and Jütting (2000) assess that while moral hazard must be taken into consideration when implementing CBHI, because utilization rates in sub-Saharan Africa are typically low, increased utilization is desirable. In this context, it is important to ensure that utilization is not increased to the extent that people use services over excessively, potentially driving up health care costs at a rate more rapidly than resources are mobilized.
2005), in any given country, membership within schemes varies. In some cases, only local groups of certain type of workers are covered, while in other cases, beneficiaries belong to various communities throughout the whole country (Wiesmann and Jütting 2000). Communities can also be defined by geographic entities, such as villages and cities; professional bodies, such as cooperatives or trade unions; and health care facilities (Tabor 2005). Throughout the literature, many different names are used to discuss CBHI. These include micro-insurance, community health finance organizations, mutual health insurance schemes, pre-payment insurance organizations, voluntary informal sector health insurance, mutual health organizations/associations, community health finance organizations, medical aid societies, medical aid schemes, and community self-financing health organizations (Dror & Jacquier 1999; Criel & Van Dormael 1999; Atim 1999; van den Heever 1997; Tabor 2005).

**History of CBHI**

CBHI has emerged in response to the lack of adequate and consistent funding of public health care and rising out-of-pocket payments (OOC) for people in developing countries, particularly in Africa. In the 1970’s and 80’s, the majority of African countries were forced to abandon free health care policies due to poor economic performance. Moreover, in most developing world countries, implementation of national insurance schemes are hindered due to the governments’ inability to collect taxes, which results from large rural and informal sectors, as well as an inability to pool or manage resources (Tabor, 2005; WHO 2000). Indeed, throughout Africa, public and private health insurance covers just 10% of the population, which almost exclusively serves the formal sector (Wiesmann and Jütting 2000). In 1987, upon initiation of the Bamako Initiative, many African countries moved to user fee or OOC policies (Ndiaye et al 2007). Indeed, in over 75% of sub-Saharan African countries, OOC continues to exceed 25% of total health resources (McIntyre and Gilson 2005). Yet, as it became apparent that such policies were extremely prohibitive to poor populations, community health insurance schemes began to emerge in the early 80’s and 90’s (Brouillet et al 1997; Dror & Jacquier 1999).

The CBHI model is rooted in the experience of social health insurance in Western Europe and Japan in the late 19\(^{th}\) and early 20\(^{th}\) centuries (Gruat 1990; Normand & Weber 1996; Criel & Van Dormael 1998; Barnighausen & Sauerborn 2002). Most CBHI initiatives have been implemented through top-down approaches by development organizations and national governments (Criel & Van Dormael 1999; Meessen et al 2002; Criel 2005). Initially, it was hoped that such schemes could eventually be the basis of national health insurance, but based on the experiences implemented to date, it does not appear that CBHI will reach the same widespread coverage in sub-Saharan Africa as was true in Europe and Japan (Criel & Van Dormael 1999).

CBHI schemes have become increasingly popular in sub-Saharan African in the past two decades. In fact, they have surpassed the number of formal sector, private, voluntary schemes in operation (Ekman 2004; McIntyre and Gilson 2005; Criel et al 2004). West Africa has led the way with 626 schemes in 2006, but CBHI is becoming increasingly popular in East Africa, and exists in a more limited extent in Southern Africa (McIntyre and Gilson 2005; Ndiaye et al 2007; Wiesmann and Jütting 2000). CBHI has emerged differently in different regions. For instance, in Tanzania and Cote d’Ivoire, it has focused on urban populations. Alternatively, in countries such as Uganda, Ghana and Benin, rural populations benefit most from CBHI (Wiesmann and Jütting 2000). Despite this popularity, there continues to be a void of empirical evidence about what is and is not effective, few initiatives have been rigorously evaluated, and its impact is not well-known (Criel 2005; McIntyre and Gilson 2005; Tabor 2005).

**Important Design Features of CBHI Schemes**

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CHF Card Evaluation 2009, GWU / Pact Tanzania  
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How CBHI schemes are designed, what they cover (e.g., obstetric emergencies, hospitalization, and dental care) and how they are managed varies greatly across Africa: a reflection perhaps of the different contexts in which they are implemented. Ultimately, how a CBHI intervention is designed must necessarily be guided by an understanding of the context. Firstly, an implementing agency must ensure that insured risks are perceived as important by the target population to encourage participation. Secondly, it is essential that micro-finance organizations market their services to those with little or no education “to ensure that these segments of the population are not excluded” (Chankova, Sulzbach, and Diop 2008). Overcoming difficulties associated with product tangibility, for example, is one challenge often encountered in CBHI interventions. In a successful program in Uganda, the CBHI organization provided mosquito nets, jerry cans, and water purification tablets to clients. Not only was this a tangible outcome of participation for clients, but also an effective way of integrating prevention into the organization's overall strategy—ultimately reducing the number of insurance claims in the long-term. Another possible design feature for an intervention includes adjusting the frequency of premium contributions to take into account the seasonal income revenues of poor farmers (e.g., yearly versus monthly collections).

**Advantages**

The potential benefits of CBHI interventions are many and include improvements in the quality of and access to health care, protection against catastrophic expenditures on health care, reduction in health care expenses, greater accountability of health care providers, and others. However, CBHI schemes are complex and difficult to sustain, requiring specialized skills and the full ownership and engagement of scheme members. Most importantly, all interventions to establish community-based insurance must be adapted to the social, economic, and political context of the target area.

One major benefit of CBHI schemes is their potential to alleviate household expenditure patterns while also increasing access to health care for low-income rural and informal sector workers. (Preker et al 2001). Inadequate access to quality health care is generally accepted as one of the most important causes of maternal and infant mortality in Sub-Saharan Africa (Lule et al 2005) and as a barrier to overcoming poverty traps. Poorer households can potentially have greater access to services through CBHI because, as opposed to user fees programs and national insurance plans, members decide collectively what the amount of contributions should be as well as what the plan covers. In this way, poor households able to make minimal payments can access basic health care services, significantly reducing their vulnerability to shocks. In their review of 45 published and unpublished reports and conference proceedings, Preker et al (2002) find that community financing makes a positive contribution to financing of health care at low-income levels, improving people’s access to primary care, drugs, and more advanced hospital care.

Improved access to health services can indirectly promote growth by protecting poor households from potentially catastrophic hospital expenses resulting in impoverishment. The costs associated with treating obstetric complications, for example, can be as high as 20%–30% of total household cash expenditures in Ghana and Benin (Smith and Sulzbach 2008). In his review of 36 studies assessing the viability of CBHI intervention, Ekman (2004) found strong evidence that these schemes are effective in providing financial protection to their members by reducing significantly the level of out-of-pocket payment for care. Additionally, Ekman's research finds moderate strength within the studies to suggest a positive effect of CBHIs on resource mobilization in operating areas.

While evidence is somewhat limited, another advantage of CBHI identified in the literature is the creation of a more balanced power relationship between health care providers and clients, which ultimately can generate health services more in line with local needs and increase the quality of
care available (Criel & Waelkens 2003; Waelkens & Criel 2004). However, in his review, Ekman (2004) finds no impact on the quality of care provided.

**Constraints**

As the amount of attention given to CBHI schemes continues to increase, the merits of the concept continue to be debated (Msuya et al 2004). One primary constraint of the CBHI initiatives is their limited population coverage and inability to transform into large-scale interventions (Ekman 2004; Criel 2005). Despite growing popularity, with over 1,000 schemes in operation in 2005, CBHI benefits just one-tenth of the developing world’s population (Ndiaye et al 2007; Tabor 2005). While adequate size of schemes is unknown for optimal risk pooling (Wiesmann and Jütting 2000), many schemes are troubled with low enrolment rates. In Africa, 95% of the schemes consist of fewer than 1,000 members (Ndiaye et al 2007; Waelkens & Criel 2004)\(^\text{13}\). Factors contributing to low enrolment and high client drop-out include poor quality of health care, which deters people from investing, limited ability to pay, and lack of trust of the schemes’ management (Ndiaye et al 2007; Cohen 2006; Criel 2005). Moreover, many pilot programs have not succeeded in implementing efficient outreach campaigns (Cohen 2006).

In theory, CBHI is supposed to garner the benefits of risk-pooling, such that an array of income groups is represented in the group. Yet, as a result of their low coverage rates, risk pools remain small and are fragmented across income groups, thereby preventing effective cross-subsidies between high and low income groups, thus weakening the effectiveness of the scheme (McIntyre and Gilson 2005; Preker et al 2001; Preker et al 2002). Additionally, many schemes are challenged with maintaining financial sustainability given the low level of resources that can be garnered from the low-income communities they target (Preker et al 2001).

Another important and common criticism of CBHI is their inability to reach the poorest and most vulnerable populations, unless government subsidization occurs (Preker et al 2001; Drouin 2007). Labeled the “exclusion effect,” this trend is identified in the studies of Ekman (2004) and Jakab et al. (2001). As members themselves manage schemes, many also suffer from poor management (Ndiaye et al 2007; Criel 2005; Preker et al 2001). Finally, CBHI receives criticism for its isolation from more formal health financing mechanisms and provider networks (Preker et al 2001). Given these constraints, CBHI schemes are “usually seen as an interim solution to help meet the financial needs of poor people and as a step towards the introduction of social health insurance (SHI)” (Joint NGO Briefing Paper 12).

**CBHI Models and Major Players**

Community health insurance is yet to gain notable consideration from most international donor agencies. However, several donor countries have prioritized support for community-based health insurance, such as France, Germany and the Netherlands (Joint NGO Briefing Paper 4). Germany is one of the main countries in the “Providing for Health” Initiative that promotes social protection mechanisms in developing countries. The Initiative creates an international platform for dialogue and collaboration on the issue of financing health systems in low-income countries. Even though it has not been on the forefront of the global health agenda of the U.S. Agency for International Development (USAID), several community health insurance programs have been funded by USAID.

One such initiative is the Ghana Health Services’ (GHS) Community-Based Health Planning and Services (CHPS) program, which aims to increase community participation and access to

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\(^{13}\) The number of households enrolled in a CBHI scheme is the typical unit of measurement, so the number of individuals benefiting from a scheme is actually higher.
healthcare. One component of the project is the establishment of a community-based health insurance scheme. Additionally, the ILO also operates a community health insurance program in Ghana. The program began after the ILO conducted a survey in Ghana, uncovering the information that only approximately 43% of the ill population had consulted a medical practitioner in the last year (ILO/STEP - GTZ 2006). This had been linked, at least partially, to the increasing health care user fees in recent years.

ILO established a system of targeting the poor with health services that initially brought in outside funding from donor groups, and then transferred the responsibility to the Government of Ghana a number of years after they had adjusted their social expenditures. A series of workshops with community leaders and social development workers established a list of beneficiaries, who were then offered a 75% discount on the insurance premium. The Global Social Trust initiative in Ghana is part of a wider ILO campaign designed to support countries in their efforts to extend social security to more of their citizens.

Another example of a CBHI initiative is “mutuelles de santé,” which was initiated in Rwanda’s health sector as a community response to the reintroduction of user fees in public health facilities, and was initially supported by NGOs and health authorities (Joint NGO Briefing Paper 12). Eventually, the Ministry of Health began subsidizing membership fees for the poorest 10% of the population, which helped to boost the coverage of the groups in 2007. However, several issues linger within the CBHI program in Rwanda, namely the exclusion of the poorest populations and low utilization of services by members.

One of the most important donor and implementing community initiatives in the arena of CBHI is **La Concertation**. **La Concertation** is a network of organizations and agencies that promotes community health insurance, mostly in West and Central Africa. The aim of **La Concertation** is to share knowledge, information and experiences about CBHI initiatives and programming in the region. Designed in 1999, it is an operational tool that responds to the growing number of mutual insurance organizations in the region who had expressed a desire to promote best practices. The network is comprised of local and international organizations, states, agencies, healthcare providers, universities, research centers, and regional organizations of workers. Activities of **La Concertation** extend to Benin, Burkina Faso, Burundi, Cameroon, Chad, Congo, Ivory Coast, Mali, Mauritania, Niger, Rwanda, Senegal, and Togo. Dialogue is encouraged through a website and a series of workshops and conferences on the subject of community health insurance. **La Concertation** members also produce and distribute a periodic newsletter for its members and a wider audience. Members engage government representatives through discussion and training on the role and function of community health insurance schemes.

**Achievements and Gains of CBHI Schemes**

As noted earlier, CBHI has gained much attention in recent years for its potential as an alternative to user fees and as a mechanism for increasing access to health care. From 1997 to 2004, the number of CBHI schemes in West and Central Africa grew from 76 to more than 800 (Gamble-Kelley et al 2006). CBHI is now a part of national health financing strategies in countries such as Benin, Ghana, Rwanda, Senegal, and Tanzania (Chankova, Sulzbach and Francis 2008). Interest in CBHI schemes as a mechanism for addressing national public health needs is demonstrated by the growth of networks in East and West Africa and by the buy-in of governments, many of whom are including CBHI in national health financing strategies. **La Concertation** network in West Africa and the Community Financing Association for Eastern Africa (CheFA-EA), for example, are linking CBHI member organizations to each other and facilitating dialog on common issues. In Ghana, as in several other countries, the national government has introduced legislation establishing a
framework for the implementation of district level health insurance schemes (Ndiaye, Soors and Criel 2004). Given a conducive political environment in which CBHI is integrated into the national development strategy, frameworks are established, and specific regulations allowing for the establishment of CBHI organizations are in place, community-based insurance has the potential to significantly impact health care for the poorest and most vulnerable.

**The Importance of Context**

Despite notable successes in CBHI and the demonstrated interest of national governments, many experts and development agencies are hesitant to embrace CBHI due to the difficulty of implementing it, issues of poor management, and institutional weakness. It can generally be said, however, that a successful intervention is one based on an in-depth understanding of the social, technical, and political context in which it will be initiated. For example, confidence in community leaders and other implementing actors, as well as previous positive experiences in similar “collective” projects, would constitute a conducive social context for implementation (ILO/STEP - GTZ 2006). Additionally, the technical skills and education levels of local leaders should be considered when setting up a CBHI intervention. Community-based insurance requires highly specialized skills related to the management of membership, premium collection, monitoring and evaluation, and assessing customer satisfaction (ILO/STEP – GTZ 2006). This is particularly a challenge for CBHI schemes, which are generally small and led by unpaid, poorly educated volunteers. Also important, perceptions concerning the quality of care offered in the area, as well as distance to health facilities, will significantly impact demand for health insurance and formal health care in general (Chankova, Sulzbach and Diop 2008). Finally, a favorable political environment, as noted above, will strengthen the effectiveness of CBHI schemes by protecting insured persons from misleading practices and by integrating them into "national strategies of social protection and risk management (ILO/STEP – GTZ 2006).

**Complementary Interventions**

It is widely acknowledged that, alone, CBHI will not be enough to bring adequate health care to all those in the rural and informal sector in need. Where implemented, it must be regarded as a complement to government financing of health care, not as a substitution (Preker et al 2001). Yet, as governments continue to grapple with the challenges of health care financing, certain complementary activities with the potential to enhance the success of CBHI have been identified.

- Improving health standards among target populations, thereby alleviating costs of health services needed by scheme members, is one way to complement CBHI interventions. Health education and sensitization, in addition to health promotion programs such as clean drinking water, sanitation and nutrition, can improve public health outcomes (Tabor 2005; Wiesmann and Jütting 2000). Additionally, through education, the quality of health care providers can be improved, thus averting over prescription of drugs and services (Wiesmann and Jütting 2000). Other valid approaches for maintaining costs under CBHI schemes are to establish effective referral systems and the implementation of case management techniques so that people are receiving appropriate care and do not access unneeded services (Preker et al 2001; Wiesmann and Jütting 2000).

- In addition to these interventions, policy measures have also been identified with the aim of strengthening and improving the effectiveness of CBHI. Governments are urged to increase and target subsidies to assist low-income populations in paying for insurance premiums, meanwhile improving the provision of publicly provided health care services (Tabor 2005; Preker et al 2001). Reinsurance, or insurance of CBHI schemes by larger insurance providers, can enlarge the effective size of the small risk pool (Partners 2004; Preker et al 2001). Given the weak management of many schemes, training and technical support can enhance managers’ capacity of local schemes. For
instance, scheme managers can be trained in identifying realistic benefits packages and premium rates, using information systems to manage data and in accounting and bookkeeping practices (Partners 2004). Finally, it is important that linkages with formal financing and provider networks are established (Preker et al 2001).

**Conclusion**

Both poor access to health care and the dismal quality of health care services available are two of the most important challenges to overcoming poverty and endemic vulnerability to shocks in much of sub-Saharan Africa. Despite laudable efforts to address these shortcomings in the health sector, through user fees and national financing, developing country governments and donor agencies have thus far been largely unable to provide quality health care to poor households in an equitable and sustainable way. However, expanding access to quality health has been recognized as an essential component of any development strategy to promote growth and improve livelihoods. The use of community-based health insurance—the focus of this paper—is being increasingly identified as one important mechanism for reducing out-of-pocket health expenses, thereby mitigating the potentially catastrophic consequences of health emergencies. Through the use of resource-pooling, members of CBHI schemes can share risks. The rapid spread of CBHI schemes throughout Africa and the establishment of networks linking these, suggests that community health insurance is effective and can be adapted to diverse contexts. Although CBHI is certainly not a panacea for Africa’s health care challenges, it is a promising intervention with much potential for improving access to and quality of health care.
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