SELF EMPLOYED RURAL WOMEN AND SOCIAL SECURITY SCHEMES: ANALYSING THE EFFICACY OF THE COMMUNITY HEALTH FUND IN PROVIDING HEALTH CARE SERVICES: A CASE STUDY OF ARUSHA DISTRICT COUNCIL, TANZANIA.

BY
Farida Awadhi BUYOGERA

Supervisor: Professor J. Stewart

A Dissertation submitted in partial fulfilment of the requirements for a Masters Degree in Women's Law, Southern and Eastern African Regional Centre for Women's Law,
University of Zimbabwe
2012

Abstract

Using a case study approach, this dissertation seeks to determine the success or otherwise of the Community Health Fund Scheme (a government national medical insurance scheme) in making health care affordable and accessible to self-employed rural Maasai women in the district of Arusha, Tanzania. Written by the legal officer who drafted the Funds' By-Laws for the Arusha Council, this research offers revealing insights into the origins and operations of the Fund which is based on a cost-sharing scheme between the Government and its intended members (the rural poor and those in the informal sector) who are entitled to receive primary health care. Using several methodologies (including the Grounded Theory and Human Rights Approaches) and guided overall by the unique Women's Law Approach, the writer gathers, analyses and interprets a wide range of material and relevant data, including information gathered from law and literature research, interviews and group discussions with her Maasai respondents and administrative and medical officials involved in the Scheme. The effectiveness of the Scheme is measured against Tanzania's duty to comply with the numerous social security commitments it has made in the form of various local, regional and international Human Rights Instruments. The scientific rigour with which the research is conscientiously conducted exposes that, since its inception in 2001, the Scheme has proved to be both a specific failure, not only to the writer's respondents, but also in general because it has been as ill-conceived as the ESAP reforms whose devastating economic and social effects it was supposedly calculated to mitigate. The researcher traces this to several key factors including: the failure, at its design stage, to consult the community the Scheme was intended to benefit, including the Maasai respondents; the inadequate benefits of the Scheme coupled with its poor promotion within the community has meant that it has attracted too few members to make it viable which, in turn, has resulted in a shortage of drugs, equipment and trained medical personnel; the complicated and heavily bureaucratic Scheme is run chaotically as a result of a failure to properly recruit and train its personnel. Finally, the writer makes several valuable structural and administrative recommendations to improve the operation of the Fund. This research should impel the people and governments of all developing countries to question the real motives of the World Bank and all supporters of its unbidden, lavish, doomed and self-serving schemes.

ABSTRACT [unedited student's version]

This dissertation tries to analyze the efficacy of the Community Health Fund Scheme in Arusha District Council, Tanzania, after the establishment of the community health fund Act, 2001. The Community Health Fund Schemes was introduced in Tanzania as part of Ministry of Health and Social Welfare endeavors to make health care affordable and accessible to the rural population and the informal sector. It is a prepayment scheme for primary health care services which covers health insurance at District level.

The study tries to examine the benefit accrued from the scheme and to see whether self employed rural women in Maasai community have the capacity to contribute to the Fund and access the quality and affordable health care services. Also it looks on the International Human Rights, Constitution provisions, Statutes and Policies to see how far Tanzania has fulfilled the International obligations in providing affordable, accessible and quality health care services as the social security to its citizens who works in the informal sector .The study reveals that on the implementation of the scheme the international obligation remain unfulfilled because majority poor and vulnerable remain uncovered by the scheme. It draws recommendation to be implemented by the council to make the Community Health Fund scheme viable Health Insurance.

Table of Contents

Declaration

I, FARIDA AWADHI BUYOGERA, do hereby declare that, this is my original work presented towards the fulfillment of the Masters' Degree in Women's Law at University of Zimbabwe, not presented before for any degree or reward in any academic institution.

Signed……Date……

Signed……Date……

Prof. Julie Stewart,
The Director,
Southern and Eastern African Regional Centre for Women's Law,
University of Zimbabwe.

Dedication

This work is dedicated to my family, my husband Mustapha, daughter Nailah and son Abdulkarim (alias SEARCWL boy) , They are the reason for my Success

Acknowledgements

This dissertation would not have been possible without the innitiative of people who in one way or another made it possible for me to put it all together .

My appreciation goes to the Norwegian Ministry of Foreign Affairs which gave me the precious scholarship to Pursue Masters Degree in Women's Law, University of Zimbabwe.

My special thanks goes to my supervisor Professor Julie E. Stewart for making all the arrangements, being caring and making my life and psyche comfortable to enable me to complete my Masters Programme in Women's Law at SEARCWL-UZ.

I would like to acknowledge M/S Renifa Madenga for giving me a face to face discussion on how to write a research proposal in my home place Arusha, Tanzania. My appreciation also goes to M/S Jester Chewa for accepting to host me at the African Court for Human Rights in Arusha to finalize my examination on Women, Labour, Social Security and Law.

I also appreciate my young sister Evelyne Muro, Dr Mbise and all my respondents for supporting me in the collection of data during my field research.

I wish to appreciate all the staff members of SEARCWL, Rudo, Blessings. Sesedzai, Ceceila, Jonhson and Primrose for making me have an enjoyable stay at the centre. To all my fellow students, thank you for helping me in one way or another.

Thank you all.

List of Human Rights Instruments cited

Universal Declaration of Human Rights, 1966
International Convention on the Economic, Social and Cultural Rights, 1966
Convention on Elimination of all Forms of Discrimination Against Women (1981)
Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2003)
SADC Protocol on Gender and Development

List of Statutes cited

The Constitution of United Republic of Tanzania of 1977, as amended at 2008.
Community Health Fund Act, 2001
Arusha District Council Health Service Board By-law, 2010
Workmen Compensation Ordinance,1966
The National Social Security Fund Act, 1997 available at http://www.parliament.go.tz/Polis/PAMS/Docs/28-1997.pdf.accessed on 06/10/2011

List of National and International Policies cited

National Strategy for Growth and Reduction of Poverty-NSGRP (April, 2005)
National Health Policy, 1990
National Policy on Disability

List of Cases cited

Rev.Mtikila vs. Attorney General (1995 T.LR-31)

List of Figures

List of Tables

Currency Quotations

1 US $ = 1,600/= Tshs as of April, 2012

CHAPTER ONE

1.0 RESEARCH OVERVIEW AND DESIGN

1.1 Introduction

My research critically examines the efficacy of the Tanzanian Community Health Fund Scheme (CHFS) in providing health care services, a form of social security, to people in the rural areas or, more specifically, to self-employed women in the informal sector.

In developing countries the term 'informal sector' has broadly been associated with unregistered and unregulated small scale activities (enterprises) that generate income and employment for the urban poor (Sabine Bernabe:2002:4). The International Labour Organization defines the term 'informal sector' as the activities of the working poor who were working very hard but who were not recognized, recorded, protected or regulated by public authorities (ILO 2002:1).

There is no consensus about the meaning of the *'informal sector'* but for the purposes of my research I will apply the definition of Weeks (1975) who argues that *informal sector units operate outside the formal system of benefits and formal credit institutions* while formal sector units are officially recognized, nurtured and regulated by the state through mechanism of tariffs and quota protection, selective monetary control and licensing measures.

It has been estimated that women constitute 43% of all entrepreneurs in Tanzania[1]. An entrepreneur is a person who makes money by starting or running a business especially when it involves the taking of risks.[2] Although women account for about 43% of micro and small enterprises, such enterprises tend to be informal and characterized by low growth and small profits because the competition is so intense which is due to the fact that starting a business in the informal sector only requires a small amount of start-

[1] African Development Bank and ILO study 2004.
[2] Oxford Advanced Learners Dictionary.

up capital. The research conducted by the Equality for Growth[3] shows that 96.2% of the women respondents had no knowledge of social security requirements and that only about 3.1% respondents were aware of the procedures and requirements for joining social security schemes (Equality For Growth: 2009).

'Social Security' means any kind of collective measure or activities designed to ensure that members of the society meet their basic needs and are protected from contingencies to enable them to maintain a standard of living consistent with social norms[4]. The aim of the policy is to realize the goals and objective set out by Vision 2025 by extending social security services to the majority of Tanzanians. The International Labour Organization defines social security as a protective measure which society provides for its members, through a series of public measures against economic and social distress that would otherwise be caused by the stoppage or the substantial reduction of earnings resulting from sickness, maternity, employment injury, unemployment, invalidity, old age and death, the provision of medical care subsidies for families with children.[5]

The majority of elderly women are very poor, tend to live longer than men and usually only earn relatively small incomes. When designing a social security system or reforms to it, focus must be concentrated on safeguarding the living standards of the elderly, especially elderly women, because they are a particularly vulnerable sector of society.

The period of permanent continuous employment is shorter for woman than their male counterparts. Furthermore, as a result of intra-family division of labour, more men leave home to seek employment while their female partners remain behind doing the household chores (J, Estelle, et. al: 2008:10), work which may be categorised as falling into the category of informal sector work which is not recognised by formal social security schemes.

[3] An Non- Governmental Organization.
[4] The National Social Security Policy 2003.
[5] ILO 1989:3 and Social Security (Minimum Standards) Convention 102 of 1952.

1.2 Reason for choosing the Topic

1.2.1 Experiential Data

I chose to research on social security schemes and self-employed rural women in order to analyze the extent to which the Community Health Fund (CHF) of the Arusha District Council, Tanzania provides such women with access to medical health services. I also wanted to find out whether there had been an improvement in the delivery of health care delivery since the introduction of the Community Health Fund Scheme (CHFS). Since I work as a legal officer involved in the Scheme I wanted to find out whether self employed women in the informal sector are able to access the health care services through contributions to the Scheme.

At the time I enrolled for the Women's Law Master's program during which I conducted this research I had drafted by-laws for the operation of the Scheme and, although they were passed into law, they were not implemented.

During my research I interviewed the staff of the Arusha District Council about the efficacy of the Community Health Fund Scheme and inquired why they had not established the Council Health Service Board as required by the by-laws. They said that they were in the process of establishing it and the Council Health Service Board was subsequently established on January 2012. This Board is an executive organ of the Council and it deals with supervising and controlling all health activities and resources.

1.2.2 Women's Law Studies

I desired to apply what I had learnt in the Women's Law Master's program (i.e., how to conduct field research into the dynamic relationship between women and the different legal contexts in which they live) to the area of law with which I was already familiar, i.e., women, especially poor rural women who are self-employed in the informal sector, and their right to social security. I was particularly interested in investigating whether such women could use the revolving fund in the form of loans

advanced to them from the Council to help them to set up informal businesses from which they could earn sufficient amounts of money to contribute to the Community Health Fund Scheme as a social security strategy.

The course on Women's Human Rights sharpened my skills and understanding about how women's rights are deeply rooted in human rights. It taught me to analyze and evaluate how the state, as primary duty bearer, is obliged to provide quality and affordable health care services to its citizens, who are entitled to expect and receive those services as their human right.

Based on this reasoning, I determined that the right to health goes hand in hand with the right to life. I connected the right to health and the right to life as two rights which are inter-dependent and must both be enjoyed by citizens. In other words, for a person to enjoy their right to health, the state is required to ensure that it will dispense affordable and quality health care in order to enrich as oppose to endanger their lives. The state is therefore obliged to provide to its citizens with both these rights for them in order for them to enjoy their life and continue with their daily activities.

1.3 Statement of the Problem

Tanzania, like many countries in sub-Saharan Africa, faces the twin pressures of a tight public health care budget and the need to improve access to health services, especially for the poor and those working in the informal sector Mulligan and Mtei (2007). The Tanzania Community Health Fund Scheme (CHFS) covers health insurance at District Level and is basically a district level prepayment scheme for primarily health care services which targets the rural population and those who are in the informal sector.

The Government made deliberate efforts during the first two decades after Independence to alleviate some historically inherited inequities, such as its introduction of free health services which suffered during the early 1980's due to many causes, including the adoption of new socio-economic policies such as the World Bank's Structural Adjustment Programmes which introduced the Public Sector Reforms. (Tanzania National Audit Office: 2008)

In 1994/95 the Government of Tanzania collaborated with the World Bank to design a new approach to improve the finance and provision of health care to households in rural areas (Shaw, 2002). The Health Sector Reform Programmes, started in 1994, were implemented to increase access to the poor. It focused mainly on the decentralization of health services by taking on board both managerial and financial reforms. This was supposed to improve access, quality and efficiency of primary health services at District Level.

Firstly, the idea of a pre-payment system for quality health services which people could afford sounded more attractive than paying out of pocket at times of injury or illness. Secondly, cost-sharing with the government meant that pre-payment by households would be effectively doubled. Thirdly, the management of Community Health Fund revenue in closer proximity to where members lived was seen as a way of improving the control over resources, assuring greater value for money and improving accountability to households (Shaw, P.R.2002).

Since 1994 the Government has embarked on a 'Local Government Reforms Programme' which established decentralization by devolution. These reforms imply that Local Government Authorities are responsible for planning, budgeting and management of government services, including health services. In 1996 the Government restructured the regional administration, giving more room for development of the Municipal and District Councils. Regions became facilitators, rather than implementers.

The Local Government Reforms were designed to complement the Ministry of Health and Social Welfare Reforms which resulted in the enactment of the Community Health Fund Act and the Arusha District Council passed the Council Health Service Board by-laws in 2010. These laws affect the rural areas. This scenario was explained and supported by Shaw, P.R (2002), who revealed that the idea carried considerable appeal in the country. The Bill establishing the Community Health Fund was passed by Parliament and became law.

The Community Health Fund Act, 2001[6] was enacted to provide the mechanism for establishing the Community Health Fund and to provide for the Constitution of the management, organs and the administration of the Fund and other related matters.

In 1996 the Community Health Fund (CHF) started as a pilot scheme in Igunga District and later on expanded to other councils with the ultimate aim of reaching and operating in every District throughout the country (Mtei and Mulligan, 2007). The Ministry of Health and Social Welfare expressed their wish to transform the CHF schemes into a viable social health insurance system, which will be able to provide social protection for rural people (Schweiz, M.M 2011). The scheme was identified as a possible mechanism capable of granting access to basic health care services to the country's population in both the rural areas and the informal sector (Mtei and Mulligan, 2007).

This dissertation tries to examine the efficacy of the Community Health Fund Scheme which is administered by the Arusha District Council, Tanzania and the extent to which the benefits of the scheme meet the social security needs of self-employed women in the informal sector and in the rural population. By scrutinising the provisions of the country's Constitution, its statutes, policies and binding International Human Right Instruments, the study also determines the extent to which Tanzania has fulfilled its international obligations to provide social security in the form of health care services to its citizens who work in the informal sector.

1.4 Objectives of the Study

1. To find out whether self-employed rural women in rural areas know that they have social security rights.

2. To investigate the extent to which the Community Health Fund as a social security scheme is relied upon by the rural people to access health care facilities and if the benefits accrued from the scheme meet women's needs.

[6] The application of this Act shall apply to the Local Government Authorities specified in the first schedule to this Act and to such other Local Government Authorities as the Minister from time to time declare by order published in the gazette.

3. To make recommendations to Government to take measures to disseminate information by implementing sensitization programmes in collaboration with members of the community in order to provide quality and affordable health care services to rural people.

4. To find a way of convincing the community to join the Community Health Fund.

5. To unearth the efficacy of the Community Healthy Fund legal framework.

1.5 Research Assumptions

1. Tanzania has a contributory Community Health Fund (CHF) which should assist self-employed rural women in obtaining basic health care.

2. Self-employed rural women are not aware of the benefits provided by the CHF.

3. Even if self employed rural women are aware of the CHF, those in small and micro enterprises are not able to access CHF schemes due to a lack of financial resources.

4. The resources in the CHF scheme are not sufficient to cater for women's needs in rural areas.

5. As a result of a lack of information about the CHF rural women are unaware of its membership fees.

6. The CHF is underfunded.

7. There is a comprehensive framework for health care delivery.

1.6 Research Questions

1. Does the Tanzanian Government assist self-employed women in rural areas in obtaining basic health care through contributing to the Community Health Fund (CHF)?

2. Are women aware of the benefits provided by the CHF?

3. Are self-employed rural women unable to access the CHF due to a lack of financial resources?

4. Are there resources in the CHF sufficient to cater for women's needs in rural areas?

5. Are there information campaigns by the CHF to inform rural women of its membership fees?

6. Is the CHF under-funded?

7. Is there a comprehensive framework for health care delivery?

1.7 Area and Geographical Setting of the Study

The area of study was located in Arusha rural where I was able to find groups of organized self-employed rural women.

My choice of study area was influenced by my work at Arusha District Council and my professional background as a legal officer. One of my tasks as a legal officer is to draft District By-laws and to see how they are implemented.

My selection of the study area and topic were influenced by the fact that the Council had implemented the Community Health Fund By-laws in an effort to provide health

care services to the rural population in order to counteract the negative effects of the Structural Adjustment Programmes which had been imposed with by the World Bank and IMF.

The rationale for looking at groups of self-employed rural women was because the research topic targeted respondents in rural areas and the Scheme covered health insurance at District rural level. I wanted to know why the Fund was being under-utilised (which I suspected) so that I could make recommendations to the Council to ensure that more people in the area join the scheme.

Due to the confusion that exists between Arusha District Council and Arusha District, I think it would be prudent to show the geographical setting of Arusha District Council where my field research was conducted. The mandate of existence and scope of operation of the Arusha District Council is provided by the Local Government District Authorities Act, Cap 278 RE of 2002. The Local Government Authority is a body corporate and has perpetual succession. It is capable of entering into contracts in its corporate name as it did with Selian Lutheran Hospital, which is now a designated District Hospital for Arusha District Hospital.

According to the Act, the Arusha District Council lies to the south of Longido District Council and north of Simanjiro District Council. The Arusha Municipal Council falls under Arusha District. Administratively, Arusha District Council is divided into 3 divisions, 21 wards, 75 villages, 294 hamlets[7] and it has 65,000 households. Also the population and housing census of 2002 showed that the Council had a population of 291,203 being 140,336 male and 150,867 females with a population growth rate of 3.4%. The Council now estimates that within its jurisdiction it has a population of 355,892, being 171,511 males and 184,381 females.

[7] Arusha District Council Strategic Plan.

1.8 Problems encountered in the Field

1.8.1 Cultural and Traditional Barriers

The Maasai people of East Africa, who fall within the study area, live in southern Kenya and northern Tanzania along the Great Rift Valley on semi arid and arid lands. The Maasai are semi normadic people who live under the communal land management system. The Maasai is comprised of sixteen sections, such as the Isikirari, Parakuyu, Kore and the Ilarusa live in Tanganyika[8] (Maasai Association, undated).

The Maasai culture and traditional rituals differ great deal from those of other Tanzanian tribes. I conducted my research at a time when the Maasai were celebrating their circumcision festival/ceremony which required members of the community to attend and celebrate together. Women and men of the Maasai community are eager to undergo this ritual but with the rising awareness of women's human rights, this traditional ritual faces many challenges, including the fact that the government has criminalized the practice of female genital mutilation.

The initiation ceremonies were a barrier to me because I was not able to go to the field to see and interview women groups in Manyire village with my supervisor, because most of my respondents were attending the initiation ceremonies. After discussing this with my supervisor we decided to go to the Oltrumet Health Centre instead.

1.8.2 Poor Infrastructure

I conducted my research during the rainy season. Therefore, on one occasion, I failed to go and interview a group of Urangini women on 18.11.2011 because they telephoned me before I was about to leave informing me that due to the rains the roads were unpassable and that a vital bridge had been destroyed by floods.

1.8.3 Gender Roles as a Mother and Wife

[8] Tanganyika after Independence is known as Tanzania.

It was difficult to start my research on time because I had just delivered my son on 1st of October 2011 by caesarian section; hence I had to stay at home until I had recovered and attended to certain family issues at home.

My supervisor e-mailed me telling me to calm down and rest but I only stayed at home for a one extra week and on the second week on the 24th of October I decided to start my field research.

Thirdly, just before I started the research my house help was taken ill, so I had to adjust my field diary and meet my targets as well as compile my data from the field while at the same time taking care of my children who, because they are so young, needed my constant love and attention.

CHAPTER TWO

2.0 METHODOLOGY AND METHODS

2.1 METHODOLOGY

2.1.1 Human Rights Approach

The Human rights approach was a very good starting point for me to begin with in assessing the impact of Community Health Fund Scheme (CHFS) for the rural poor; I used the human right methodology to help me to know whether the Articles enshrined in the Tanzanian Community Health Fund Act of 2001 were in line with the human rights standards for the rural poor for example whether the Scheme was affordable and accessible to them.

This tool revealed that the Community Health Fund Scheme was not actually targeting the human rights paradigm for rural poor because it failed to comply with the Community Health Fund Act of 2001 which assures the provision of quality and affordable health care services through a sustainable financial mechanism hence the health care will be improved.

The approach of human rights helped me to discover that rural women were indirectly discriminated against in benefiting from the health scheme and the Act was not well targeted at the rural poor for example. One respondent said:

> I do not know how much I am supposed to pay and get health care services because I buy exercise book from local shops at Tanzania shilling 500 which is equivalent to 2.5 cents, I pay consultation fees whenever I go to hospital, I pay for the drugs using my money. I do not know how this Health scheme can help me.

In relation to the above, the Tanzanian government has a duty to ensure the protection, of full enjoyment of the right to life as a human right to all the citizens to be able to enjoy the health care services.

2.1.2 Grounded Theory

When I started planning my research in Tanzania I had in mind that I would interview women using the grounded theory approach, but I thought that women in rural areas were different from urban areas, I still could not interview women alone. I had to interrogate the social actors in the community. It is very important to note that the grounded theory was another important analysis tool that guided me very well. Bentzon et al,(1998:15) describes grounded theory as:

> *"…..an interactive process in which data and theory, lived reality and perceptions about norms are constantly engaged with each other to help the researcher decide what data to collect and how to interpret it."*

Using this approach I was able to determine what to collect in relation to quality of health care services provided in the rural areas. Also I was able to find out that self employed women lacked capacity to contribute to the Community Health Fund scheme as their social security not because of financial resources but due to lived realities of Maasai women in relation to the adherence to their customs and norms of the Maasai culture.

The above approach can be explained better in the dung beetle method because I used it to scrutinize my data and analyze it at every point in the field. I would also at one point determine on what to collect next or meet the needs then continue the collection and analysis circle. (Stewart et al, 2001).

This approach helped me to know whether my assumptions were holding or were not and this was to my benefit in the field because all my assumptions were all holding. Grounded theory methodology assisted me to collect unexpected data. For example in the Maasai culture women not to make decisions before consulting their husbands. It is important to note that as a result of using this methodology I interviewed various stake holders in the rural areas of Arusha which gave me an understanding of different perceptions of various people. For example in relation to government officials, when I wanted to determine the number of members who are contributing to the scheme at

Nduruma Health Centre, women in the community, Maasai men and local leaders in Arusha were important in that I was able to interpret and triangulate my findings regarding Community Health Fund.

2.1.3 Actors and Structures Perspectives

Actors and structures helped me to have a different perspective of rural women's experiences and urban women's experiences. In this context, the community became the actors because they observe what takes place in Community Health Fund Scheme. Therefore the methodology became successful because it involved so many different stake holders including, for example, Government officials like health workers, district internal auditors. All the above stake holders were engaged because I needed various actors and structures to make my final analysis of the community health scheme.

2.1.4 Sex and Gender Analysis

When I started my journey to the area inhabited by the Maasai I knew the history of their quite well, including, for example, that they do not recognise women as being important. I therefore needed a practical strategy that would assist me to get information from the people without hurting anyone's cultural feelings. Although most Maasai women are bread winners in their homes, their husbands do not generally recognise their input, because their society ascribes roles that women and men should take. In their culture women are expected to work for men for no recognition.

The Sex and Gender approach helped me to identify the gender roles of the Maasai women and why they d not contribute to the Community Health Fund Scheme. Women encouraged their husbands to let them have permission to have an evening out by giving them money. I also found that the women could afford to contribute to the Community Health Fund Scheme but they feared doing so without first consulting and receiving permission from their husbands. To me this was an obstacle preventing women from contributing to the scheme for the good of their health; this framework was appropriate in analysing the factor that gave rise to women not contributing to the

funds given the fact that men and women had different roles and responsibilities in society. Due to patriarchal nature, women had little opportunity to benefit from the Fund. One woman said:

> According to my customs and traditions I get everything from my husband, even if am the one who works during the day, selling charcoal at the end of the day I'm supposed to give my husband the money because he is the head of the household I cannot therefore contribute for myself unless my husband allows me to do so.

In relation to the above, sex and gender became the starting point for me to assess why women were not contributing to the health scheme. Many decisions are made by men which is still accepted in Maasai community whereby women lack capacity and value in the eyes of men. It was through this approach I realized the reason why Maasai women are voiceless.

2.1.5 Radical Feminist Approach

Feminism refers to the ideas produced by women with the aim of changing the position and experience of women within contemporary societies. Feminists assume that men and women are socially formed, thus social explanations can be given for why men are dominant in almost all institutions in a society. This situation is still happening in the Maasai community as the society treats a girl child and women differently from men, women are not recognized, if luck can be recognized using the husband identity, this recognition has been attributed by Maasai association, (undated)[9] that women do not have their own age set but are recognized by that of their husband.

I used the radical feminist approach because I wanted to see women in a feminism perspective, this was very important for me because I got various ideas from female respondents' experiences in relation to Community Health Fund Scheme. This approach helped me to understand why women were not too much involved in matters to do with the Community Healthy Fund Scheme. At a certain point women revealed

[9] Maasai heritage and rituals in preserving and celebrating Maasai culture heritage. Found on http://www.masai-association.org/ceremonies.html accessed on 31/03/2012.

that there was nothing they could do without the knowledge of their husbands. This was explained by one writer that men have an interest in maintaining their dominance and will use violence to keep and maintain power and domination. (Kritizinger, undated)

I opted to use the theory propounded by radical feminism to show how Maasai women have been oppressed by their male counterparts since time immemorial due to adherence of their culture. Simon Ntukuiyuan Nkoitoi [10] attributed in his article about the life of Maasai women that a Maasai woman has to do more work than her husband. This does not mean that men do not like their wives but this has been the tradition since the beginning of the history of the Maasai people. In the Maasai community culture and tradition require women to be submissive towards their husbands. Radical feminism has argued that women are oppressed everywhere by a system of patriarchy and that patriarchy exists as a near universal social form because men can master the most basic power source to establish control (Kritizinger, undated).

In the Maasai community women are breadwinners, child bearers and rearers; they are also home makers and pay their children's school fees. They have to give a token to their husbands to get permission to go and work for the betterment of the family. I asked myself why Maasai men enforce that tradition. According to radical feminism men regard women's bodies as essential to the production of children, as tools of and they are symbolic of men's status and power; they also fulfil an important emotional function for men. (Kritizinger, undated)

The government has tried to empower women to become integrated into a different economic and social life. The lives and situation of women also involve positive experiences. Even if feminine culture in many ways is a reflection of ruling male culture via patriarchy, subcultures have their own positive and renewing qualities that women researchers are helping to make people aware of. (Dahl,S.T.1987:21)

The Arusha District Council through its Community Development Office has managed to provide funds for women to use as their capital in starting their business. Some

[10] 2005. The Life of Masai Woman. Found on http://www.ofcd.org/story.html accessed on 31/03/2012.

women have used the money to pay school fees for their children and buy food for their families. Sometimes the money is misappropriated by the their husbands without their consent. Men not only have the resources to maintain patriarchy but have an interest in maintaining power over women's bodies. Radical feminism thus provides an explanation for universal gender oppression as well as a way of understanding cross-cultural variation in that oppression. (Kritizinger, undated)

2.2 METHODS OF DATA COLLECTION

2.2.1 Sampling of Respondents

The methods of Data collection was based on the sampling of respondents. I chose my respondents from the Council staff at the headquarters where I work, and in rural areas where I was able to find self employed women groups, council staff who are working in health centres and dispensaries and patients were involved in the discussion.

Table 1: Showing the Respondents interviewed

Respondents	**Women**	**Men**	**Work Station**
Community development office	2	-	Council Staff-headquarters'
Council Health Management Team	1	6	Oltrumet Health centre
Social Welfare office	-	1	Council Staff-headquarters'
Varwa group	12	4	Ngorbob Village
Eselian women group	3	-	Sekei Village
Emnyak women group	3	-	Sekei village
Enjula women group	6	-	Sokon II Village
Mungu atosha group	9	6	Siwandete Village
Neema B group	13	11	Siwandete Village
Olorien women group	12	-	Ngaramtoni Village
Woman in street	1	-	Arusha Municipality
Manyire dispensary	2	2	Manyire Village
Community Health Fund Coordinator	-	1	Oltrumet Health centre
Medical officer in-charge	-	1	Oltrumet Health centre
District planning office	-	2	Council Staff-headquarters'
Ngorbob dispensary	1	1	Ngorbob Village
District Internal Auditor	-	1	Council Staff-headquarters'
District Treasurer	-	1	Council Staff-headquarters'
Chairman-manyire village	-	1	Manyire village
District Medical Officer	-	1	Oltrumet Health centre
Patients	16	3	In the health facilities I visited
GRAND TOTAL	**81**	**42**	

My sampling of respondents was done regarding to the importance of my data. The selections of my respondents were based on my expectation that they would be able to furnish me with answers to their problems concerning the provision of health care services. I was able to obtain statistics of people utilizing the health facilities and the quality of service they got. It also helped me to know the statistics of government

official stationed in the health facilities. I interviewed them, triangulated my data and from this I learned the statistical information relating to the problem.

2.2.2 Individual Interviews

I used the individual interview method with my key respondents and several actors like Government officials. I prepared myself to ask structured and unstructured questions. I asked unstructured questions to complement the structured questions in order to clarify the data which I wanted to get from my respondents. I had to find a translator when interviewing one of my respondents because we were not able to communicate due to the language barrier. In one case, my respondent was a Maasai elderly women and she knew a bit of the Swahili language. Through a translator I was able to find out that my respondent had not benefited from health care services and she was not aware of the Community Health Fund scheme.

2.2.3 Focus Group Discussion

The focus group discussion was very useful especially with self employed rural women groups; I found that women were more active in contributing and sharing more information than in individual interviews. Through this method discussions with the participants explored many issues that prevented them from contributing to the scheme. I learnt that the persistent shortage of drugs made these women reluctant to contribute to the Community Health Fund Scheme.

It is vital to note that the focus group discussion was very useful in this research because most participants brought out real issues that I had not captured during individual interviews. For example, women had said that they were in a position to contribute to the scheme but they could not do it without first seeking permission from their husbands. As a result of the focus group discussion these women showed that they did not have the capacity to decide on matters concerning matrimonial house/issues; they depended entirely on the decisions of their husbands in relation to these matters.

2.2.4 In-depth interviews

This method was helped me to discover know the perspectives of women and men in the matters regarding the Community Health Fund. It was also useful for me to know the number of men and women I interviewed through administering structured and unstructured questions.

In depth interview method unearthed the reality that although rural women in the Maasai community were able to contribute to the scheme yet due to gender stereotypes and patriarchal systems of Maasai which incapacitated them in the decision-making process, they had to seek for permission from their husbands

The in-depth interview was very important because through it some techniques like using the village assemblies to create awareness of important community issues were discovered. Also during these discussions information flowed from reliable sources like the Government village assemblies can be taken seriously by their husbands rather than inquiring the information from them.

2.2.5 Observation

The observation method was useful for me especially where actors could not provide information. This was evident when I went to Arusha International Conference Centre Ngorongoro wing to see the officer responsible for managing the community health Fund in the region, I was told that the officer in charge was involved in exams and I had to book a new appointment to see him. I was amazed that I was not allowed to interview him on the agreed date. As a result I observed that I could not receive reliable information from them because of the inconsistent stories they were giving me; I also observed that their boss was not in a position to be interviewed.

The observation method was useful for me to capture unsaid information. For example, when I wanted to interview the Community Health Fund Coordinator and

District Medical Officer they completely avoided responding to my interview. I therefore concluded that they were hiding some information from me or there was something that they were doing which was not appropriate in health service delivery.

2.2.6 Desk Research

I applied desk research methods at the time of writing a research proposal, before and during the field research to see what as written by other authors and to see the gap which exists between the theory and the reality of the issues under investigation. This method assisted me in making the material of my interviews relevant so that I could observe the reasons why Maasai women were not receiving the health care services they deserved and, based upon them, to make recommendations in order to assist to do so. Once my respondents understood that this was the aim of the study they saw it as a window of hope in starting their first attempts to enjoy quality health care services provided by the Council.

2.2.7 Mobile phone method

I used mobile phone method during the field research to make appointments. I opted to use this mobile phone method in making appointments due to the geographical set up of rural areas, most of the roads are not passable due to rainfall and the texture of the soil. I also used the mobile phone to make follow ups of documents that I had been promised by my respondents.

Furthermore, I used the mobile phone method during the analysis of the data for presentation of my findings, to ask the correct amount of the fund at my work place in Arusha, Tanzania. This was due to the directions received during the discussion with my supervisor at the centre to ask on the funds allocated to health department. I was able to know the amount of funds allocated by the Central Government for use by the health department for the financial year 2010/2011 and 2011/2012.

CHAPTER THREE

3.0 LAW AND LITERATURE REVIEW

3.1 Introduction

This chapter seeks to review the law, policy and literature available relating to my assumptions, and to analyse the provisions of International and Regional Instruments, National Laws and Policies in order to find out whether the National laws and Policies conform to International Standards. It also involves what has been written by various authors by the Community health Fund.

3.2 International Framework

The Universal Declaration of Human Rights[11] requires members of the society to have a right to social security. It goes further to declare that every person has the right to a standard of living adequate for the health.

The International Convention on the Economic, Social and Cultural Rights[12] requires state parties to recognize the right of every one to social security and health services in the event of sickness.

The Convention On the Elimination of All Forms of Discrimination Against Women[13] (CEDAW) requires state parties to tackle particular problems faced by rural women in their role of economic providers for their families. It also advocates that all discrimination against women in their access to health care facilities and social security programmes be eliminated.

[11] Article 22 and 22(1) of the UDHR, 1966.

[12] Article 9 of the ICESCR.

[13] Article 14, 14(1), (2) of CEDAW.

I connected the right to health with the right to life and social security, for a person to enjoy health care services there must be a guaranteed in the existence of people's life. As far as my research topic is concerned I decided to look at International laws on how they dealt with the right to health and the social security to be able them to apply in my National laws and to see how these rights has been implemented.

The Protocol to the African Charter on Human and Peoples Right on the Rights of Women in Africa[14] or 'The Women's Protocol' is the most extensive international instrument which deals with the rights of women in Africa and it has comprehensive provisions on the rights of women. It deals with economic and social welfare rights and urges states to protect and ensure these rights particularly for women and those who are working in the informal sector. It also requires state parties to take all appropriate measures to provide adequate, affordable and accessible health services including education and communication programmes to women especially those in rural areas.

The SADC Protocol on Gender and Development[15] requires state parties to conduct time use studies by 2015 and to adopt policy measures to ease the burden of the multiple roles played by women. It goes further to urge states to adopt policies and enact laws which ensure equal access, benefit, and opportunities for women and men in trade in entrepreneurship, taking into account the contribution of women in the formal and informal sectors. Also in line with the SADC Protocol on Health and other Regional and International commitments by members states on issue relating to health, adopt and implement legislative framework, policies programs and services to enhance gender sensitive, appropriate and affordable quality health care in particular.

[14] Article 13(e),(f),14(2).
[15] Article 16 and 26 of the SADC Protocol.

3.3 National Framework

3.3.1 Constitution of United Republic of Tanzania, 1977

The provision that the State shall make provisions for realization of person's social welfare[16] has been enshrined in Part II of the Constitution which explains that the fundamental objectives and directives of State policy is to provide to its citizens the right to work, to education and other pursuits.

I believe that In order for people to enjoy the abovementioned rights, a link should be made between the state's duty to guarantee the right to life of people with the provision that the state should provide quality and affordable health care services. The right to life[17] is enshrined in Part III of Tanzania Constitution which covers the basic human rights and duties. It guarantees that everyone has the right to live. The Article states that:

> *Every person has the right to live and to the protection of his life by the society in accordance with the law.*

Human rights are fundamental rights which a person enjoys by virtue of being a human being. They are not dependent on being provided for in a particular legal document. It is said that these rights are inherent and therefore should be recognized, respected and enforced. This sacred aspect of the human right to life has been expressed in the case of *Rev. Mtikila v Attorney General (1995.T.LR-31),* by Judge Lugakingira, a High Court Judge, who aptly observed at page 49:

> *"Fundamental rights are not gift from the state they inherent in a person by reason of his birth and are therefore prior to the state and the law….."*
>
> (Shivji, G.I, ET .al:2004)

Therefore the government of Tanzania must guarantee its citizens the right to life by providing them with affordable social security in the form of access to quality and affordable health care services.

---

[16] United Republic of Tanzania Constitution , Article 11.
[17] United Republic of Tanzania Constitution , Article 14.

3.3.2 Community Health Fund Act, 2001

The Tanzanian response to the international law which requires it to provide accessible and affordable health care services to its citizen in rural areas, came with the Community Health Fund Act[18] which is a voluntary community-based financing scheme in terms of which households pay contributions to finance part of their basic health care services to complement Government health care financing efforts[19]. The Act states that,

> *There shall be a Community Health Fund which is a voluntary Community based financing scheme whereby households pay contributions to finance part of their basic health care services to complement the Government health care financing efforts.*

The Act states that the objectives in the implementation of the scheme are as follows[20]:

> *(a) to mobilize financial resources from the community for the provision of health care services to its members; and*
>
> *(b) to provide quality and affordable health care service through a sustainable financial mechanism; and*
>
> *(c) to improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health.*

The Arusha District Council Health Service Board By-Laws, 2010 provide that the function of the board is to ensure that the population receives appropriate and affordable, promotive, preventive, curative and rehabilitative health care services and that it mobilizes adequate resources that will ensure effective, efficient, and equitable access to health services in the District. Even though the Government has put both

[18] 2001.
[19] Section 4(1) of the Community Health Fund Act, 2001.
[20] Section 5(a),(b),(c) of the Community Health Fund Act, 2001.

policy and law into place, they are yet to be implemented or enforced which means that its international obligations remain unfulfilled. This is because the State takes the view that its duty to provide its citizens with social security fulfils not so much a right but rather a citizen's privilege to access social security.

The vision of Tanzania's National Health Policy is to improve the health and well being of all Tanzanians with a focus on those most at risk and to encourage the health system to be more responsive to the needs of the people (Mtei and Mulligan 2007). The Health Policy ensures that health services are available and accessible to people whether in urban or rural areas. It also aims to improve the general health of the population by making essential drugs and equipment more readily available.

It is also the aim of the government to put in place mechanisms for risk sharing and cross-subsidization so as to ensure solidarity and equity. In addition the Tanzania National strategy for growth and reduction of poverty places a greater emphasis on the equity in the delivery of health and social services so as to improve access for children, women the poor and other vulnerable groups especially in rural areas (Mtei and Mulligan, 2007).

3.3.3 Health Sector Strategic Plan III

According to Mtei and Mulligan (2007), this Health Sector Strategic Plan III (HSSP III) is the crosscutting strategic plan for the health sector of Tanzania for the period July 2009 – June 2015. It provides an overview of the priority strategic directions across the sector which are guided by the National Health Policy, Vision 2025, the National Programme for Economic Growth and Poverty Reduction and the Millennium Development Goals.

They added that Health Sector Reform programme continues with further strengthening of Local Government Authorities and hospitals to improve performance within the institution. The Primary Health Service Development Programme aims at improving accessibility and quality of the health services for all members. Policies,

strategies and work plans are in place for health related issues and for disease control. It serves as the guiding document for development of Council and hospital strategic plans and for annual implementation plans.

There is extensive literature on the efficacy of the community health fund and social security in general but not specifically on the analysis of self employed rural women and their capacity to contribute to the Community Health Fund Scheme as the social security upon which they rely. Most of the literature talks about the implementation of the guidelines, enrolment, accessibility, coverage and management of the Scheme but does not consider specifically how the Scheme specifically impacts on women.

I have focused on the self employed rural women as a disadvantaged group specifically from the rural areas, to see how women have been affected by the introduction of community health fund scheme. Therefore my research tries to bridge a gap because there seems to be no discussion of this aspect of the fund in relation to the status of women in the society.

Mtei and Mulligan, (2007) work on the community health fund embraces its coverage, enrolment and successful strategies to reach the poor. It also highlights obstacles in reaching the poor, including the lack of information on the social economic status of members and non members. The report shows that there are still challenges to overcome in the implementation of waiver decisions to protect the poor.

The review by Musau (2011) on transforming the community health fund scheme in Tanzania into a viable social health insurance scheme analyses the community health fund structure and identifies a number of limitations and structural problems which threaten the design, enrolment, servicing and sustainability of the scheme.

According to Haazen (2002) who described the implementation and impact of Tanzania community health fund wrote that the Community Health Fund initiated a prepayment scheme as an alternative to user fees that were new to the country's health system. They tried to emphasize the national health system should not only seek to improve health status per se but should aim to improve financial fairness and risk pooling. The report added that the goals of the community health fund are also

consistent with the World Bank's goals to improve the targeting of poor people through risk pooling.

The Ministry of Health and Social Welfare has tried to provide guidelines on how to manage the community health fund. It describes the community health fund as a risk pooling mechanism among families in the informal sector and that it strengthens community participation and ownership of health services by monitoring the quality of services offered to them through health committees. This study indicated that the managerial skills gaps could be addressed imparting the right skills, knowledge and tools of best practices in relation to management and administration of community health Fund. The manual was written and developed to address the management skill gaps in starting and operating the Community Health Fund. (MOH: 2005).

Ginneken (1999), explains the literature on the lack of social security coverage in developing countries. In regard to social assistance the author quotes the work of Midgley 1984a (SIC) who maintains that even though the benefits paid may appear derisory when compared with those paid in industrialized nations, they do supplement the income of the poor. Nevertheless, he admits to various problems that limit the usefulness of social assistance in developing countries, including, the lack of government resources, the lack of appropriate policy-making and the lack of administrative capacity as well as stigmatization of claimants.

He also discusses the low coverage of the system which reflects a failure by countries and the international community to meet their obligation under Article 9 of ICESCR which recognizes the right of everyone to social security, including social insurance. He also discusses the extension of statutory social security programmes which, he says, cannot be a simple answer to satisfying the social security needs of the growing number of workers and their families. He holds that special social assistance measures must be put in place for the most vulnerable groups outside the labour force, including the disabled and old people who cannot count on family support or cannot be reached by other social services and who have not been able to make provision for their own pension.

He also adds that the exclusion of informal sector workers and other vulnerable groups from social security protection is part of larger process of social exclusion that can be seen both as an attribute of individual and as property of society.

Laterveer, et.al (2004), explains that the introduction of the Community Health Fund has not provided the expected benefits for poor people due to a number of constraints, including the delays in the introduction of the scheme and the weak management at the district and lower levels. More importantly, the study team found that poor people often cannot afford to pay the Community Health Fund premium because it is too high and has to be paid at one time. They suggested that if membership of the Community Health Fund were made compulsory and poor people were not effectively exempted from paying the premiums and co-payments, the impact of the Scheme could be disastrous and lead to the 'double exclusion' of poor people.

Shaw, (2002), argues that the government's motivation in establishing and supporting the Community Health Fund was to provide households with an alternative to paying user charges at publicly operated hospitals, health centre and dispensaries. It aimed to improve health outcomes through better access to quality services, improved risk protection through prepayment and found that perhaps the most enthusiastic supporters of the Community health fund were the community themselves.

He also argues that implementation worries stem from the huge menu of preparations required, the importance of finding people who are capable of executing the task, and the need to demonstrate results in a political environment that was predisposed to be cynical. He holds that the Community Health Fund will continue to face trying times due to the low rate of membership, the high exemption rate and the fact that poverty is too widespread to suggest the scheme will be able to operate on a sustainable basis without stronger public support and subsidies.

All the literature reviewed has failed to show how the implementation of Community Health Fund affects women in rural areas and whether they have the capacity to contribute to the fund so that they can rely upon its as their Social Security.

CHAPTER FOUR

4.0 STRUCTURE AND ORGANIZATION OF THE SCHEME

4.1 Introduction

In Tanzania a coherent system of Government policies, legislations, strategies and programmes is emerging, giving direction to the development in the country (MOH,2005). Consistency between general and sectoral policies is increasing. According to Makene (2007), attributes to this situation happened after the Structural adjustments programme (SAPs) advocated by the International Monetary Fund (IMF) and the World Bank required nations to implement user fee, particularly in education and health care. Most developing countries in the world including Tanzania have implemented the SAPs.

Devolution has a far-reaching impact on the health sector, whereby Local Government Authorities (Arusha District Council) are responsible for providing health care services in rural areas and the Ministry of Health and Social Welfare has withdrawn from direct service provision at district and municipal level.

The structure and organization of local government is currently based on an elaborate committee structure inherited from the one party era that prevailed after Independence. The three types of committees generally recognized include; political committees, administrative political committees and technical committees. These committees are also multi-tiered ranging from the Village Council which is the lowest formal committees in a local government system (Ginneken, 1999).

The Government structure is used to support the community structure at each respective level: at District level the district authorities support the Council Health Service Board which is a community structure with the responsibility of managing the Community Health Fund in the District. At the Ward and Village level, the respective Community Health Fund structure is supported by a peer Government structure. The

Community Health Fund organization structure builds on existing structures of government operations to avoid building new and parallel structures. (MOH, 2005).

4.2 Social Security System in Tanzania

In Tanzania the social security system is divided into two main groups which are formal and informal. The formal social security refers to conventional social security which covers pension schemes, health insurance and workmen compensation schemes. The National Social Security Fund and the Community Health Fund are the only formal schemes which cover social protection to workers in the informal sector.

Dau (2003) researches the fact that the National Social Security Fund already has initiatives towards the integration of the informal sector into the formal social security schemes. The National Social Security Scheme offers social security coverage relating to maternity benefits, old age pensions, employment injuries, social health insurance, funeral grants, survivor pensions and invalidity pensions to those who are in the informal sector.

The social insurance health benefit of the National Social Security Fund has no specific contribution rate prescribed by law. Members covered by the scheme must go to accredited health facilities in order to obtain health services. According to the Workmen Compensation Ordinance[21], employers in the private sector are required to buy private insurance cover for their employees to guard against the risk of occupational injuries and diseases. In short, the social security system categorizes its benefits through providing protection in case of sickness and health care benefit, social insurance that covers contingencies such as old age in the form of pension and a component that obliges employers to protect their employees against accidents.

Even though the National Social Security Scheme covers private sectors workers, theoretically it is capable to incorporating informal workers and those who are self employed. In reality those who are self employed do not benefit from the scheme.

[21] 1966.

They have failed to show how the people in the informal sector contribute to the scheme which shows that the informal workers lack the opportunity to participate in the regular pension system.

The situation has been put forward by Mahori, (2008) as follows:

> *The social security schemes provided for in the statutes are employment-based and therefore exclude women in the informal sector. However, this exclusion does not place the women in the informal sector at any meaningful disadvantage as the benefits are too little to make any meaningful change in those receiving them. What can be said about the schemes is that they are good in principle but they are of no value in practice.*

According to Olivier and Kaseke there are two types of informal social security system in Africa namely traditional support systems and self-organized mutual support systems. Informal social security systems can be described as self-organized informal safety nets which are based on membership of a particular social group or community including but not limited to family, kinship, age group, neighbourhood, profession, nationality, ethnic group, gender and so forth.

These types of informal social security systems are also found in Tanzania and they cover the social protection of workers in the informal sector and rural population. They have come about due to the needs of the society and the kind of social risk which they encounter.

Traditional support systems operate on the basis of solidarity and generalized reciprocity and revolve around kinship and family ties, while the self-organized mutual support systems transcend kinship boundaries and are community or neighbourhood based and are intended to respond to specific risks as determined by the membership. The mutual support system operates on the basis of the principle of solidarity but unlike traditional support system they observe balanced reciprocity and the assistance is rendered on the understanding that it will be reciprocated in the same form. They are intended to fill the gap that cannot be adequately met by traditional support systems. (Olivier and Kaseke)

The self-organized mutual support system embraces the principle of mechanical solidarity. '*Mechanical solidarity'* is a form of social cohesion based on the similarity among the members which make them interdependent; they think of themselves as individuals first and operate on the basis of balanced reciprocity. This has been explained by Preker, S.et al (2004) who observes that community initiatives have recently begun to bridge the large gap in social protection between people covered by formal schemes and those with no protection at all against the cost of illness who are exposed to the impoverishing effects of users fee. Ginneken (1999) outlines good examples of the self-organized mutual support system and that in the United Republic of Tanzania there are two main categories of private social security arrangement. The first category is known as UPATU[22] which in 1995 covered more than 10% of members in the informal sector; the second category is UMASITA[23] a demand-oriented scheme in Dar es Salaam which provides access to primary and some secondary health care.

Furthermore, the traditional social security also embraces the principle of mechanical solidarity which is a form of social cohesion that is based on the similarity of the members whereby everyone does much the same work, the members are all socialized in the same pattern and share the same experiences and hold common values. There is little individuality for people to think themselves primarily in terms of their membership and loyalty to the group basically of a collection of kinship with similar characteristics. A good example of traditional social security system is '*ujamaa'* which refers to collective responsibility, compassion, equality, human respect and dignity with generalized reciprocity and revolves around kinship and family ties. The traditional practice binds people together to develop a sense of belonging and togetherness in providing mutual support in the event of calamities. Traditional social security systems have tended to decay and change form in response to the forces of urbanization and industrialization.

---

[22] A form of cooperation in which members help each other by contributing amounts of money into a common fund over a specified period of time and lend an amount/s of money to eligible members on a rotation basis.

[23] '*Umoja wa Matitbabu wa sekta isiyo rasmi'* which means Informal Sector Association for Heath Care in Dar es salaam. This scheme was started in 1995 with a mission to provide health care services to its members.

Moreover, self organised mutual support systems transcend kinship boundaries and are community or neighbourhood based. They are intended to respond to specific risks as determined by the membership. Unlike traditional support systems, self-organised mutual support systems observe balanced reciprocity, in other words the assistance is rendered on the understanding that it will be reciprocated in the same form. This system emerged because of the inadequacy of the traditional support systems or the absence of conventional formal social security.

4.3 Laws which provide Social Security Benefits to Workers in the Informal Sector

In Tanzania there are various laws which provide social protection rights to citizens working in the informal sector of which self employed rural women are not spared. According to Tungaraza K,S.F,(2003), the protection of social rights is provided for under Article 11, 22, and 23 of the Constitution of the United Republic of Tanzania of 1977. The Constitution recognizes the right to adequate minimum income, housing, education and health care.

In case of statutory frame work for the protection of the social rights for employees in Private sector including organized groups on the informal sector and self employed persons, we have the National Social Security Fund Act of 1998 and the Community Health Fund Act No 2 of 2001.These statutes confer social rights on the members of the scheme but it must be noted that these social rights depends on the level of social and economic development of an individual.

The National Social Security Policy of 2003 liberalized the social security sector in Tanzania by re-organizing the activities of social security providers to respond to the market demands as related to free market economy. Social security in Tanzania mainland is characterized by limited coverage in terms of membership; scope and access to benefits.Tungaraza and Mapunda (2000) argue that the scale of benefits payable under the different schemes should be known to members. Benefit formulae and conditions for payment should therefore be clearly spelt out in the laws

establishing the respective schemes. Entire informal sector lacks coverage and has limited resilience to economic shock hence vulnerable to fall into poverty.

4.4 Self-employed Rural Women and their Capacity to contribute to the Scheme for their Social Security

One of the major concerns regarding the definition of 'work' is the inherent prejudice it carries against women. Women perform various forms of unpaid labour in order to sustain the household. However, these forms of labour are not recognized as 'work' for social security purposes. Some writers argue that the social security value placed on the productive and reproductive roles fulfilled by women should be increased. This will be possible only once the formal economy recognizes that reproductive and unpaid work performed by women is also economic activity, albeit in the 'care economy'. (Olivier and Kaseke).

During my field research I was able to interview 58 women who are self employed and receive funds in the form of loans from the Arusha District Council. The Council, through the community development office, provides loans to self-employed women who live within the jurisdiction of the council. The loans given to the women are based on a revolving fund programme which is aimed at empowering self employed rural women. They are required to organize themselves in groups of five people, register their group, and apply for a loan to the council. Due to the expenses emanating from the registration of a group and the opening of a bank account, the number of people in a group varies from five to more than thirty people, although the most effective groups number between five and ten people.

I wanted to assess whether they had the capacity of contributing to the Community Health Fund after receiving a loan. The loan provided by the council is very small and self employed rural women cannot rely on that loan to be able to contribute to the scheme. The inequalities of treatment in social security, as regards both access to protection, and allocation of benefits, are just some of a multitude of economic and social distortions which affect women at all stages and in all aspects of their working life.

When I was interviewing members of Varwa Group during the discussion they affirmed that lack of the financial resources has contributed to their failure to become members of the scheme and they had this to say:

> We usually apply for a loan to the council, the maximum amount provided is Tanzania Shillings 1,500,000 (approximately US$937) and we are 36 members, it means we divide among us on which each member will be supposed to get 41,667 approximated to US$ 25.it's not fair.

Usually the loan given to groups varies from Tanzania Shillings 800,000 (US$500) per group which is the lowest amount, up to Tanzania shillings 1,500,000 (US$937,50) per group which is the highest amount. They complained a great deal about the fact that the loan amount is too small for the kind of business they can run in order generate enough money to contribute to the fund and to repay the loan.

Also I was informed that because of the scarcity of resources and the capacity of the fund the Arusha District Council has only managed to extend loans to only 21 women's groups in the district amounting to Tanzania Shillings 22 million (US$13,750). To keep the Fund viable the women are required to return 10% of the loan as interest within a financial year.

4.5 Health Care Services and Social Security as a Human Rights Issue

Human rights have been used as a basis for justifying the provision of social security and health care services. Social security is recognized as a human rights issue either directly or through associated rights as is the case of international instruments (Kanyongolo, R.N:). Tanzania has ratified a number of UN treaties guaranteeing the right to social security. Also it has tried to domesticate some of those rights including the provision of Article 11 of the United Republic of Tanzania Constitution which stipulates that the State authority shall make appropriate provision for the realization of a person's right to work, to self education and social welfare at times of old age, sickness or disability and in other cases of incapacity.

Based on a human rights approach, Tanzania as a state has a principal duty to ensure that it protects, provides, fulfils and facilitates the enjoyment of human rights by all its citizens who are rights holders. These rights must be communicated to citizens so that they may acquire a full working knowledge of their rights; the state is also accountable to put in place a mechanism for the right bearers to enforce their rights by enacting a law which will allow them to enforce their rights in a court of justice.

Although Tanzania has ratified several international human rights instruments concerning the provision of the social security and health care services to its citizens, there is still, unfortunately, inadequate coverage of social security and health care services to the population of Tanzania. This has been attributed to the following:

The international obligation remains unfulfilled because there is a failure to implement strategies based on an understanding and application of human rights principles which protect the elements of accountability, affordability, and accessibility of health care services which are to be provided by the duty bearer (the State) and enjoyed as a right by its citizens, the right receivers. These are fundamental elements which the state must respect and fulfil in the discharge of its duty towards its individual citizens. Tanzania must be in a position to plan, monitor and evaluate the rights of citizens in order to be able to protect, provide and to facilitate the enjoyment of health care services by the right receivers (i.e., its citizens), instead of regarding social security a privilege rather than a right.

Many developing countries including Tanzania have failed to implement and enforce these rights because of the negative impact of inconsistent demands placed on them by donors and the international community in general. On the one hand, international regional and national laws urge the state to guarantee and provide social security to its citizens and some states have domesticated these international laws in order to comply with them. But at one and the same time the World Bank and IMF have forced these same countries to comply with rigorous economic and anti-social structural adjustments programmes. The effect of donor conditions has been attributed by

Kasente, D[24] to the negative impacts of structural adjustment policies (SAPs), limited state capacities, slow economic growth in most of Africa and persistent poverty have increased the vulnerability of some social groups and therefore undermined social security.

Tanzania was forced to adopt Structural Adjustments Programme and introduce public sector reforms which require cost sharing, leaving poor people without the health care services to rely on. As I have said earlier since the Tanzania government was previously providing health care services for free it appears that it is because of donors the abovementioned conditions which prevent Tanzania from fulfilling its international obligations.

4.6 The Design of the Community Health Fund Scheme (CHFS)

The CHFS is a prepayment scheme which offers a household or an individual the opportunity to acquire a health card after paying a premium (MOH:2005:2). Membership of the CHF is voluntary and each household within a district contributes the same amount for membership which amount has been agreed by the members of the community themselves. The health card normally covers the head of the household and other household members below the age of eighteen years (Mtei and Mulligan:2007). The membership fees are matched by the government subsidies a strategy which is calculated to encourage people to join the scheme and to ensure the fund's sustainability (Euro health group, 2006).

4.7 The Community Health Fund (CHF) and the District Health System

Since the introduction of the CHFS in Tanzania, the scheme is almost like a partnership arrangement between the community and Government whereby the management and operations of scheme have been left to the communities and their

[24] Gender and Social Security Reform in Africa.

structures. The government provides technical and financial support by allowing the use of its network of health facilities in the district (MOH, 2005).

Health insurance is the most urgent social security for informal workers because they have limited access to public health care services. The majority of contributory health insurance schemes provide primary health care service rather than coverage against hospital care costs (Ginneken, 1999). One of the greatest challenges facing the CHF is the extent to which the scheme should be funded by government. This is due to the fact that the administration of the scheme is unable to deal with special circumstances of the self employed rural women who rely on the scheme as their social security in order to access health care services. The situation has resulted in a low health status of the population and low service level of medical care.

Limited access to public health care has been explained by Bungura (2010). The majority of those employed in the informal economy have limited access to public health care services and generally rely on traditional and informal intra-family or intra-community networks for income support during old age or upon becoming sick or disabled.

4.8 The Implementation of the Community Health Fund (CHF) in the District

The CHF was established as an alternative to the payment of user fees at the point of service to make health care affordable and available to the rural population and the informal sector (Mtei and Mulligan:2007). The idea was to extend health insurance to rural populations which face exclusion because they are not covered by the formal social security system. Informal sector workers and those who are not covered by formal social security in the provision of health care services may join the scheme on a voluntary basis and thereby access health care services.

In the case of Arusha District Council, a household[25] may join the Community Health Fund Scheme upon payment of Tanzania Shilling 10,000 (US$6.25[26]) as a prepaid annual membership fee.

The conditions necessary to ensure the full operation of the scheme require (1) a sufficient number of people to join the scheme, (2) the availability of adequate funds to run the scheme and (3) by-laws which prescribe the amount of fees to be paid by each and regulate how the fund is to be managed. These requirements pose constraints for a number of districts. They have not been able to meet these conditions, especially due to the difficulties involved in the bureaucracy of implementing the by-laws. Furthermore, the scheme does not give a member the security of decent social protection because there are insufficient skilled human resources to satisfy the demands of its target market (i.e., the rural poor and the informal sector) and the health insurance offered limits members referral up to the level of a health centre only (My experiential data).

[25] According to the Community Health Fund Act, 2001, a household means: (a) A mother, father, and children under the age of eighteen years, or (b) A member who has attained the age of eighteen years or more with or without children under the age of eighteen years; (c) An institution.

[26] At the time of writing this dissertation, the exchange rate is that US$1 is approximately worth 1600 Tanzania Shillings.

CHAPTER FIVE

5.0 FINDING AND ANALYSIS

5.1 Reluctance to join the Scheme and falling Enrolment

When the Community Health Fund was introduced people were eager to see how the scheme would operate. The user fee was introduced and charged to those who were/ are not members in order to stimulate enrolment in the scheme. When interviewed some of my respondents were willing to join the scheme but most people were reluctant because of poor service delivery accelerated by the shortage of drugs. This situation was discussed by Mtei and Mulligan (2007), who argued that poor enrolment rates in many Community Health Funds may be linked to a perception of poor quality of care. Thus those who register initially into the scheme may drop out quickly if the quality of care does not reach their expectations.

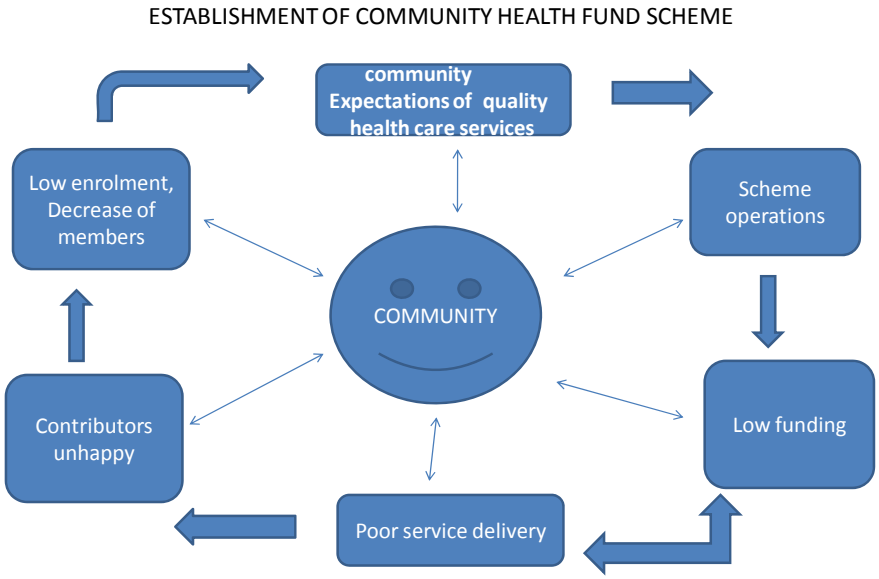
The original design of the scheme recommended that at least 65% of households should enroll in the scheme in any particular district or locality for the scheme to be successful. This has not yet been achieved and in fact the maximum that has been reached in the best district is 30% (MOH: 2005:4). The Arusha District Council has 65,000 households who depend on farming for their subsistence. To make the scheme viable, the Health Department has a strategy to enroll 35,000 households which is equivalent to 50% of all household in the district.[27] This needs to be increased to 65% in accordance with the operational manual[28], which provides that this as the minimum number of households which need to be enrolled to make the scheme viable.

Below is a diagram to show the operation of the Community Health Fund in the District. When the scheme was established and started its operations people expected a great deal from it. Unfortunately because the Scheme faces low funding its delivery service is poor. This situation has caused disappointment among its members whose

[27] Information based on the paper presented on the District Consultation Committee; the CHF scheme was one of the items on the agenda.
[28] Operational manual for managing the Community Health Fund, produced by the Ministry of Health and Social Welfare, 2005.

community members have been reluctant to enrol and this in turn has negatively impacted on the efficiency of the Scheme.

Figure A: **Diagram showing the operation of the Community Health Fund Scheme and the Public's Perception of it**



Bungura,Y (2010), argues that informal social security can be effective in protecting their members, however due to their fragmentation, limited resources, coverage and risk pooling they cannot provide comprehensive and sustainable solution to the structural social needs of the population.

5.2 Absence of a Health Facility Governing Committee

Ward Health Committees and Dispensary Committees are intended to be the local arms of the Council Health Services Board. Of these bodies, only the Council Health Services Board has been established and this occurred in January 2012. The Board has done nothing since then and the Board members complained that the board was still in its infancy.

Also according to Mtei and Mulligan (2007), the members of the Council Health Service Board and Ward Health Committee are expected to deliver information to the other CHF members about the operation of the scheme. The intention is to make them feel involved in the operation. This, however, has not been done. At the health facility I visited no committee was in place and therefore no CHF member had been informed about the operation of the CHF Scheme.

5.3 The Council Health Service Board

Prior to initiating community health financing, each District Council has to have in place a Council Health Services Board and Facility Committees, and has to pass Community Health Fund By-Laws[29] (MOH, 2005). The Council Health Service Board is responsible for overall routine and monitoring of the Community Health Fund Scheme operations. According to the CHF By-laws, 2001, the Council Health Service Board functions[30] are as follows: to provide district health services and monitor Community Health Fund operations and activities; to work in consultation with the Council Health Management Team to ensure quality health care and professionalism; to mobilize and administer funds for the Community Health Fund; to set exemption criteria for users of the health care services provided by the Fund; to set targets for the Fund; to review reports from Ward Health Committees or any other source; to monitor and make verification on the collection, expenditure and control of funds and to design an annual health plan for approval by the respective Council.

The law requires the Council to establish the Board, which, according to the law, must be responsible for the overall routine monitoring of the CHF operations and sets exemption policy criteria. The law[31] states that:

> *There is hereby established a board, to be known as The Arusha District Council, Council Health Service Board.*

[29] http://www.districthealthservice.com/cms/upload/polycat_139_7602.pdf.
[30] Section 15(1),(a),(b),(c),(d),(d),(e),(f),(g),(h) of Community Health Fund Act, 2001.
[31] Section 4(1),Council Health Service Board by-law, 2010.

It works in constant touch with Council Health Management Team to ensure quality care and professionalism. In the course of my interviews with the Council Health Management team and other staff of the Council on the efficacy of the Community Health Fund, I asked why they had not established the Council Health Service Board as required by the by-laws, and the response was that they were in the process of establishing it. The Council Health Service Board was eventually established in January 2012. The Board is an executive organ of the Council responsible for supervising and controlling all health activities and resources.

5.4 The Ward Health Committee

The Council Health Service Board By-laws provide for the establishment of the Ward Health Committee[32]. The law requires each Ward to establish Ward Health Committees with the following members: one member appointed by private for profit providing health services in the area, the officer in-charge of the health centre who shall be the secretary, three persons of reputable character appointed from amongst the members of the community from each ward receiving services or registered to receive services from the health centre, one member appointed by private note for profit providing health services in the area, one member from the Dispensary Committees and one member from the Ward Development Committee.[33].

Also the Community Health Fund Act provides for the function of the Ward Health Committee which shall be to mobilize the community to be members of the Fund, to prepare the Fund's list of members and monitor the number of members in the community, to supervise the collection of annual contributions, to monitor the level of contributions and user fee revenue, to review fund operations, make recommendations and take remedial actions, to initiate and coordinate community health plans and to organize general meetings and any other meetings of members of the fund.[34]

[32] Council Health Service Board By-laws, 2010.
[33] Section 26(1),(a),(b),(c),(d),(d),(e),(f),(g) of the Arusha District Council, Council Health Service Board By-Laws, 2010.
[34] Section 19(1),(a),(b),(c),(d),(d),(e),(f),(g) of the Community Health Fund Act, 2001.

5.5 The Dispensary Committee

The law requires the dispensary to establish its own committee; the Dispensary Committee shall have the following roles and function[35]:

To ensure that the population in its area of jurisdiction receives appropriate and affordable health services; to receive, discuss and pass the dispensary plans and budget; to receives the implementation reports prepared by the dispensary Management team; to identify and solicit financial resources for running dispensary services; to liaise with other health bodies and partners in health provision and promotion; to promote sustainable health infrastructure and reliable supply and logistic system; to advise and make recommendations concerning human resources relating to their recruitment, training, selection and deployment to relevant authorities; to assist and facilitate the dispensary management team in planning and management of community based health initiatives within its catchment area in the context of the ward development plan; to submit quarterly, biannual and annual reports to the council health service board; and to do any relevant activity as may be directed by the Ward Development Committee.

Their duties include helping the Council Health Service Board to ensure that facility reports are submitted in a complete, accurate, and timely fashion. In The health facility I visited, there were no health facility governing committees established, I was told by the staff at Nduruma Health Centre, as I triangulated my data, by the Medical officer in charge, that there were no health committees in any health centres in the District.

I inquired from the District Medical officer as to why they had failed to establish the committees and was informed that they said that they had planned to establish the same since they had already budgeted money for the financial 2012/2013 for giving a sitting allowance to members as an incentive for their volunteer work for attendance at facility

[35] Section 42(1),(a),(b),(c),(d),(d),(e),(f),(g),(h),(i),(j) of Community Health Fund Act, 2001.

meetings. It was waiting for approval by the Council Health Service Board and later by the Council Committees[36].

Even if the Central and Local Governments have made efforts in enacting the laws for the operation and establishment of the ward and dispensary health committees unfortunately there is no ward or dispensary health committee established in any health centre which I visited.

Also on the setting criteria for exemptions, the Board has done nothing which leaves the poor unable to access health care services. Haazen, (2011) argues that the identification of the poor is major problem because of the absence of guidelines to determine eligible candidates and no money had been set aside to reimburse facilities in the event of their waiving fees.

5.6 Insufficient Supervision

I found that the administrative structure had a problem in the management and monitoring of the health centres and dispensaries. This was clearly seen when I asked the Community Health Fund Coordinator if he had managed to calculate the value of the drugs used by the Community Health Fund members in order to know the actual cost of drugs used by the members. He responded that they had not done that but they would start to do so.

To add to the above, demarcation of the premium was against to participation of the community from the grass roots who are the user and contributor to the scheme through the village assembly where the consensus can be easily found, that means the community would have been participated on the financial feasibility on setting the premium.

Furthermore the tendency of the staff at Manyire Dispensary to arrive late at their work station leaving the patients unattended was caused by the lack of supervision. When I

[36] Council Social Service Committee and Full Council.

visited to Manyire Dispensary, I arrived at Manyire 07:30 which is the working hours in Tanzania unfortunately the staff had not arrived. The staff arrived about 09:45 hours. In the meantime I managed to have interviews with the patients who were waiting for the staff to come. It was about 10:32 hours when I saw one staff member of the dispensary; I had to wait for some time for her to attend to patients.

If there was supervision, then the staff would not have been arriving late in their duty station. When asking the chairman of the village about the provision of health care services in his village, he had this to say;

> In fact the services are very poor because of the lack of staff, the staff most of the time they arrive late, the villagers are suffering. As a leader I have tried to report the matter to the District Medical Officer, talk to the staffs but I don't see change. Villagers have tried to donate 40 million Tanzania shillings for building a dispensary, approximately 25,000 US Dollar. We have not received any support from the council in spite of writing to District Medical Officer begging to come to see the way villagers have put more efforts to build the dispensary but he has failed to come.

The chairman of Manyire village claimed that staff members at Manyire Dispensary usually arrived late because they stayed in town, he gave me an example basing on the kilometers which a staff are supposed to walk to reach the dispensary. He told me that one is staying at Usa[37] she had to take a daladala[38] to town about 25 kilometers and it costs Tanzania Shillings 500/= approximated to 3.0 cents US dollar. From Town she has to take another daladala to Nduruma village which costs Tsh.1000/= approximated to 6.0 cents US dollar about 40 kilometers, from Nduruma village she had to walk using short cut up to Manyire Dispensary which is about 4 kilometers and repeat the same process in the evening.

The chairman said:

> After a staff member has walked her away to this place, she would not be in a position to discharge her duty well, considering that she has also used her money for transport

[37] A name given to a hamlet in Meru District.
[38] A town bus.

> about Tanzania Shillings.3000/= per day approximated 1.9 US dollar where did they get money for those costs the only alternative is to sell the drugs provided in the dispensary to compensate for the cost incurred.

I interviewed the District Medical Officer at Njake petrol station, he did not know whether the staff member arrived late to their duty station, but promised to make follow up. I interviewed the District Medical Officer At the petrol Station because I had tried to phone him several times to make appointments unfortunately he was busy preparing material and data for budget session which was going to take place in the beginning of January at Karatu District . He promised to call after two weeks when he got back to Arusha. He didn't call me but on 30th of January we met by chance at Petrol Station and I was interviewed him because I had no option rather than doing that and it was the end of January making preparations back to Zimbabwe.

When asked about the shortage of drugs he replied it was a national issue and was beyond their capacity to control.

5.7 Funding of the Scheme

Local government mainly depends on central government financing. Development projects are almost wholly funded by annual block grants from the central government of which 70% of recurrent budget is similarly funded. The sources from which Local Governments in Tanzania can raise money to finance services as articulated in statutes[39] include taxes, licenses and user fees, charges, rental income from council properties, government grants, and donations. Despite being empowered by existing statutes to raise revenue from a variety of sources the actual performance in general revenue has been low (Ginneken, 1999).

[39] Chapter 290 of the Local Government Laws.

There are insufficient resources for running the scheme; the law requires the scheme to receive contributions from its various sources.[40]. Council has done nothing to fund the scheme, when interviewing the District Treasurer he said:

> I didn't know if I'm supposed to remit the money to Community Health Fund account, remittance is not a problem but nowadays Council is facing problems in the revenue collections because the Central Government has provided the directions to stop collecting some of council's sources of revenue so Council is paralyzed.

The data which I have shows that the council receives Tanzania shillings 678,221,000 million from donors equivalent to 423,888,125 USD, a block grant of Tanzania shillings 259 million equivalent to 161,875 USD and Tanzania shillings 98 million equivalent to 61250 USD for procurement of drugs which the Ministry of Health and Social Welfare sent directly to Medical Stores Department. In spite of all the funds the scheme is under-funded.

Primary health care is financed mainly by the Government and the donors, Block grants are directly released to the local government authorities by the Ministry of Finance and Economic Affairs. The allocation of funds is based on a formula in which the following factors are considered. Population 70%, Poverty count 10%, District Medical vehicle route 10% and under five mortality rate 10%. (NAO[41]: 2008:14-15) (SIC). The allocation of the basket funds follow the same formula.

5.8 Procurement Processes

The Public Procurement Act 2004 provides for competitive tendering procedures through decentralized procurement and enabled procuring entities to be responsible and accountable for their individual procurement decisions and actions. As a general

[40] According to Section 23 of the Community Health Fund Act 2001, the funds and resources of the Fund shall consist of: (a) all moneys received in respect of contributions paid by members; (b) user fee payable for using a government health centre or dispensary; (c) Government contributions; (d) Grants from councils, organizations or any other donor; (e) any other money lawfully acquired from any other source.

[41] National Audit Office.

rule the council cannot procure anything without following the procedure on procurement. The Council tender board is mandated to regulate procurement activities of all public procuring entities. If the council wants to procure anything it has to fulfil the requirement set by the Public Procurement Act of 2004 and its regulations. One of the staff said,

> Government procedures on procurement consumes a lot of time, once the dispensary or health centre needs to procure drugs they place order in writing to District Medical Officer then District Medical Officer writes a letter to District Executive Director for approval .After District Executive Director approval the letter is forwarded to the District tender board on which the secretary will convene a meeting to decide on the procurement methods.

Depending on the method of procurement, if the council tender board authorizes the procurement using the quotation, the advertisement takes seven days to give chance to bidders to apply for the tender, if it is for competitive bidding the adverts takes 21 days. After tender opening, the secretary of the council tender board informs the director in writing and proposes the names of persons who are going to form the evaluation team for doing the evaluation to District Executive Director. The director, however, is not bound to appoint anyone from the list submitted by the tender board secretary, can decide otherwise. If the Director appoints the evaluation team has to take seven days to give time for the team to evaluate the tenders and come out with the lowest evaluated tender price[42]. Lastly the secretary of the Tender Board convenes a board meeting for the tender board members to award the tender, after the award the secretary informs the bidder the decision of the board and instructs to come to sign and execute the contract. (My experiential data)[43]

The procurement Procedures affects the Fund because once there is a delay in procurement of drugs it accelerates the shortage of drugs at the health facilities which leads to users to complain on the quality of service delivery.

---

[43] Acquired in my work place when acting in accordance with the Public Procurement Act, 2004 and its Regulations of 2005. I am a legal officer and have been a member of the Procurement Management Team and member of the Council Tender Board.

5.9 The Confusion over and resulting Mismanagement of 'Exemptions' and 'Waivers' in relation to access to Health Care Services

The terms *'exemption'* and *'waiver'* are often used interchangeably in the literature although they refer to different groups. An *'exemption'* is statutory entitlement to free health care services granted to an individual who automatically falls under the categories specified in the cost sharing operational manual. A *'waiver'*, on the other hand, is granted to those patients who do not automatically qualify for statutory exemption but are in need of the same and are classified as being unable to pay in the operational manual (Mtei and Mulligan:2007).

The system for exemptions and waivers was originally introduced to ensure that particular groups of the population had access to appropriate health care. The groups ranged from various population groups, including, pregnant women, children under 5 years to group of people with particular diseases like TB, leprosy and in epidemics. The reasons for introduction of the exemption and waivers system was as a result of the recognition of the importance of providing easy access to these groups of the population, for whom appropriate care and treatment is crucial.

The system of exemptions was introduced prior to the introduction of social insurance schemes such as the NSSF[44] and the NHIF[45], which provide cover for formal sector employees and their families and civil servants and their families, respectively. The exemption and waiver system was expanded with the introduction of the Community Health Fund scheme and user fees for the primary health care level. While the exemption and waivers concept is still entirely valid for poor individuals and households participating in the CHF and for those not covered by any other insurance scheme, the policy requires updating to take account of the possible impact of the NHIF and the NSSF schemes.

[44] National Social Security Fund.
[45] National Health Insurance Fund.

Membership is open to all, however certain people may not be able to pay the required contribution, and these are orphans, destitute or elderly people with no one to take care of them (Ministry of Health: 2005). Thus the exemption policy makes sure those people in need of health care services and who do not have means to pay are not denied medical care.

The Community Health Fund Act of 2001 requires the Council Health Service Board to set exemption criteria for users of the health care services provided by the Fund, the requirement is according to Section 15(1) (d) of the Act, 2001[46] .When I did the focus group discussion with the Council Health Management Team (CHMT), I asked them the criteria used to give exemption on medical care and the officer responsible for giving exemption, I was referred to the District Social Welfare Officer.

The power to issue an exemption is vested in the Ward Health Committee, the law states that[47]:

> *The power to issue exemption to pay community health Fund annual Contribution to any person shall be vested into the ward Health committee after receiving recommendations from the village council and council shall authorize that person to obtain a community health fund card. The exempting authority shall seek alternative means of compensating the fund, Notwithstanding subsection one of this section, the minister after consultation, with the respective council, may by order published in the gazette issue exemptions as he may deem fit.*

The process of exempting a person or persons from fee for medication takes the following steps: the village council or its committees should identify people who are very destitute i.e. the poorest of the poor. The list is forwarded to the ward health committees for further scrutiny; once endorsed, the list is forwarded to the council health service board which will issue a Community Health Fund membership card for those people to access health care services. In exceptional circumstances such as for accident victims, non CHF members who are critically ill (life threatening status) and have no money to pay the user fee individuals are considered for exemption (MOH:

[46] The function of a Council Health Service Board shall be to set exemption criteria for users of the health care services provided by the Fund.
[47] Section 10,(1),(2),(3)(1) of the Community Health Fund Act, 2001

2005:19). According to UNICEF and Bitran (2003), the performance of exemption and waiver systems is seldom evaluated (Laterveer Leontien.et.al.2004).

The law[48] states clearly who has the power to issue exemption to get heath care for free. In practice District Social Welfare officer, Village Executive Officer and Ward Executive officers are responsible for recommending which people get exemptions from paying for medical care. The people who are exempted are required to be given community health fund cards, that has not been done, those people who were given exemption just have letters introducing them.

On top of that the law requires the exempting authority to seek alternative means of compensating the fund; again, nothing has been done in this respect. Members of the Board were complaining that the board is still in its infancy and has not started functioning, while the District Treasury officer was of the view that the Council has no money from its own source to contribute. At the end of the day the poor and vulnerable people are the ones who suffer because they are left without health care services.

When interviewing the district social welfare officer on the criteria used to provide exemption to people, I wanted to know about the elderly and vulnerable people like the disabled. Why older people? Because self employed women may reach a point of old age such that they fail to do business. Women from the Maasai tribe are the ones who are supposed to take care of the family and sell their products, at the end of the day they are forced by the customs and traditions to give all the money to the husband, since their customs and traditions do not allow women to own land or any property. Hence in their old age they needed to be assisted in getting free health care services.

For vulnerable people like the disabled they are supposed to get free health care services but because of widespread poverty amongst disabled people and their families limit them from accessing required technical aids which would assist them to easily reach health facilities. As a result the majority of people with disabilities particularly in the rural areas are unable to access health services. (National Policy on Disability, 2004).

[48] Section 15(1)(d) of the Community Health Fund Act, 2001.

The criteria used to identify elderly and vulnerable to get exemptions and receive basic health services for free through the community health fund is based on the ageing policy of 2003 which assist in identifying older people to receive social security, The policies assists social welfare officers to consider on those who are determined to be vulnerable and most vulnerable, in a sense that they did not own anything, or have anyone to take care of them and they live in poverty.

For example the data gathered from Oltrumet Health Centre and Selian Lutheran Hospital which is a Designated District Hospital[49] for Arusha District Council. Showed that there were 11,170 older people of whom 5,457 were men 5,713 were women, unfortunately, only 67 elderly women had managed to get exemption and use the health card in getting health care services.

When I interviewed patients at Manyire Dispensary I found they had the letter from the Village and Ward Executive officer giving them exemptions because they were poor and could not pay. Well and good, the ideas of Government provision for exemption is to make sure that destitute are able to get health care services when they are in need. The number and the cost of people who receive exemptions like pregnant women, children under five years and elderly, waivers like vulnerable social groups and poorest of the poor are not known because there is no mechanism in place to identify or track them.

Even if the mechanism was there still there is a loophole and contradictions on who is supposed to grant exemption on health care services. This is because when the Government enacted the Community health Fund Act and vested the power of giving exemption to ward committees, the Social welfare cadre was not part of the Local Government, the cadres were found in the Central Government. Due to the Local Government Reforms the Government established the cadre of Social Welfare in Local Government intending to deal with the welfare of people in the rural areas including giving exemption and waiver where there is a need of doing so.

[49] A 'Designated District Hospital' means a voluntary agency level 1-hospital, established and empowered to act as the District Hospital on a contractual basis with the Government.

One staff member from the social welfare department is supposed to be part of the Council Health Management Team and is stationed at Oltrumet Health Centre, to provide assistance in evaluating patients who needs medical care and do not have any means to pay. So far there is no clear provision set by the Community Health Fund Act to give power to the Social welfare officer. On top of that the people in the committees are not knowledgeable enough to assess people who need exemption and some of them volunteer their time to work without any pay.

People who receive exemptions are many and District councils are expected to fully subsidize the Community Health Fund membership fee for those who have been exempted or waived. In addition to that the former Tanzania President Benjamin Mkapa emphasized that relevant councils should set aside funds in their budgets for purchasing CHF card for their less fortunate constituents without the means to afford them (President Benjamin Mkapa:2005). Yet this has not been done by Arusha District Council.

The poorest people do not have access to waiver and exemption due to lack of information. I managed to interview an elderly self employed women to see whether she knew about the scheme, she had no any information of whether she was entitled to get free health care services. Also she affirmed that the gender roles and impair self employed rural women's ability to contribute to the fund due to their adherence to the custom and traditions of Maasai community.

The National Ageing Policy[50] recognizes that laws do not protect older people and the current social and legal system does not provide adequate protection and security to older people as a special group. They do not receive deserving care and older women are denied the right to own property. Also they do not belong to any formal social security system and those retired older people who are members of social security schemes face problems resulting from inadequate benefit and bureaucratic bottlenecks.

[50] 2003.

The policy went further and refers older women and incompatible traditions. Older women are more affected by old age problems and they live longer than men besides their struggle against problems are related to their gender. Also the policy realized that majority of people become old with poor health due to poor life style and poor nutrition during their childhood. Women heavy work load and frequent pregnancies further harms their health. In addition, health services are not easily accessible to the majority of older people besides they are expensive and health care professionals on the other hand lack motivation and are not adequately trained to handle older people's illnesses.

Furthermore the existing poverty reduction does not include older people. Therefore the rationale of the policy is to guide the provision of services and the participation in the life of the community is not effective.

The picture below shows a self employed woman approximated who appears to be older than sixty years of age. She is selling charcoal and uses the donkeys, which are owned by her husband, to carry the bags of charcoal. According to the National Ageing Policy of 2003 she is supposed to get free medical care but she is not aware of her right to do so. Furthermore, she does not earn enough from selling charcoal to contribute to the Scheme and even if she did she has to give all the proceeds of her income to her husband who remains in control of the disbursement of what she earns.

Figure B: Photograph of a Maasai woman charcoal seller with her two donkeys

5.10 Inadequate Law

At the time of selecting the topic I thought the Community Health Fund by-law was in place because I had already finished the preliminary procedure of making it, unfortunately the by-laws were mistakenly printed with mistakes and was withdrawn so I took it that there was no law in place. I tried to inquire from the responsible authority whether it was in place they said they were in the process of correcting the mistakes.

5.11 Political Intervention in the Health Care Delivery

Politicians envisaged Oltrumet Health Centre to offer health care services which are supposed to be provided by a district hospital. The services offered by the health centre are similar to those offered by the dispensary but the health centre offer more specialized services which include an inpatient department for patients who require short hospitalization and to supervise dispensaries as well as provision of primary health care (National Health Policy: 1990). When interviewing the medical officer in charge he said:

> This has become a big challenge because Oltrumet Health Centre provides surgical services which we are not supposed to do. This led to the National Health Insurance Fund to refuses to refund costs of the health services which were not supposed to be offered by the health centre.

5.12 The Scheme is not geographically accessible

Geographically the health facilities are not accessible due to long distances coupled with poor roads, inadequate and unaffordable transport facilities. This limits the poor from accessing the health care. Makene.S.F (2007) consider that since Independence the government has put much emphasis in rural health care. However the rural focus in the health sector is not accompanied by the development of infrastructure which still reflects Tanzania's ongoing process of urbanization.

For the majority of the rural population especially those working in the informal sector primarily in subsistence agriculture, it is difficult to cover transport cost, as a result rural dwellers do not access referral facilities even if they are members of financing scheme that offers this benefit (Haazen, 2012).This situation happened in the facilities which I visited as the allocation of vehicle are not proportional to the needs of health facilities, it's not easy for a patients to walk hence they incur costs if they want to reach a referral hospital

The health policy[51] requires Health Centres to have at least a four wheel drive vehicle in addition to motorcycle and bicycle. A dispensary to have a bicycle as a means of transport, unfortunately this facility was not available to Nduruma Health Centre, Ngorbob and Manyire Dispensaries the only appropriate transport was available at Oltrumet Health Centre.

[51] National Health Policy of 1990.

CHAPTER SIX

6.0 EMERGING ISSUES

6.1 Poor Record Keeping

There is poor record keeping in the health facility I visited, even the staff member responsible to keep record at the Oltrumet Health Centre was just recruited a few months ago. This meant that before there was no one responsible for taking the CHF members record so as to keep accurate record their utilization of the facility in timely manner. There was no patient register that showed treatment of CHF members. This will cause difficulties when it comes to auditing to know whether the patients were valid CHF members or not.

The table below shows Community Health Fund members who were attending Oltrumet Health Centre and got health care services since 2004-2011. I got the statistics from Medical Officer in charge of the Oltrumet Health Centre after accessing the ledger. This was after failing to get it from the Community Health Fund Coordinator. I checked from the ledger the daily correspondence from the beginning of January up to the end of the month till the month of December and recorded the number of members who were attending daily. I did the same recording to the year 2005, 2006, 2007, 2008, 2009, 2010 and to 2011 to see the attendance of patients.

Table 2: Showing the Community Health Fund Members who attended Oltrumet Health Centre during the period 2004-2011

	2004	2005	2006	2007	2008	2009	2010	2011
JAN						01	02	02
FEB					03	01	05	01
MARCH					04	-	02	-
APRIL					09	-	-	01
MAY					02	03	2	07
JUNE				14	09	03	-	03
JULY				11	20	09	08	-
AUG				25	14	11	06	05
SEPT				17	03	03	12	-
OCT				07	02	05	08	-
NOV				36		01	07	-
DEC				08			02	09
TOTAL	120	166	98	118	68	37	54	28

Based on the above table, the year 2004 up to 2006, I was not able find the monthly records for patients who went to the health centre to get health care services. When asked the Medical in charge officer if there were no patients attending the health centre he said no and added that patients were attending but the problems at that time was that there was no staff responsible to keep record on the transactions. In those days they used to record if they had chances to do that since then they had other duty of attending patients.

The table reveals that the community has not responded to the scheme because since the establishment of the Community Health Fund Act, 2001, the number of people who have enrolled in the scheme is very few compared to the number of Household in the district. In 2007 was peak, I was told that it happened because at that time the District Medical officer had put many efforts in creating awareness and sensitization on the scheme and Oltrumet was a pilot area. Unfortunately when was transferred to another District the programme become stagnant. The SWISS TPH, (2010), observed this situation and argued that the District Medical officer plays key role in determining the viability of a fund.

When I asked for the financial ledger to see if was kept up to date with the revenue collected daily at the health facility, I was told to ask the Community Health Fund

coordinator or the accountant who is at the headquarters of the council about 40 kilometers away. Council Health Management Team is not given daily updates of Community Health Fund money as required, the records are supposed to be maintained at District Medical officer office but none of the ledgers had been reconciled with the District Medical Offices office to reflect on the transactions that occur at the district level.

I wanted to know the statistics on people in the district who had contributed to the fund and had benefited from the health care facility. This question was directed to the Community Health Fund Coordinator who said that at the time there were 4049 members who are benefiting from the health care facility through the Community Health Fund in the District. On that note I wanted to find out how many self employed women had managed to contribute to the scheme and he asked me to give him time to prepare the data. Unfortunately I was not able to get the data as promised; he gave me excuses whenever I reminded him of the data.

When I wanted to get the statistics of community health fund members who get health care services at Nduruma Health Centre and Manyire Dispensary, the staff at Nduruma told me that they had been taken by the health fund coordinator. I went to the health fund coordinator to ask about the register he said he did not have it, I asked why and he replied that he had already returned to them. At the end of my field research I had been not able to get those statistics.

The Community Health Fund coordinator was not sure of the amount of money that had been contributed by members that year. He said that the person to ask was the accountant who was responsible for the health department. When I asked him how much had been added by the government as a matching fund, he said they had just applied for the matching fund and did not know what they were going to be given.

If he had the register book, he might have been in a position to find out the number of people who had contributed to the fund. Matching funds are given depending on the number of members who have been contributing to the scheme, as a prudent administrator he should have been in a position to know the Community Health Fund members and amount of money contributed. To me it seemed that there were no

records of CHF members in Nduruma Ward who got the health care services at Nduruma Health centre and Manyire dispensary using the community health fund card.

6.2 The Concept of 'mechanical solidarity' is not well known

The concept of 'mechanical solidarity' is the form of social cohesion based on the similarity of the members whereby they share responsibility; it is the value of underpinning social security (Kanyongolo lecture, 2011). The concept of 'Mechanical Solidarity' is a term used by Emile Durkheim[52] (1858-1917) to refer to a state of community bonding or interdependency which rests on a similarity of beliefs and values, shared activities, and ties of kinship and cooperation. It is the social integration of members of a society who have common values and beliefs. These common values and beliefs constitute a "collective conscience" that works internally in individual members to cause them to cooperate.

There is a misconception of the whole idea of mechanical solidarity within the Maasai community, this is due to the fact that when a member has contributed in a particular year and does not fall sick the contribution is considered to be a loss. This concept has been discussed by (Euro health Group,2006) that the misconception of the idea of solidarity, if someone in the household does not fall sick in a year the contribution is considered to be a loss.

According to (Kanyongolo and Gwisai: 2011). Solidarity can be conceptualized as a value or merely in relational terms, as characteristics of social relation important for social cohesion. In their analysis they emphasized that solidarity is how its conception

[52] Emile Durkheim introduced the terms 'mechanical solidarity' and 'organic solidarity' as part of his theory of the development of societies in "The Division of Labour in Society" (1893). In mechanical solidarity, its cohesion and integration comes from the homogeneity of individuals. People feel connected through similar work, educational and religious training, and lifestyle. Mechanical solidarity is found in "traditional" and small scale societies. The basis of organic solidarity is abstract and may be weakened by anomie when people fail to comprehend the ties that bind them to others.

and the way it is translated in practice, has serious differential implications for survival of risks between and among men and women and hence for their social security.

People do understand the concept of solidarity in situation such as funerals and weddings where they are able to contribute and raise funds to assist members of their communities but not in health care services. This is partly due to the fact that after independence health care services in Tanzania was provided for free but due to social economic policies like the World Bank structural adjustment programme required cost sharing in health care services people are reluctant to adapt the cost sharing and they do not put in any effort to contribute to the scheme. One of the government staff interviewed had this to say;

> The scheme is very new and I don't know if I'm supposed to audit the community health fund account. Community Health Fund is like a crush programme because at the time when the government introduced the scheme there was a need of conducting trainings to all the staff and people who in one way or another they will come to deal with the scheme. But the government was not prepared and it forced a scheme to run, he gave me several examples of the programmes which were implemented in the level of a district that were trained on how to audit but for Community Health Fund nothing have been done.

The government has not put any mechanism in place to make people aware of the scheme from the grassroots level where majority of rural people are found. During the interview one respondent said,

> Government should educate people and disseminate knowledge on the schemes benefits from the hamlet, village and ward level through the village assembly where the majority of villagers attend the meeting.

6.3 Loss of Trust in Health Care Delivery

Among the people I interviewed some revealed that community has the capacity of contributing to the scheme but people do not want to contribute because of the poor delivery of health care services.

Community health fund was introduced in order to alleviate the poor services delivery in the health sector. The scheme has proved to be a failure because of the persistent shortage of drugs and other medical supplies which are available only for a period of one or two weeks in a month soon after the regular monthly delivery of supplies. One of the respondents has to say this:

> It's better to have my money in my pocket rather than contributing to the Fund, if you contribute the time you want to use the service they tell you there is no drugs, the solution to that is to buy the drugs in the private hospital. Are you still convincing me on the facility provided through the community health fund? No way it's better to remain with my money.

6.4 The persistent Shortage of Drugs

The persistent shortage of drugs is caused by the inadequate and late allocation of funds. There is a shortage of drugs and medical supplies from medical stores department and most of the time they face financial instabilities because the Government delays in releasing money for buying drugs.

Haazen, (2012) has attributed that Medical equipment such as microscope and drugs are often in short supply or lacking altogether at public health facilities. This is a common complaint among both National Health Insurance Fund and Community Health Fund members, however this problem adversely affect Community Health Fund members more than other schemes because their health insurance in most cases offers treatment only at public primary facilities within their home district. Also Gottret, P.et.al. (2009), argued that the quality of health care will decline in the absence of critical inputs such as equipment and medicines.

The funds for drugs are allocated annually from the Ministry of Health and Social Welfare to the Medical Stores Department based on analysis for each health centre. The Medical Stores then play the role of procuring, storage and distribution of the required and approved drugs as per health centre request (NAO, (2008). There is a lack of financial stability in the health centre and dispensaries which causes persistence shortage of drugs. A staff member at Ngorbob dispensary revealed;

> Usually we receive drugs quarterly, last kit was in September 2011 but up to January 2012 we have not yet received another kit. There is a shortage of drugs we tell patients to go and buy in private pharmacy, sometimes they borrow drugs and medical supplies from other Government dispensaries because they don't have many patients who went to get health care services. In November and December 2011 there was a crucial shortage of drugs to the extent of deciding to write a letter to District Medical Officer seeking a permission of using CHF money to buy drugs but since that time up to now we have not yet received the answer.

The issue of Shortage of Drugs was discussed by Euro Health (2006) that District with continuous kit supply experience severe shortage of drugs at primary health facility level during the second half of the month. Also the issue of shortage of drugs was addressed by a patient whom I interviewed and who had this to say;

> There is persistent shortage of drugs, in December 2011 there were no drugs at oltrumet health centre, and we ended paying 2000 Tanzania shillings for consultation without being given any medication. The Government is stealing from us because the staff knew the shortage of drugs but failing to tell the patients, taking our money for consultation telling us to go and buy drugs from private pharmacy that is stealing.

On top of that another patient at Oltrumet Health Centre said that

> The Government has failed to provide us with the quality health care services because we are poor and we don't have any means of complaining, they just accept what comes to them, we are dying and death is our destiny.

6.5 Inadequate Participation in Decision-making

It appeared that the scheme was introduced without community participation; government had put in place cost sharing as one of the conditions of structural adjustment programmes for which the community were not prepared.

Community participation is very limited in regards to determining health care priorities, deciding where funds should be allocated, and monitoring expenditures. I also inquired if they have done a financial feasibility to see whether the premiums set could make the Community Health Fund scheme viable, the responded were negatively and they added that as a matter of practice they usually looked at the social situation of the certain community before the Council Health Management Team endorsed the premium. This was contrary to what is supposed to be done on the ground; Council Health Management Team endorsing the premium was to be by the Board.

6.6 Insufficient Compliance with the Operations Manual

Ministry of Health and Social Welfare has produced the guidelines on how to utilize the funds of the CHF Scheme. But there is inadequate management of the funds as directed by the guidelines, also the information systems have not been put in place to ensure appropriate collection and utilization of fees.

Communities in the Maasai area were not involved in planning and financial management of health services to ensure that health services focus on meeting their priority needs. The Government staff especially in the health department have failed to follow those guidelines which may help to sharpen the quality of health care delivery.

6.7 Overburdening of Health Officers

Health officers have the duty of providing health care to patients, at the same time making sure they prepare reports, daily recording and reconciliation of fees collected at the end of the day. This is tedious for them because accountants are supposed to do that yet they are stationed 40 kilometers away.

The Council Health Management Team is responsible for supervision and monitoring of the Community Health Fund, as well responding to the problems regarding the CHF at the facility and ward levels. Council Health Management Team members are required during supervisory visit to review CHF Financial ledger to see if the in charge of a health facility is recording all the information in a complete and in a timely manner. This includes fees collected, expenditures, deposits, and the balance of the Community Health Fund account (MOH: 2005:3).

The Council Health Management Team member should calculate the amount of money that should have been collected and oversee if the money has been transferred correctly. This creates extra work that supposed to be performed by accountants who are specialized in managing and dealing with the financial matters, health staffs are required attend patients only.

6.8 Understaffing and Overstaffing of Health Facilities

Although the staffing level is being revised to take into account the increased density of health under the primary health care development programme, there is no doubt that significant human resources shortages exist (Haazen, 2012). During my field research I found out that there was lack of staff at Ngorbob and Manyire dispensaries. Also I found out that there is understaffing at Nduruma health centre and overstaffing at Oltrumet health centres.

Table 3: Showing the number of Personnel at the Health Facilities visited

Cadre	Health Policy requirement		Ngorbob dispensary	Manyire Dispensary	Nduruma health centre	Oltrumet health centre
	Dispensary	Health centre				
Medical officers	-	-	-			2
Medical Assistant /Assistant medical officer	1	1	-			7
Rural Medical Aide		1	-			
MCHA or Public Health Nurses or Nurse Midwife	1	4	5	1	1	40
Pharmacist	-					2
Pharmacal assistant	-	1				
Laboratory technician	-					2
Assistant laboratory technician	-	1				
Nutritionist	-	-				
Health secretary	-	-				
Clinical officers	-		3	1	1	16
Assistant Clinical officer					1	
Medical attendant	-			1	1	
Health officers	-	1				4
Rural health assistant	1					
Ass. health officer	1	1				
Guards						2

The table above shows that Oltrumet Health Centre has 2 Medical Officers, 7 Medical assistant and 16 Clinical officers, while other health facilities faces shortage of staff members. There is a need of a Council to distribute Health staff members stationed at Oltrumet Health Centre proportionally with other health facilities to reduce the workload to staff members at Nduruma, Manyire and Ngorbob.

According to health policy dispensary services shall cater for between 6000 to 10,000 people and the long term objective is to have 1 dispensary for each village to expand the scope of primary health care. The health centre services are expected to cater for 50,000 people, which is approximately the population of one administrative division.

Based on Arusha District Council strategic plan, Oltrumet ward has a population of 7031 according to census of 2002, the population was projected to reach 8944 in 2010. Therefore the approximately population projected by the health policy for a facility to provide health care services at oltrumet health centre is within its limit.

The Nduruma ward has a population of 10,279, according to the census of 2002 and the population is projected to reach 13,075 in 2010. For this case Nduruma Health centre is within the demarcation of providing quality health care services as approximated by the Health Policy, but it faces understaffing of health officers.

Ngorbob village has a population of 3310 according to the census of 2002, the population was projected to reach 4210 in 2010.Although the number of people supposed to get the health care services at Ngorbob village is within the projected number provided by the National health policy, Ngorbob dispensary has to provide health care services to of about seven other villages which are Kisongo, Mateves, Elkerin, Lemgur, Meserani, Moita, Musa and Likamba.

According to the National Health Policy each village is supposed to have one dispensary for expanding the scope of health care services. Staffs at Ngorbob dispensary are attending to more than seven villages; it means they attend more than 10,000 people which is in contravention of the health policy. Also the resources allocated to run the dispensary are not enough to cater for the number of patients who access the health care services at Ngorbob dispensary .This scenario was also discussed in the report of the National Audit Office (2008)[53], that there is no criteria for allocation of resources, the allocation of resources from the council to the health centres does not reflect the actual performance by terms of workload, waiting and processing time the consequence is they have fewer resources as compared to low workload .

CHAPTER SEVEN

[53] National Audit office. Report done by the office of the Controller and Auditor General of Tanzania

7.0 CONCLUSION, DISCUSSION AND RECOMMENDATIONS

7.1 CONCLUSION

The health sector is seriously under-funded despite the fact that it is a priority sector in the Poverty Reduction Strategy.

The Community Health Fund is a tool for decentralizing decision making and improving management of health care services within the district whereby the community participates and owns health services and monitor the quality of service offered to them through health committees.

The Community Health Fund scheme is a cost sharing programme to complement the government provision of health care services. It started its operations with many expectations from the community. The scheme has proved to be a failure because it has failed to provide what is required and expected by the rural population. This situation is caused by lack of awareness and sensitization on the programme, low enrolment of members, and lack of funding from its various sources, persistent shortage of drugs in health facilities which led to the poor service delivery. Therefore the members were unhappy and their numbers started to decrease as a result of the loss of trust in the health care delivery.

Tanzania has signed the Memorandum of Understanding with the National Health Insurance Fund to manage the Community Health Fund, to increase coverage of health care services to rural people. Still the majority of rural people remain uncovered by the formal social security schemes. This situation was attributed by Schweiz, (2011) on the unclear roles and responsibility of NHIF whereby there is no distinction between the responsibilities of the council and of the NHIF, as the law still stipulates the councils as being responsible for the management of Community Health Fund. Also the situation has been explained by Borghi, J.et.al (2009), as based on health care financing is relatively being high but little is known about the mechanism to extend health insurance coverage. Insurance implies pooling health fund and risks such that

citizen can be provided with financial protection against the potentially high cost of health care when in need.

Tanzania has potential that remains uncovered in the social security schemes and which call for the government's intervention to increase coverage. The National Social Security Regulatory Authority which was created under the Social Security Regulatory Act of 2008 should come in place to integrate formal and informal social security schemes by removing dichotomies in order to make sure there is ultimate developed, coordinated and comprehensive social security system that caters for people in rural areas and self employed women that are in the informal sector.

7.2 RECOMMENDATIONS

To make the scheme viable the following needs to be implemented by the council -:

7.2.1 Improvement of Medical Service Delivery

Social protection provided by the government through the CHF to rural people does not provide an adequate response to their health problems, thus there is a group categorized as the informal sector who are not covered by the formal social security.

7.2.2 Awareness and Sensitization Programmes

There is a need for raising the awareness to the community by conducting sensitization programmes on the community health fund through the village assemblies where leaders and elders will get opportunity of addressing the benefits of their contributions to the whole community. I have made this suggesting recommendation because what I found in the field shows that the majority of my respondents do not know about the programme and even some of the staff who are supposed to assist in its implementation do not know that the role they play forms part and parcel of the success or failure of the scheme.

7.2.3 The Provision of Proper Training

Low motivation of health staff endangers the quality of service provision in health care facilities. All the staff who are dealing with the programme must get the opportunity of attending those training offered by the government and stake holders on how to manage and implement the community health Fund scheme. The issue of training to people who run the scheme was emphasized by Dekker, (2006), who states that the Government can ensure that technical support, advice and training are available to groups switching to the establishment of the informal social security schemes and to groups already operating informal social security scheme. Members of staff who have managed to attend those workshops must share with their fellow staff members on what to be done to improve the quality of the health care services.

7.2.4 The Holding of Members' Meetings

The community health fund coordinator must make sure that members of the scheme met to discuss on their problems concerning the scheme. Although women in Maasai community are engaging in self employment they have to seek permission from the husband for making contributions in Community Health Fund scheme, the council should convene members meetings for women and show that women must be fully integrated in getting the quality health care. The Community also need to improve the situation of women in society as health issues are human rights issues and health must be enjoyed by everyone in the community.

7.2.5 Improvement of the Referral System

The Council should improve the referral system to allow Community Health Fund members able to use the CHF health card to the level of District Hospital. Currently CHF members are able to use the CHF health card to the level of Dispensary and Health Centre which covers primary health care only. The cost of primary health care services at the Dispensary and Health Centre is very small compared to the cost incurred by members when they get a referral to a District Hospital (Selian Lutheran

Hospital which is a designated District Hospital for Arusha District Council). The covering of the referral system to Selian Lutheran Hospital will encourage people to join the scheme.

7.2.6 Improvement of the Procurement Process

The government staff must use the exceptions provided by the Public Procurement Act,[54] on the procedure and methods of procurement at times of scarcity of drugs at the health facilities in order to overcome the problem of shortage of drugs.

The Public Procurement Act[55] provide exceptions on the selecting of the methods of procurement in circumstances where there is urgent need for the goods, works or services such that it would be impracticable to engage in open national or international tendering or competitive selection or there is need to achieve certain social objective by calling for the participation of local communities, the procuring entity may either restrict the issue of tenders in accordance with the procedure set out in the regulation provided that the circumstances giving rise to the urgency were neither foreseeable by the procuring entity nor caused by dilatory conduct on its part. The procuring entity shall include in the records under the Act a statement of the grounds for its decision and the circumstances on which relied on to justify the restriction.

Also the services must be improved to the extent of the drugs being available in private dispensaries for free in case they are not available in Government Dispensaries and Health Centres.

7.2.7 Improvement of Physical Accessibility to Health Care Facilities

The health centre and dispensaries are not geographically accessible due to the poor infrastructure and walking distance. The Government should allocate money in their budget for road maintenance to make sure roads are passable at all times. Also if there

[54] 2004 and its regulations of 2005.
[55] Section 54(1),(2),(a),(b),(c),(d),()().

are inadequate financial resources in the Government budget, the council should look at available resources at Oltrumet Health Centre and distribute accordingly.

7.2.8 Implementation of an effective Monitoring Mechanism for exemptions and waivers

The aim of the Government is to assist vulnerable people, the destitute, poorest of the poor and in exceptional cases those people who are critically ill in circumstances of accidents and have no money to pay for health care services. Monitoring and evaluation programmes should be introduced in the council and placed in the Social Welfare Department in order to know the number of people who are exempted and waived by the laws and policies to get free medical care in the government health facilities and be given Community Health Fund medical card for their use .

Also the staff at the headquarters should visit dispensary and health centres, talk with employees in remote areas and the community who uses the health facility so as to be well informed with their challenges to look for immediate solution to their operating problems.

This will assist in getting the information on the costs incurred on the consumption of the drugs and medical supplies hence those cost to be deducted from the council own source budget or included at the time of budgeting.

7.2.9 Improvement in the Sourcing of Funding

Donor funding have been explained under the law as one of the sources which the scheme relies on. There council through the Council Health Service Board should apply for the sources of funding from the potential donors to finance the scheme. This should be done by writing proposals and collaborating within and outside the country.

Bibliography

Bentzon,A.W.,et al(1998). Pursuing grounded Theory in law,South,South-North experience in developing women's Law. Harare

Brocas, A. M., Cailloux, A.M., Oget,V.(1990).*Women and social security: Progress towards equality of treatment.* ILO, Geneva.(ILO research Work in the field of social security).

Borghi, J.,et.al.(2009).Methodological challenge in evaluating health care financing equity in data- poor context: lessons from Ghana, South Africa and Tanzania. In: Chernichovsky, D and Hanson, K., eds(2009).*Innovation in health system finance in developing and transitional economies* ,.Emerald Group Publishing Bingley.UK

Bungura, Y.(2010).*Combating Poverty and inequality, Structural change, Social Policy and Politics*. Geneva,. United Nations Research Institute for Social development (UNRISD).

Christianson,M.(2006)."Health Care".In: Strydom, E.,ed. *Essential Social Security Law*. Cape town, Juta.

Dahl, T S (1987); Women's Law: An Introduction to Feminist Jurisprudence. Oslo. Norwegian University Press

Equality for Growth (undated), Empowering women in business. Available online at http://equalityforgrowth.org/, accessed on 03/04/2011

Ginneken,W.V.,ed(1999).*Social Security for excluded Majority* (Case Study of developing Countries . ILO, Geneva.

Gottret,P.,et.al.(2009).Protecting Pro-Poor Health Services during Financial crisis. In: Chernichovsky, D and Hanson, K.,eds(2009).*Innovation in Health System Finance in Developing and Transitional Economies*,. Emerald Group Publishing, Bingley, UK.

Haazen, D. (2011). Making Health Financing work for the Poor People in Tanzania:*A health financing Policy note*. Africa Region. The World Bank Publication

Haazen, D. (2012). Making Health Financing work for the Poor People in Tanzania: Washington DC. The World Bank

James, E.,Edwards,A.C.,Wong,R. (2008).*The gender impact of social security reform*. University of Chicago Press.

Jutting, J.(2003)."Improving Health Security in low-income countries: What role for Community Based Health insurance scheme? In: Hein, and Kohlmorgen.,eds. *Globalization,Global health governance and national health Politics*.Hamburg, GIGA

Kanyongolo, N.R.(2011). Lecture given to the Labour and Social Security Class, SEARCWL, Harare, Zimbabwe: Orally

Kanyongolo, N.R and Gwisai, M.(2011).”Women, Labour, Social Security and Law.In: Tsanga, A and Stewart, J.eds (2011) *Women and law: Innovative approach to teaching research and analysis*. Harare, Weaver Press and SEARCWL

Kritizinger, A. (undated).*The status of feminism and feminist theory*: Occasional paper 4; Institute for Women and Gender Studies, University of Pretoria
.
Laterveer L.et.al. (2004), Equity implications of health sector user fee in Tanzania: Analysis of literature and stakeholder view. ETC Crystal, Leusden.

Maasai Association.(undated). Maasai ceremony and rituals. Available at http://www.maasai-association.org/ceremonies.html

Makene,S.F.(2007). *Tanzania Negotiation of Conflicts in International Legal Requirements for the Treatment of Children and Elders*. Dissertation submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy, University of Minnesota(Published).
Available at http://books.google.co.zw/books/about/Tanzanian_negotiation_of_conflicts_in_in.html ?id=TdCHGX0NV7gC&redir_esc=y,

Mtei, G and Mullingan,J.A , (2007). *Community health funds in Tanzania*: *A literature review*. (Ifakara Health Institute, Dar es Salaam).

Nkoitoi,N.S.(2005).The life of Maasai Women.OFCD,Salt Lake City. Available online at http://www.ofcd.org/story.html.

Norman, M (2008).”*Out but not missing out*”: a study of the implications and coping strategies resulting from exclusion of the female dominated informal sector from the national social security schemes in Zimbabwe. Dissertation, submitted in partial fulfillment for the Masters Degree in Women’s Law, University of Zimbabwe. (unpublished)

Olivier, P.M and Mpedi, G.L(2009).*Understanding Social Security Law*.Capetown.Juta Law.

Preker,A.et al.(2004). “Rich Poor difference in health care financing”. In: Preker, A. and Carrin, G. *Health financing for poor* people,pp.3-51. Washington DC. The World Bank

Mkapa,B.W. (2005). Presentation given at the Regional Medical Officers Meeting. Mtwara,Tanzania: Orally

Machira,P.(2011).”Regulator to improve social security in Tanzania”, In: The Citizen Reporters, 2 January. Available on line at http://www.thecitizen.co.tz/business, accessed on 06/10/2011

Semkwiji,D.(undated),Challenges and opportunities towards social integration and inclusion; the Tanzania experience. Available online at

http://www.un.org/esa/socdev/egms/docs/2009/ghana/semkwiji/pdf accessed on 06/10/2011

Shaw , R. P. (2002).” Tanzania community health Fund: prepayment as alternative to user fee”. In: *Flagship On-line Journal on Health Sector Reform and sustainable financing*.World Bank

Stoermer, M.V., Radermacher,R and Vanderhyden, M.(2011). “Transforming the community health funds in Tanzania into viable social health insurance schemes: The challenges ahead”. In *Bulletin von Medicus Mundi Schweiz, no.120*

Shivji, G.et al., eds (2004).*Constitutional and Legal System of Tanzania*.Dar es salaam. Mkuki na Nyota Publishers.

Tanzania, Ministry of Health and Social Welfare (2005); *Managing the Community Health Fund*. An Operation Manual.

Musau,S.(2004). Partners for Health Reform Plus Project (2004).The community health Fund: assessing the implementation of new management procedure, Hanang District Tanzania. PHRplus, Bethseda, MD

Tungaraza, F. (2003)”Developing an Integrated and Inclusive Frame work for Social Protection in SADC: Tanzania Country report” In:

Tungaraza, F. & Semkwiji, D. (2006) Gender, and Security in SADC: The case of Tanzania.Published by whom?where?

Tsanga, A and Stewart, J.eds (2011) Women and law: Innovative approach to teaching research and analysis. Harare, Weaver Press and SEARCWL

Tanzania. Ministry of Health and Social Welfare (1990). *National Health Policy*.

Tanzania.Ministry of Labour, Youth development and Sports (2003). *National Policy on Disability*.

Muller,M.(2005).The Political dynamics of the informal sector in Tanzania, 2nd module Project, International Development Studies, Roskilda University Centre. Available online at http://rudar.ruc.dk/bitsteam/1800/785/i, accessed on06/08/2011

Wehmeir, S and Ashby, M.eds (2000) Advanced learners Dictionary. New York, Oxford University Press