EFFECTS OF COST SHARING ON HEALTH SERVICES AMONG POOR COMMUNITIES IN RURAL AREAS OF CHEMBA DISTRICT IN DODOMA REGION

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK OF THE OPEN UNIVERSITY OF TANZANIA

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CERTIFICATION

The undersigned certified that he has read and hereby recommends for acceptance by the Open University of Tanzania a dissertation entitled. **"*Effects of cost sharing on health services among poor communities in rural areas of Chemba District in Dodoma Region*"** in partial fulfillment of the requirements for the Degree of Master in Social Work of the Open University of Tanzania.

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Dr Fauzia Mohamed

(Supervisor)

……..

Date

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DECLARATION

I, **Rufina Boba Khumbe** do hereby declare that, this dissertation is my original work and it has not been presented to any other University or Institution for any award.

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Signature

……

Date

DEDICATION

This work is dedicated to my beloved mother Mary Khumbe Boba who laid a foundation to my Education. She is source of my inspiration, care and love.

ACKNOWLEDGEMENT

Firstly, I thank the almighty God for seeing me through this work and all the blessings. My sincere appreciation goes to my supervisor Dr Fauzia Mohamed for her encouragement, advice, suggestion and guidance which complemented and directed my efforts towards completion of this study. I also extend my appreciation to Peter Mosha alecturer at the Institute of Rural Development Planning for advice, counseling and support during research analysis.

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ABSTRACT

The study on the effects of cost sharing on health service delivery was carried out in five wards of Chemba District which included: Chemba, Kwamtoro, Farkwa, Paranga and Kidoka. The main objective of the study was to: Assess the effects of cost sharing on health services in rural areas in Chemba district. The specific objectives was to: explore community perception regarding cost sharing; identify factors affecting cost sharing on health services in rural communities and investigate the challenges of cost sharing on health services in rural communities of Chemba District. A case study design was adopted involving administration of structured and non- structured questionnaires complemented by necessary documentation. Data were collected from 100 households heads randomly selected in five wards of Chemba District using questionnaires, Focused Group Discussion and Key Informants Interview as methods. Astatistical Package for Social Science(SPSS) and Microsoft Excel were employed in data coding and analysis. The studies revealed that majority of household heads (68%) are aware of the cost sharing on health services. Generally, the community perception on cost sharing on health services was significantly positive despite their request for reduction of costs and demand for clear dissemination of information on government's initiatives through CHF, its usefulness and limitations. The effects were lack of treatment leading to severe illnesses and death 30.4%. The study also found challenges related to cost sharing such as shortage of health professional, shortage of medicines and supplies, medical cost were expensive and shortage of reliable health facilities. Based on the findings of the study, it was recommended that government should authorize rules and regulations to ensure proper utilization of revenue collected as a result of cost sharing as well asrecruit qualified personnel, use of modern technology such as advanced computer and machines to issue receipt and ensure proper financial records for proper utilization and management of funds.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Problem

In 2012, United State of America (USA) spent more than 2.8 trillion United States dollars (US$) that is more than 17% of its gross domestic product (GDP) and more than the entire GDP of the United Kingdom of Great Britain and Northern Ireland on its health care systems (WHO, 2014).This spending meant that, in 2012, health care expenditure per capita was substantially higher in the USA than in any other country. Consequently, the USA for example had 50% higher than the organization for Economic Cooperation and Development (OECD) country with the next highest health care expenditure per capital.

Despite such spending on health care in 2014,many united states residents had no health insurance and several aggregates measures of health quality and outcomes recorded in the USA were poorer than the corresponding data from other high income countries. Immediately before the implementation of the key elements of the Affordable Care Act or Obama Care (ACA) in 2014, 18% of the residents younger than 65 years lacked any form of health insurance(USA- Health System Review, 2013).

The United States of America has a strong health insurance scheme covering a big proportion of population as opposed to developing countries where health insurance schemes cover a small proportion of the population (Mills *et al*., 2012). Health financing is covered by public sources which constitute 48% of health care

expenditures in the United State, private third party payer sources 40%, with the remaining 12% being paid by individuals out of pocket. Even though the proportion of public and private spending on health care is roughly comparable, only a minority (30%) of the United States population is covered by the public financing system through Medicare and Medicaid.

Currently, the majority of Americans (54%) receive their health coverage from private health insurance, with most privately insured individuals obtaining coverage through an employer (USA- Health System Review, 2013). However, governments are responsible in making sure that citizens in their respective countries are provided with social services. These services may be provided to people using two ways; free provision through public subsidization or through the contribution from both citizens and respective governments for the purpose of bringing quality health services(WHO, 2014).

Health financing in sub-Saharan Africa in 2009 spent 6.1% of its total GDPon health (WHO, 2014).According to WHO (2010),Africa as a region has increased its health spending per capitato $83.It was further anticipated that, Economic growth in the region will facilitate additional spending on health in the sub Saharan countries. Seeing the increasing in health financing, International Monetary Fund (IMF) projected on the increment of economic growth across the whole of sub-Saharan Africa average 5% per year (IMF, 2011). This suggest that, when health receives the same share of GDP, health expenditure would grow, it is likely that health spending would receive an increasing share of GDP and thus grow at a greater rate. The governments in Sub-Saharan Africa, implemented exemption policies, sometimes

targeted to population groups such as children under five, pregnant women and citizen above 60 years. However, the exemptions were organized within unstable health systems reduction of cost sharing collections (Perkins and Mwakajunga, 2009).

In South Africa, health care is financed through a combination of mechanisms. In 2005 for instance, allocations from general tax accounted for about 40%, private medical schemes about 45%, and out-of-pocket payments about 14% of total health care financing. The burden of the various mechanisms of funding on households of total incomes was high compared with R381 billion (representing 51%) by the top 10% of the population. This alarming misdistribution of income is accompanied by high poverty and unemployment figures.

There are also correspondingly large inequalities in socio economic status and access to social services between population groups, provinces and socioeconomic groupings. The distribution of total health financing incidence in South Africa shows that the richest 20% of the population spend about 18% of their resources on health care compared with the poorest 20%, who spend about 5%. Looking at the individual funding components, it is clear that general tax and private medical scheme contributions are progressive while Out Of Pocket (OOP) payments are regressive (Continuing Medical Education, 2010).

The Structural Adjustment Program (SAP)which began in 1986 was imposed by the World Bank and IMF which carried with it various conditionality including cost sharing in major social services such as health and education (Kiwara, 1994). Later in 1991, private practice was officially allowed and governments accepted to introduce

user fee in all health care providing units under the cost sharing policy. However, there are few studies that look on cost sharing in health service accessibility among poor communities in rural areas in the country; most of the studies have focused on health change on general public health care (Abel-Smith and Rawal, 1992). Direct effects of the structural Adjustment Program on health care include fewer subsidized health services and health centers, so that individuals must purchase health care from the private sector. Public facilities are likely to have fewer staff, less equipment, inadequate supplies, or lower quality services (Peabody, 1996).

In developing countries like Tanzania, the pressure to reduce government expenditure on health, and to reorganize the health sector to bring in private provision and payments for service, has been seen by many as a major threat to equity. Almost thirty years ago, Leon & Walt, 2001 proposed the inverse care law, stating that "the availability of good medical care tends to vary inversely with the need for it in the population served". To date a number of issues with regard to benefit and disadvantages from user fees or cost sharing are still unresolved. It is not yet clear as to whether cost sharing is generating the anticipated impacts in terms of quality improvement and universal access to basic and quality health care at the primary level, particularly by those deemed vulnerable to such fees in rural area (Ngelela, 2015).

Tanzania introduced cost sharing schemes to complement budgetary shortages especially to procure medicines, medical equipment and supplies (Akazili *et al*., 2012). In 1977, the government of Tanzania declared the principle of universal free medical services for all Tanzanians (Ministry of Health, 1998). However, in 1993

Tanzania government faced difficulties, which necessitated the introduction of cost sharing. The difficult economic conditions which Tanzania suffered in the late1970 and 1980s made it difficult for the policy of free health services for all.

As a result Tanzania introduced cost sharing schemes in government health facilities to generate revenues in order to supplement the government budget. The moneys collected from cost sharing were used to provide quality care, ensuring adequate supplies of drug and procure medical equipment as well as human resources (Ministry of Health, 1996). However, according to Ngelela (2015) more than 67% people earn less than 50,000 per month and more than 10% do not attend hospital services when they become sick. Also, more than 58% of people are not aware about cost sharing on health service in rural areas (Ngelela, 2015).

Various studies in health systems established that 59% Tanzania rural population were in extreme poverty(Twaweza, 2013): in the 1990s while health services are worse in rural than urban areas. In rural areas, they found that 42% failed to meet the need for cost sharing. The country follows a mixed type of system for health care financing. Tanzania largely uses tax financing which dominates and assistance from developing partners (Mtei *et al*., 2012). For example in the financial year 2012/2013, the country allocated 10% of total public expenditure which includes taxation and development partner funding on health care financing (Anon, 2013).

Regardless of efforts of the government to increase the budget of health to 10 % of the Gross Domestic Product (GDP), a gap of 24% still exists. This gap needs to be partly complemented by cost sharing funds in health facilities (HSSP III). The ministry of

health requires health facilities to spend at least 67% of cost sharing revenues for procurement of complementary medicines and supplies. Therefore, a big proportion of cost sharing fund should be utilized to improve availability of medicines in a Drug Revolving Fund (DRF) system (MoH & SW, 2008). It is this gap in cost sharing that invoked this study which aimed to investigate cost sharing on health service utilization among poor communities in rural community with a focus on Chemba District in Dodoma Region.

1.2 Statement of the Problem

In 1990s, Tanzania began to implement multi-sectoral reforms including health sector (Lugalla, 1997). In line with other reforms, the health sector reforms and local government reforms aimed to transfer power, functions and responsibilities from the central government to the Local Government Authorities (LGAs). With the health sector reforms, the central government and LGAs were mandated to provide health services that might result into improvement of life expectancy of the people. Both central and LGAs are to ensure availability, adequacy, accessibility and affordability of health services (inputs) in their areas of jurisdiction (Adams *et al*., 2002).

There was a slight improvement of health services as 53% appreciated that health facilities like buildings, medicines, and patient beds were at least satisfactory (WHO, 2014). Despite the improvements, there still exist under skilled and de-motivated personnel, deficiencies in quality of care, weak and confusing management systems, lack of information provided to health consumers, and lack of access by the very poor to treatment (Whitehead *et al*., 2001). Rural public primary health facilities have persistently faced shortage of medicines and supplies. The shortages are at an average

of 40% and involve very essential medicines (TGPSH, 2011).These facilities serve the majority of Tanzanians (80%) who are most rural poor (MoHSW, 2008).

Shortages of health facilities in rural areas have more impact as accessibility to alternative private medical store is limited. Regard less of the introduction of cost sharing systems, there has been little evidence of its use in improving availability of medicine and supply (Sacca, 2000). Similar challenges were reported to exist in Chemba District whereby majority of people in need of health were forced to travel to Kondoa District Hospital and Dodoma Referral Hospital for further medical attention because of absence of reliable medical facilities in Chemba (Mkamia,2017). Most of the previous studies have focused on health service provision yet cost sharing has remained a challenge in rural area. Since there is limited information on the extent, proper use of health facilities and cost sharing creates a gap that necessitated the current study.

This study was focused on Chemba District because it is a new district formed in 2012 with twenty six wards its administrative Centre being Chemba town. The district has shortages of health facilities, trained personnel and medical equipments and supplies which forces them to seek medical attention in distant areas. Communities are poor, relying mostly on agriculture and animal husbandry with less productivity due to unreliable weather conditions.

1.4 Objectives of the Study

1.4.1 General Objective

The general objective of this study was to: Assess the effects of cost sharing on health care service in rural areas in Chemba district.

1.4.2 Specific Objective

(i) To explore community perception regarding cost sharing in Chemba District

(ii) To identify effects of cost sharing on health services in rural communities of Chemba District.

(iii) To investigate the challenges of cost sharing on health services in rural communities of Chemba District.

1.4.3 Research Questions

(i) What is the perception of rural communities towards cost sharing in Chemba District?

(ii) What are the Factors affecting cost sharing on health services in rural areas of Chemba District?

(iii) What are the challenges of cost sharing on health services in rural area in Chemba District?

1.5 Significance of the Study

To professional social workers this study gives insight within the practice, to assess the needs and resources within the environment as well as the impact of social policies in health sector. The outcomes of the study in cost sharing on health services among the poor should pave the way to develop appropriate intervention strategies. Social workers practices evidence based research to connect the disconnected in this study the disconnected are the poor rural communities.

Furthermore, the study is potential to policy makers, planners and program managers on health services who need to develop a guideline for improvement of health services

to bring a balance between the urban and the rural areas, which could lead to direct relationship between healthy people and productivity. To the public and community as a whole, this research create awareness and insight to enable community members understand the importance of cost sharing on health services, since good health is a vital and fundamental right required for socio economic development. The research had involved community members and organizational representatives throughout the research process to help fill in the action gap. The research findings can further be used as a reference for similar studies to make necessary rectifications by the community members or public as a whole.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents literature review on the assessment of the effects of cost sharing on health services among poor communities in Chemba District. Specifically, the chapter covers, key concepts used in the study by providing their definitions, the theoretical framework and the relevant empirical studies. It begins by presenting relevant key concepts used in the study, followed by the theoretical framework, empirical studies and ends with the description of research gap and an outline of conceptual framework.

2.2 Definition of the Key Concepts

2.2.1 Health Care

Zastraw (2008)defines health care as the maintenance or improvement of health via diagnosis, treatments, and prevention of disease, illness, injury, and other physical and mental impairments in human beings. Healthcare is delivered by health professionals (providers or practitioners) allied health professions, chiropractic, physicians, physician associates, dentistry, midwifery, nursing, medicine, optometry, pharmacy, psychology, and other health professions (Mbabala, 2007).

According to Mtei *et al*., (2012): health care: “refers to those resources society uses on people in ill health in an attempt to cure them or care for them”. This can be prevention care, cure or rehabilitation. Every society requires adequate resources for its population but the financial ability of its people to cater for the most vulnerable in the society is imperative.

2.2.2 Rural Areas

Rural areas are the localities that exist or primarily depend on agriculture and or natural resources based production for their livelihood. A relatively low population density, with threshold of 5,000 to 10,000 square kilometers in most countries usually characterizes them. In many developing countries, rural areas generally experience relatively high level of poverty, illiteracy and declining employment opportunities (World Bank, 2000). Chemba district fits the characteristics defined for rural areas.

2.2.3 Health Cost Sharing

Cost sharing in health services is the portion of project or programme cost not borne by the sponsor. The "cost share" pledge may be either a fixed amount of money or a percentage of the project costs. The term "cost matching" often refers to cost sharing where the amount from the sponsor is equal to the amount from the cost-share partner. This is also known as a dollar for dollar cost sharing or cost matching (UW, 2007).

It is the community share of the cost of running any project. Cost sharing typically takes the form of in-kind resources includes contributed project personnel effort, manpower and cash. Tanzania Health Sector Strategic Plan (HSSP II) of July, 2003); aligns that, the money accrued to the fund shall be used for payment of health care services provided, procurements of drugs, medical supplies and equipments based on health plans, health promotion and preventive measures, minor rehabilitation works in pre-selected government health care facilities in accordance with the approved plan and any other essential health purposes or activities as may deem relevant and approved by the Board.

2.3 Theoretical Framework

The theoretical background includes information on individual behaviors on the adaptation of health cost sharing and funds or insurances that have been established to improve the burden of costs to patients in need of health care services in public health facilities.

2.3.1 Microeconomic Theory

Microeconomic theory as founded by Andreu Mas-Colell (1995), generally views medical insurance as lowering the out-of-pocket price of curative inputs relative to the price of preventive inputs and thereby distorting the choice of inputs because preventive and curative services are typically substitutes in the production of health.

As a consequence of its relatively higher out of pocket price, prevention declines, the probability of sickness rises, and an increased consumption of medical care occurs (Pauly and Held, 1990). The medical costs of maintaining a given level of health rises and production inefficiency develops as a result. Because of “nine limiting conditions”, however, some researchers note that medical insurance may not generate much *ex post* hazard (Kenkel, 2000).

First, health care providers may possess market power. The resulting restriction of output negates the typical *expost* moral hazard effect of medical insurance towards overconsumption. Second, the *ex post* moral hazard effect may be small because medical insurance does not completely cover the utility loss associated with sickness (pain and suffering). Third, preventive inputs may remain attractive because the choice of health inputs actually involves completely preventing versus incompletely

curing illness (Nyman, 2003). The attractiveness of preventive inputs, however, is limited by the fact that prevention can never reduce the probability of illness to zero. Fourth, medical insurance premiums may be risk-rated and thereby deter both ex ante and ex post moral hazard. Fifth, health insurers such as managed care organizations (MCOs) may invest directly in prevention to reduce the probability of a loss. Sixth, employers may offer subsidized worksite health promotion activities such as smoking cessation programs (Dave and Kaestner, 2006).

This subsidization of preventive activities may offset the distortional effect of medical insurance on the price of curative care. Seventh, people may tend to transition frequently between insured and uninsured status so insurance matters little when the decision to purchase medical care is actually made (Pauly and Held, 1990). Finally, medical insurance may promote efficient ex post moral hazard by providing low-income individuals with financial access to life-saving medical care they could not otherwise afford (Nyman, 2003).

Monitoring gives the health care provider the ability to prescribe unnecessary tests or surgery when a financial incentive exists to engage in opportunistic behavior or supply inducement of this sort (Rawal, 1992). The consumer's out-of-pocket costs are largely unaffected by the unnecessary services, the consumer has little incentive to seek a second opinion.

2.3.2 The Relevance of Microeconomic Theory in this Study

Based on the potentialities of health qualities and health workers' responsibilities addressed in Microeconomic theory; most especially where it views medical insurance

as lowering the out-of-pocket price of curative inputs relative to the price of preventive inputs.

The theory further establishes that; the medical costs of maintaining a given level of health rises and production inefficiency develops as a result because of “nine limiting conditions” mentioned above.In the current study the theory helps to inform what has to be done and the way it has to be done through a study on community perception regarding cost sharing, effects of cost sharing on health services and the challenges of cost sharing on health services in rural communities of Chemba District.

The study has further establish whether cost sharing is generating the anticipated impacts in terms of quality improvement and universal access to basic and quality health care at the primary level, particularly by those deemed vulnerable to such fees in rural area.

2.4 Conceptual Framework

Before cost sharing, all medical services delivered right from government were free of charge (Mubyazi, 2004). Cost sharing started in 1991, it intended to reduce government spending and encourage self reliance (Rawal *et al.,* 1992). For improvement of community health services and utilization there is need for community self awareness on cost sharing, staff competence enables proper fund utilization and adherence to guidelines on utilization of funds, planning for procurement of medicines as well as effective supportive supervisions, mentoring and training to facilities that will improve staff competence at facility level.

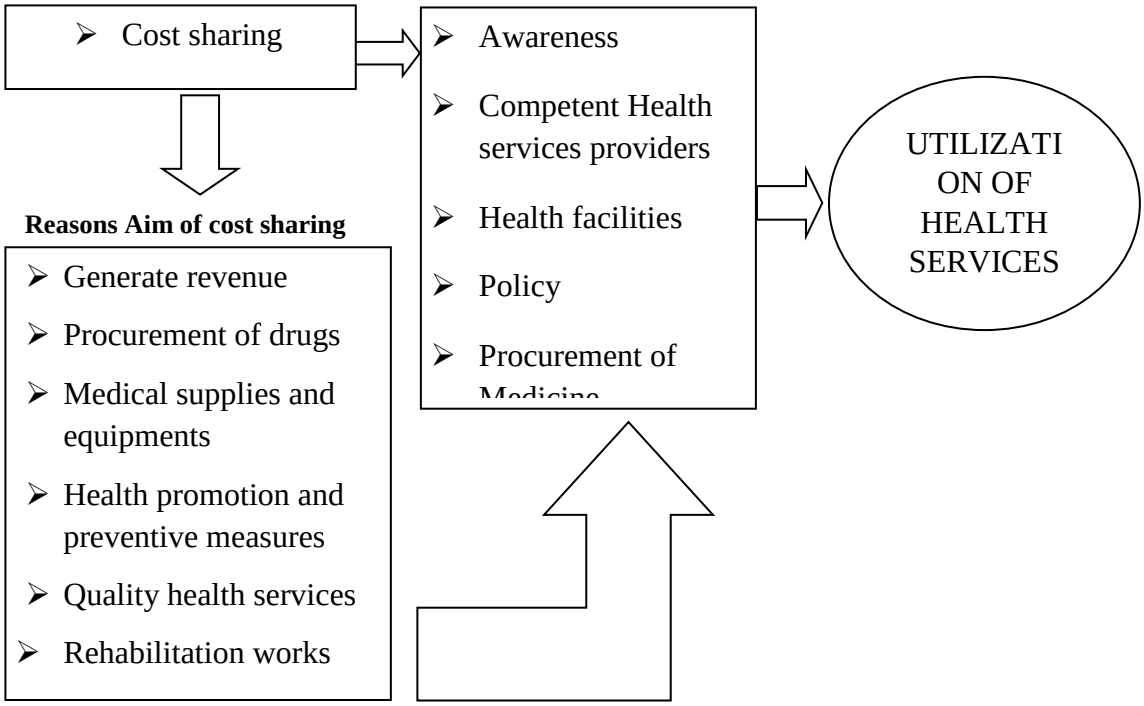

Figure 2.1: Conceptual Framework

Source: Author, 2017

2.5 Review of Empirical Literature

2.5.1 Community Perception on Cost Sharing

Cost sharing has been valued and regarded as an important health strategy to enhance low income inners to access health services in the country. For example the study conducted by Murale Pantaleo (2013) indicated that the perceptions of patients towards cost sharing was positive, however, the study further concluded that, various factors contribute towards low collections of revenue through cost sharing.

Similarly the study conducted by Robert (2015) revealed a significant relationship between access/affordability and perception of people on health service under cost sharing, the probability was 0.03 while Beta statistic was 0.221. This finding revealed that as the number of people perceives that cost sharing is for everybody and is, therefore, the purpose of improving public health service increases, the number of

people to attend and afford health service under cost sharing will increase. Mushi (2003) indicated that, in 2002 most community contributions for the health services in the country came from user fees through cost sharing system. However, some studies whose results indicate that the poor and other vulnerable social groups fail to access health care because of cost sharing (Mwabu, 2013).

But on the other hand there are studies whose results suggest that cost sharing is delivering the intended objectives except that the exemption and waiver facilities are inefficient (Smith, 2004). Generally, the studies which were done immediately after the introduction of user fees in public hospitals indicate that, access to health care declined significantly as a result of the programme.

2.5.1.2 Community Perception on Quality of Health Services

Provider-patients interaction is of critical importance. In Tanzania, situation has been perceived to be deficient because of bad language, poor reception, and lack of attention and responsiveness to patient needs (Leon, 2003; Kamuzora and Gilson, 2007). The kind of health care-provider interaction a patient experiences affects compliance to treatment and continuum of care that is one of the most important issues for clients.

Interaction has a profound impact on the ability of the patient to communicate symptoms to his/her provider and on the patient's feelings of being respected or disrespected (Akin and Hatchnson, 1999; Leonard et al., 2002; Kamuzora and Gilson, 2007). However, for most of Tanzanians, the quality of health care services is indicated by availability of medicine and medical supplies/equipments (Alba et al.,

2010). Therefore, lack/shortage of essential medicines and supplies in health facilities is a major obstacle for populations to access quality health care services (MOH and SW 2009, Alba et al., 2012). So far, shortages of supplies and medicines are a persistent problem in most of public health facilities. It results into communities obtaining health services below quality.

As a result, some community members opt to diverge from seeking services from public health facilities. Instead they do depend on traditional healers for most of services, including maternal and child health services. Maternal and under five mortality rate has not been reduced to planned targets. This trend has compromised efforts to achieve the Millennium Development Goals (MDG) number four and number five (Kamuzora, 2014).

Similarly, frequent shortages of medicines and supplies in most of public health facilities have affected the National policy of universal coverage of health insurance.Most of community members are being sensitized to join various insurance schemes, such as Community Health Fund (CHF), Tiba Kwa Kadi (TIKA). However, these customers have negative perception regarding these insurance schemes. Very few community members have accepted to join the insurance schemes, the rest completely refused to join the schemes.

For example, the study conducted in Hanang district on the community health fund status, revealed that, the most common reason given for not joining the scheme was shortages of medicines and supplies in most of health facilities. Poor communities were not convinced on the role of these insurances because most of facilities do not

have adequate supply of medicines. For the community, health services in public facilities are not reliable, therefore joining voluntary health insurances schemes does not have any impact to them(Chee and Smith, 2002).

2.6 Effects of Cost Sharing

Cost sharing was found to have a negative effect on the lives of people. When people fail to access health and medical services they miss treatment, develop severe illnesses and ultimate death. Most sick people and those caring for the sick usually fall into debts while getting money for treatment. As a result they fail to perform development activities and remain in a vicious poverty circle. Because of poverty they could not access formal education (Twaweza, 2014).

Despite the improvements, there still exist under skilled and de-motivated personnel, deficiencies in quality of care, weak and confusing management systems, lack of information provided to health consumers, and lack of access by the very poor to treatment (Whitehead *et al*., 2001). Rural public primary health facilities have persistently faced shortage of medicines and supplies. The shortages are at an average of 40% and involve very essential medicines (TGPSH, 2011). These facilities serve the majority of Tanzanians (80%) who are most rural poor (MoHSW, 2008).

2.7 Challenges Associated with Cost Sharing

Cost sharing, has impact on health across socio-economic groups (Akazili et al., 2012) and the most at risk groups (Ataguba and McIntyre, 2012). However, various studies revealed that there are some challenges associated with cost sharing fund management and information systems, especially in the operation at the facility level. An important

question is whether facility staffs that are often left with the day to day management of the funds are capable of handling fund in addition to delivering services to patients (Mulligan, 2007).

Lack of knowledge, capacity and experience in community mobilization and financial management is among the factors that have hindered the quality of services (Chee et al., 2002, MOH, 2006). Some studies recognized incompetence of facility and district staff in utilization of funds (Laterveer et al., 2004). Most of the previous literatures revealed that,cost sharing fund needs to be well managed for provision of quality medical care services in all health care levels. Well-managed cost sharing funds improves availability of medicines, supplies, and health facility infrastructures. It can also be used as an incentive to improve health workers motivation status (Sacca, 2000; Family and January, 2009; Khalafalla and Ali, 2009).

2.8 The Situation of Essential Medicine in Rural Communities

Shortages of essential medicines in public health facilities are a major issue in Tanzania that has persisted despite increasing attention to these issues and numerous reform attempts and initiatives. Medicine stock-outs in Tanzania are the result of not only resource constraints and technical problems, but a series of political logics that allow and reinforce short-term policy making, weak oversight and a lack of meaningful accountability (Twaweza, 2014). In urban areas this usually means paying a premium for essential medicines that should be available for free or at a discount from public facilities. In rural areas, where private facilities are fewer, it often means having to pay for transport and medicine costs or simply going without needed medicines (Sacca, 2000).

Rural public health facilities are poorly staffed with persistent shortages of medicines, supplies and medical equipments as compared to urban and private facilities. These shortages usually result into paying out-of-pocket at health facilities for costly outpatient and inpatient services which again often has out of stock of medicines and supplies.

Therefore, cost sharing funds need to be properly utilized for procuring medicines and supplies in order to complement government budget. This will reduce many, among other challenges affecting provision of quality health services in developing countries such as, shortage of medicines, medical equipments and supplies (Machal *et al.,* 2012). Majority of health facilities in Tanzania about (70%) are government owned (MOH and SW, 2008a).

Efforts from the government to expand the number of Accredited Drug Dispensing Outlets (ADDOs) are also supporting this goal (Twaweza, 2014). The goal of the ADDO programme, launched by MoHSW in 2002 with support from development partners, was to improve access to affordable, quality medicines in retail drug outlets particularly in rural and peri-urban areas, which may have few registered pharmacies.

While the rapid expansion of ADDOs from roughly 2,000 to over 4,000 outlets between 2010-2013 represents notable progress, some concerns have been raised in relation to supervision and compliance of these facilities with regulations for example inadequate record keeping and the sale of unauthorized medicines (MoHSW, 2013). Most of public health facilities often run short of medicines and supplies, situations being worse in rural facilities. As most of councils are rural, majority of Tanzanians

about (80%) live in rural areas. They get health services from rural facilities that often suffer from stock outs of medicines and other essential supplies.

The Tanzania government established a Medical Stores Department (MSD) in the year 1993 by an Act of the parliament. The purpose was to enhance supply of essential medicines, medical equipments and supplies to public health facilities. It also established an Integrated Logistic System (ILS), Request and Report (R&R) for public primary health care facilities to order medicines according to local needs.

However, the Medical Stores Department (MSD) supply gap (gap between what was ordered to what was delivered) is usually big (20-46.4%) and often constant Tanzania German Programme to Support Health (TGPSH, 2011). Apart from the supply gap, delivery of medicines from MSD is usually irregular and late due to overload, a condition which worsens the out of stock conditions. Shortages involve essential medicines such as anti-malarias (ALU, SP), diagnostics like Malaria Rapid Diagnostic Tests (MRDT), Uterotonics such as Oxytocin, Ergometrine and antibiotics (TGPSH, 2011).

The Tanzania German Programme to Support Health (TGPSH) conducted a study to assess availability of medicines and supplies in public health facilities. The study was conducted in four regions of Tanzania, namely; Lindi, Mtwara, Tanga and Mbeya. Assessments done in 2011 to 87 Health facilities in these four regions of Tanzania (Mtwara, Lindi, Mbeya and Tanga) revealed severe stock-outs of essential medicines, supplies and medical equipments. Malaria diagnostic supplies like MRDT have a stock out rate of 75%, oxytocin and ergometrine 50-70%.It was also found that, the MSD fulfillment rate was as high as 65% in average (TGPSH, 2011).

Sikika (2010), found that, while there were similar shortages in percentage terms across government facilities in rural and urban areas, staff deployed to urban areas were far more likely to report for duty compared to rural areas (93% compared to 74%). The gap of supply requires an alternative source in order to reduce its severity. Cost sharing is among of important resources to complement medicine shortages at facility level. However, the pattern of utilization is unclear, requiring a study to examine the sources that are collected and spent for medicines and supplies. (Mtei *et al.*, 2012). As a result, patients are obliged to pay at private medical stores/pharmacies or seek more expensive services elsewhere. This situation results into patient dissatisfaction to quality of health services provided in most of public health facilities (Mtei *et al.*, 2012).

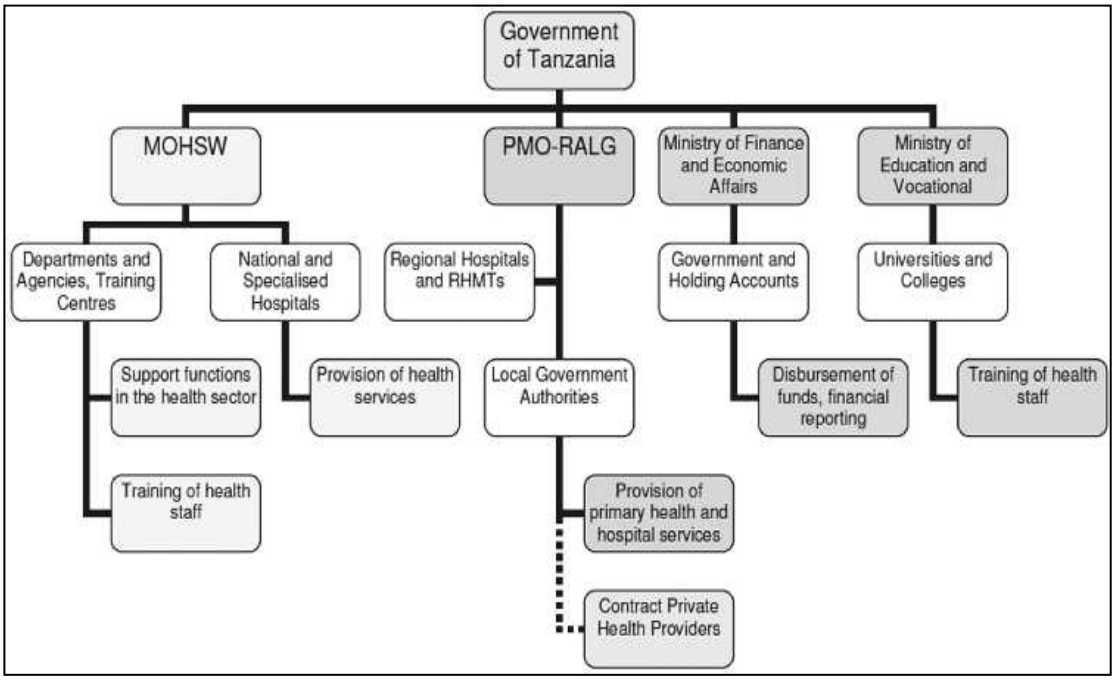

Figure 2.2: Organization Structure of Health System in Tanzania

Source: Tanzania, URT (2008)

2.9 Research Gap

Most of the previous studies in health service and health systems in Tanzania have focused on health service provision yet cost sharing has remained a challenge in rural area. Literature review established limited information on the extent, proper use of health facilities and cost sharing in Dodoma region and particularly Chemba District. It is this lack of information that created a gap which necessitated the current study.

This study was focused on Chemba District because it is a new district formed in 2012 with twenty six wards its Administrative Centre being Chemba Township. The district has insufficient health facilities which are not enough compared to the population and geographical locations of wards and villages, shortage of qualified trained personnel and medical equipments and supplies which forces them to seek medical attention in distant areas including Kondoa and Dodoma, despite the existence of cost sharing on health services. Communities are poor, relying mostly on agriculture and animal husbandry with less productivity due to unreliable weather conditions. This study gives insights to the government and private investors that will facilitate establishment of appropriate measures of intervention towards the needsof people in Chemba District.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Research methodology details the methods that are employed in execution of a project. It provides information on collection of data, criteria for selection of study area, sampling method, sample size and important variables to be considered in data processing and presentation (Kothari, 2004). This chapter covers the research design, area of the study, sampling design, data collection methods and types of data, demography, validity and reliability of data, data analysis procedures and ethical consideration.

3.2 Area of the Study

The study was conducted in Chemba District within Dodoma Region. The area was chosen because of many challenges faced as a newly founded District. The district occupies a major part of rural areas and majority of its people are poor relying mostly on agriculture and animal husbandry for their livelihood, though there other small scale business activities. There are only four health centers and 30 dispensaries located in some wards of which had shortage of health workers, medical equipment, laboratories, health facilities and drug. Majority of people in Chemba area often forced to travel to Dodoma and Kondoa Municipal for further medical attention because of absence of reliable health facilities in Chemba District (Mkamia, June, 2017). Shortages in rural facilities have more serious impact as accessibility to alternative private medical stores/pharmacies was limited. Despite the existence of cost sharing on health services, no study have been undertaken in this area focusing on the effects of cost sharing on

services among poor rural communities. Therefore, this study aimed to assess the effects of cost sharing on health services among poor communities of Chemba District

3.3 Research Design

Chamwali (2006) asserts that, a research design is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the researcher's purpose with economy in a procedure. This study used a case study approach. A case study is a very popular form of qualitative analysis and involves careful and complete observation of social unit, be that unity a person, a family, an institution, a cultural group or even the entire community. It studies in depth rather than breadth (Kothari, 2004).A case study is the research design that entails the detailed and intensive analysis of a single case (Bryman, 2004). This design waschosen because of its flexibility in terms of data collection, data analysis as well as its depth of studied variables.

The current study employed a case study that involved both qualitative and quantitative research as necessary means to understand the research problem in a single study. Qualitative research relied on categorical data as described by Charles and Mertler(2002).The study also dealt with subjective assessment of attitudes, opinions, and behaviors that were helpful in portraying intangible aspects in the community such as social norms, socio-economic status, gender roles, and ethnicity and religious (Denzin and Lincoln, 2000).

In addition, qualitative research was employed because of its usefulness in collecting information such as attitude, opinion, experience and expectation from the targeted

population. This enabled gathering of information from multiple factors related to the effects of cost sharing on health services among poor communities in rural areas of Chemba District. Quantitative research relays on numerical data (Charles and Mertler, 2002; Kothari, 2004) quantitative research was based on the measurement of quantity. Quantitative approach was used because some data were in terms of numbers, figures, decimals and percentage hence data were captured and measured to provide right information.

Moreover, no qualitative or quantitative research method is sufficient in its self to describe the trend and details of the situation like the effects of cost sharing on health services among poor communities of Chemba District in Dodoma hence, both methods were used simultaneously to complete analysis of the events to the problem as in accordance with (Creswell and Clark, 2011).Therefore, the study was based on qualitative and quantitative methodologies. The aim of the study was to obtain the right information related to the nature of the study through study sample on the effects of cost sharing among poor rural communities of Chemba District in Dodoma-Tanzania.

3.5 Sampling Procedure and Techniques

3.5.1 Sampling Design

Sampling design is a specific plan for obtaining a sample from a given population which is usually determined before data collection (Kothari, 2004). Purposive sampling was adopted based on research problem and solely focused on health professionals. Simple random sampling was used to increase sample efficiency and ensure that key treatment and comparison areas are used the same provides equal opportunities for selection of

each element in a population (Thomson, 2012). Purposive sampling, describes purposeful sampling as a deliberate choice of an informant because of the qualities possessed by the informant (Bernard, 2002). Quantitative data was collected through questionnaires. Therefore, this study used household heads, Key informants and Focused Group Discussion.

3.5.2 Sample Size

According to Kumar (2005), the larger the sample the more representative, it is likely to be and more generalized the results of the study are likely to be. Both purposive and random sampling techniques were employed using the equation described by Kothari (2004). Purposive sampling was employed in this study to select key informant. Random sampling technique is the most practical way of sampling (Kothari 2004), in this study random sampling was employed in selection of five wards out of twenty six wards. The sample size for household head survey was 100 respondents from household in five selected wards. Key informants were 10 participants for five wards of which include; Clinical officers, Nurses, Medical attendants and WEO. Respondents for FGD comprise of 10 respondents for each wards, for reliable data the larger the sample sizes the better. A total sample size for this study was 160 respondents. The sample size of the study was drawn from five wards out of the twenty wards of Chemba District.

The sample size (n) of this study is calculated using the equation described by Kothari (2004):

n = N/1+N (e) 2

Where:

n is a sample size ,**N** is Total number of heads households and **e** is the margin of

error on (0.1). In this case,n = N/1+N (e) 2

n= 54609/1+54609 (0.1)2

n= 54609/1+54609*0.01

n=54609/547.09

n=99.8172147

n≈100

3.6 Sampling Techniques

Sampling technique is a definite plan for obtaining sample from a given population. Kothari, (2004) referred to sampling technique as a procedure that the researcher would adopt to select items for the sample. Sampling technique lay down the number of items to be included in the sample. Sampling is important in reducing bias in the findings (Veal, 2007 and Flick, 2008). Therefore, random sampling was employed to avoid bias in which the targeted population of house hold and other community members aged eighteen and above for FGD were selected.

All respondents were given equal chance of participation. On the other hand, purposive sampling was used for obtaining key informants. Mason (2008) argues that, purposive sampling is a set of procedures where the researcher manipulates the analysis, approach and sampling activity interactively during the research process to a much greater extent than in statistical sampling.

Table 3.1: Number of Participants for each Category

S/N	Category of Respondents	Numbers	Clarification
1.	Household	100	5 weeks
2.	Key Informants	10	2 for each ward
3.	Focused group discussion	50	10 for each ward
4.	Total	176	

Source: Author, 2017

3.7 Data Collection Methods

Data collection is a process of obtaining proof in an efficient and logical way so as to establish answers to the research problem (Dawson, 2002). Data collection is important in research as it allows for dissemination of accurate information and development of meaningful programme (Kothari, 2004). This study used both primary and secondary data in gathering information whereby Primary data are collected by the researcher direct from the field (Cohen at el., 2000; Kothari 2004), while Secondary data consists of information that has undergone formal statistical process and is nationally and internationally recognized (Kothari, 2003).

3.7.1 Primary Data Collection Method

In this study, different methods were used during primary data collection. The diverse methods were employed because no single method is adequate in itself in collecting valid and reliable data on a particular problem. Similarly, Bogdan and Biklen (2002) observe that, exclusive reliance on one method might cause bias or distort the researcher's picture of a particular reality. Therefore, based on this fact data were collected through structured questionnaire, Key Informant Interviews and Focused Group Discussions.

3.7.1.1 Structured Questionnaire and Surveys

A questionnaire is simply a ‘tool’ for collecting and recording information about a particular issue of interest, mainly made up of a list of questions, but should also include clear instructions and space for answers, it consists of a number of questions printed or typed in a definite order on a form or set of forms(Kothari, 2004). Questionnaires were developed in open and closed- ended questions to capture the response.

This method was used due to the fact that it gives in-depth information about particular case of interest and it is systematic in the sense that the researcher intensively investigates particular issue before moving to the next (Cohen and Manion, 2000; Dawson, 2002).This method was convenient and useful in collecting demographic information as the study gathered specific quantitative information on the effects of cost sharing on health services.100 households, 20 households from each ward were involved. The structured questionnaires were administered through interviews, the structured questionnaire covered all the specific objective of the study and it took a maximum of thirty minutes for participant to administer.

3.7.1.2 Key Informants Interviews

Interview is a purposeful interaction in which one person is trying to obtain information from another (Gay, *et al*., 2006). According to Kothari (2004), interviews are interpretive research methods aimed at understanding and interpreting subjective views. This method enabled follow up that allowed the researcher to understand the meaning attached to people by daily life practices through observation and practice (Patton, 2002). In the current study, respondents were purposively selected based on

their knowledge of the subject matter and the relevant position they hold who in this case were health professionals, experienced workers and administrative leaders. Ten Key Informants two from each ward were involved. The information from the key informants were obtained through Checklist interview which covered the three specific objective of the study. The information obtained from the key informants were used to complement the information from the respondents and this was done in one week time.

3.7.1.3 Focus Group Discussions

Focused group discussion is a qualitative method used purposely to obtain an in depth analysis on concepts, perceptions and ideas of group members (Cohen and Manion, 2000). Checklist questions were used to guide discussion with different focused group. Parallel discussion groups of 10 people in each community were used to make it manageable and reliable. This method was used because of its flexibility and ability to discover the unexpected issues during discussion.

Furthermore, the results of this method have high validity because it is widely understood hence the findings were realistic. The information obtained was sufficient since the method provided a room for members to respond openly during probing. 50 FGD participants 10 from each ward were involved. Each FGD take not more than two hours covering the three specific objective including; community perception on cost sharing on health services, effect of cost sharing on health services and Challenges of cost sharing on health services among poor communities of rural area of Chemba District.

3.7.1.4 Observation

The observation method is a method which provides the study with the opportunity to accumulate rich data and develop an in-depth understanding of the subject under investigation (Kothari, 2004). Participatory observation in this particular study adopted monitoring of social interaction in relation to effects of cost sharing on health services in rural areas of Chemba District. The observation also asses the use and utilization of health facilities, effects and the challenges faced also the study observe the living conditions of rural communities, health facilities and the services provided. Therefore participatory observation was used to collect data which is valid since the data collected were used to supplement and countercheck the response provided by the participants.

3.7.2 Secondary Data collection

Secondary data consists of information that has undergone formal statistical process and is nationally and internationally recognized (Kothari, 2003). This method aimed to gather information relevant to the study with appropriate resources related to effects of cost sharing on utilization of health services among poor rural communities in Chemba district. This type of data collection constituted important source of data which were collected through, journals, books, articles, newspaper, reports and electronically stored materials.

3.8 Data Processing and Analysis

Data processing means editing, coding, classification and tabulation of collected data that is ready to analyze while data analysis is a systematic processes that involves organization into manageable unit, searching for patterns, discovering what is

important and making a decision on how to inform others (Kothari, 2004).Based on the qualitative nature of the study, Statistical package for social sciences (SPSS software version 20.0 and Microsoft excel)helped in making analysis. Qualitative techniques began by thematically analyzing the data and relationships between the themes. Qualitative technique was used to analyze data in the form of logical statements and arguments. Quantitative analysis was used to analyze data mathematically, whereby calculations of numbers and percentages. Quantitative data was summarized and presented in the form of tables, charts and histograms.

Content analysis is "a wide and heterogeneous set of manual or computer assisted techniques for contextualized interpretations of documents produced by communication processes in the strict sense of that phrase (any kind of text, written, iconic and multimedia) or signification processes (traces and artifacts), having as ultimate goal the production of valid and trustworthy inferences (Stemler, 2013).

3.9 Instruments Validity and Reliability

Validity and reliability are two components aimed at controlling the quality of research (Dawson,2002).Validity and Reliability are factors that were considered during designing of the study, data analysis and judging the quality of study.The factors were observed and abided during the course of study.

3.9.1 Validity

Validity is the instrument capable of measuring what is accurately, effectively and efficiently (Omar, 2011). According to Cohen and Manion (2002), Validity refers to the degree to which the study accurately reflects the specific concept being attempted

in the course of given research work. Validly is a measure of accuracy and whether the instruments of measurement are actually measuring what are intended to be measured (Christman, 1997).

Validity was achieved through setting standards on constructing questionnaires and checklist questions which were related to the research objectives and questions. This helped to ensures that the checklist guides and questionnaires focused on the topic under investigation and the purpose of the study was clearly explained to the respondents and issues concerned were resolved satisfactorily. In this study, it was ensured through pre-testing of questionnaires before commencement of the actual questionnaire survey as insisted by Hesse-Biber and leavy (2004).

3.9.2 Reliability

According to Moskal *et al*., (2000)reliability means the degree to which an assessment tool produces stable and consistent results. According to Kumar (2005),reliability refers to the extent to which results are consistent overtime. Reliability should ensure that results are of high degree of reproducibility mainly under similar methodology. In this case reliability was ensured through the use of appropriate sampling techniques such as simple random sampling and purposive sampling as well as selection of appropriate sample size.

3.10 Ethical Considerations

Sullivan (2001) argues that, social researchers are bound to ethical considerations in their studies. Informed consent is the major ethical issue in conducting research which means that a person knowingly, voluntarily and intelligently, and in a clear and

manifest way, to give his or her consent. Informed consent seeks to incorporate the rights of autonomous individuals through self- determination. Respect for anonymity and confidentiality, anonymity is protected when the subject's identity were not to be linked with personal responses. Confidentiality means that individuals are free to give and withhold as much information as they wish to the person they choose. The researcher is responsible to maintain confidentiality that goes beyond ordinary loyalty (Journal of health, 2016). The study followed and considered all research directives such as seeking permission from the required offices and officers.

CHAPTER FOUR

FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter presents research findings and discussions on effects of cost sharing on health services among poor communities in rural areas; the case of Chemba District Dodoma Region. The current research was guided by a case study design that provided precise and valid information of data collected. Moreover, gathering of information from the respondents was done through questionnaires, Focused Group Discussion and checklist. This chapter therefore; addresses the findings and the discussions on key research questions as presented in chapter one.

4.2 Findings

The research findings presented in detail include; demographic characteristics of the respondents, by age, sex, education level, marital status, occupation, household income and household size. The variables in consideration are primary basis for demographic classification which is commonly used in census and survey as they both utilize statistics in nature (URT, 2005b).

4.2.1 Distribution of Respondents by Age

The distribution of age as presented below in Figure 4.1 indicates in a descending order; twenty seven respondents equal to 27% were within age bracket of 29-39 years, followed by the twenty four respondents equal to 24% of age bracket of 40-49 years, twenty respondents representing 20% of the age bracket of 18-28 years, 60 years and above had sixteen respondents equal to16% of respondents and 50-59 age bracket had

only thirteen respondents equal to 13% respectively. The biological characteristic that defines human as a female or male is an important factor in research as it helps in identifying groups of respondents based on their age differences.

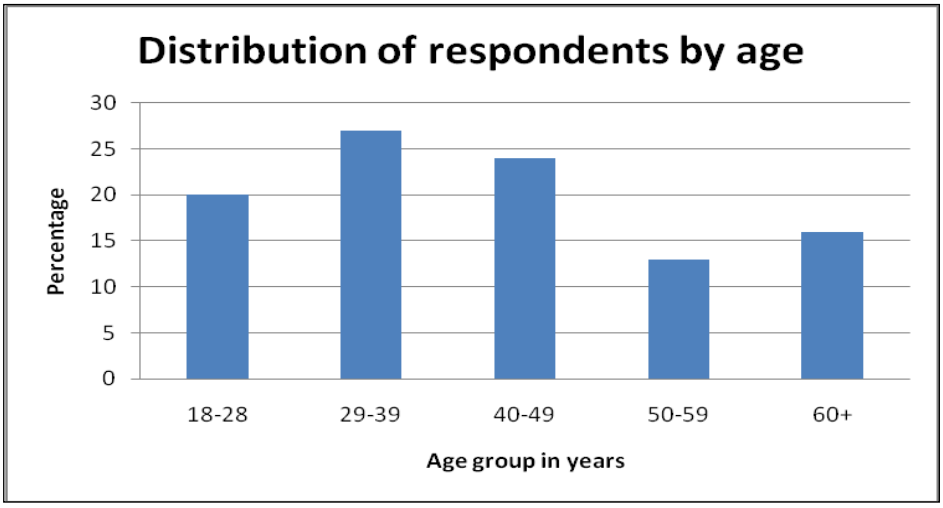

Figure 4.1: Distributions of Respondents by Age

Source: Field Data (2017)

4.2.2 Distribution of Respondents by Sex

The findings of this study as shown in Table4.1 below presents the respondents by sex of which 57 (57%) of respondents were females and 43 (43%) were Males. The above figure clearly indicates that there are more females than male respondents; this is due to the fact that most of women are house wives while men are working outside homes to earn income. Sex of the respondents had profound influence on how men and women differ in utilization of health services. The studies reveal that women children and elders utilize health services more frequently than men.

Table 4.1: Distribution of Respondents by Sex

Category of response	Frequency	Percent
Male	43	43.0
Female	57	57.0
Total	**100**	**100.0**

Source: Field Data (2017)

4.2.3 Distribution of Respondents by Education Level

Figure 4.2 indicates the findings of the respondents education level whereby 71 (71%) of respondents obtained primary Education which is basic Education based onthe Education policy of Tanzania (1995), it is fundamental to the strengthening of higher levels of education, laying a foundation in scientific and technological capacity thus means to self-reliant personal and national development. About 24 (24%) of respondents had no formal Education while 5 (5%) of respondents attended secondary Education.

These findings suggest that, majority of respondents in Chemba District had primary education level. These findings are further supported by Handley et al, (2009) who emphasize education as an important parameter in relation to human capital which can be used to reduce inequality and poverty also for laying the foundation for sustained economic growth, effective institutions and sound governance. Owen et al., (2005) state being knowledgeable of something increases the ability to control ones livelihood.

The research findings shows that, majority of respondents have basic Education and some are none educated which has implications to health seeking behaviour, because it is difficult for one to secure employment which makes difficult to utilize health services from health facilities due to high cost hence alternative mode for health service including traditional healers.

Different scholars have argued that, Education is regarded as a key to better opportunities for employment, accessibility to information, services and independent

and correct actions with regard to survival and development (Nkurunzinza, 2006). According to Duncan (2010), education is important in the development process. It helps society address the social and ethical questions raised by new development, policies and projects, ensuring that conversation of long term interest in given priority over short term gains. Furthermore Education tends to stimulate self-confidence and self-reliance. Moreover, education is important in adapting to business skills and strategies, which leads to improve household prospects. This is precisely because education has a significant influence on household's income strategies, land management and labour use (Nkonya et al., 2004). Therefore, education is the source for enhancement of quality of life of household's especially rural communities for progress and development in general.

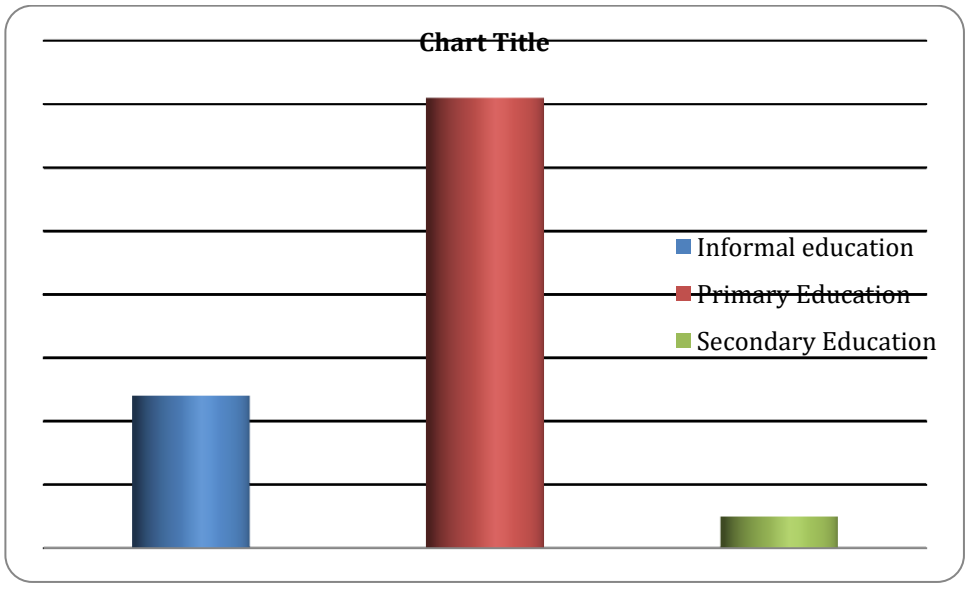

Figure 4.2: Distributions of Respondents by Education Level

Source: Field data (2017).

4.2.4 Marital Status of the Respondents

The finding of this study indicated in the Figure4.3 revealed that, the respondents differ with regard to their marital status whereby; seventy four respondents equal to

74%respondents were married, thirteen respondents equal to 13% were separated, Six respondents equal to 6% divorced, four respondents equal to 4% widows and three respondents equal to 3% were single. These findings are supported by the arguments brought forward from previous studies by different scholars who assert that, marriage is a factor that is closely related to poverty or welfare of the households (Maselle, 2009). Philip *et al*., (2003), observes that, married couples show a high level of participation in community development activities probably due to cooperation among them in a marriage institution and in the society. The findings of this study suggest that, the bigger number of married couples within the community showed the responsibility presented in their families, the study also reveals that most house wives were engaged in small business of making local brew and sold it from home to earn income, while, some participate in economic empowerment groups commonly known as vicoba (Village Community Bank).

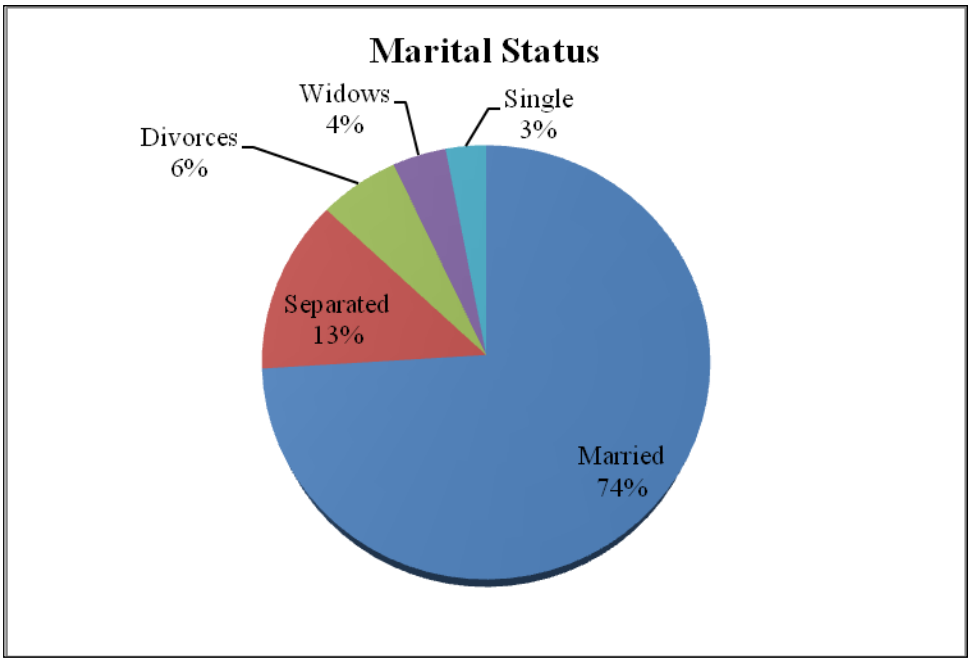

Figure 4.3: Marital Status Among Respondents

Source: Field data (2017)

Women are in the forefront making efforts to improve family income because most husbands in the studied community were drunkards, jobless and are not committed to their families all they do is to wait for agriculture season to attend their farms.

4.2.5 Occupation of the Respondents

The results from the findings as indicated in Figure 4.4 shows that, seventy two respondents equal to 72% were farmers, twenty seven respondents equal to 7% of were self-employed and one respondent equal to 1% of total respondents was unemployed. These findings indicated that, majority (72%) of respondents in Chemba district are engaged in agricultural activities as their main occupation.

This study result is in line with the results of the study conducted by Mbwana (1992) stating that, about 90% of total populations of Tanzania of about 28 Million people depend on Agriculture for livelihood contributing about 40% to the national GDP. Furthermore; the results are similar to the observation made in 2002 Population and Housing Census in Tanzania which indicate 85% (majority) of Tanzanian populations were farmers (URT, 2004a).

Therefore, there is need for intensive capacity building through continuous mentorship on the importance of improved agricultural practices to scale up incomes and raise the household capacities to be able to participate in cost sharing, utilization of health services and preventive measures towards diseases control and hence a healthy community.

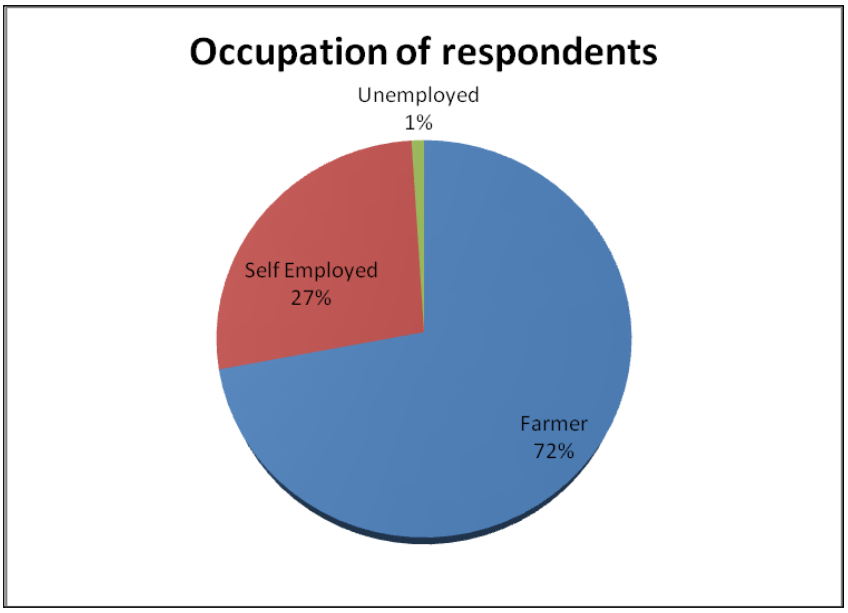

Figure 4.4: Occupations of the Respondents

Source: Field data (2017**)**

4.2.6 Household Income and Household Size

Household income and members of the household is an important factor when it comes to cost sharing, the larger the family, the higher the cost, smaller the family, lower the costs. According to Ellis (2000), income comprises both cash and in kind contributions to the materials of the individual or household deriving from the set of livelihood activities in which household members are engaged.

The table below indicates the findings that, the maximum income is Tanzanian shillings 300,000 per household, this is for employed and self employed and minimum is 3000 per household in rural communities in Chemba district. Despite the Tanzanian economic growth based on the 2012 Household Budget Survey Basic needs poverty, which refers to the minimum resources needed for physical wellbeing, declined from 34.4% in 2006, to 28.2% by 2012. During the same time period, extreme poverty also decreased from 11.7% to 9.7%although there has been recent growth that has helped

Tanzania's poorest, the report emphasizes that approximately 70% of Tanzanians continue to live with less than $2 per day (World Bank, 2015).

Table 4.2 also summarizes household size that, the maximum number of household members for male is 7, while 5 of household members are female, also house hold members below the age of 18 are 5, children's under five years are at maximum of 3 and 60 and above years are 4. The result of the findings indicated that, the maximum size of household members is seven. This indicates that, the household size in the study area is big and this might be due to extended families.

These finding indicate that, there is need for intensive intervention on agricultural sector as it is the backbone to majority of Tanzanian whereby three quarters of Tanzanians are involved; also population should be controlled as it is becoming higher. This can be done through empowering people on continuous mentorship, education, clear dissemination of information and employment support.

The size of household can improve sharing of forces particularly when it indicates significantly skewed dependency ratio that overcomes burden of household head (URT, 2002).This is also similar to the study conducted by Robert (2009) who notes that, the number of household members has influence on income stabilization of household, the large household size reflects demand for funds to meet family obligations, sometimes it hinders the expansion of business income generated as it is used to sustain family needs, which reduces capacity of household to invest. Large families in rural communities become obstacle in poverty reduction.

Table 4.2: Household Income and Household Size

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Monthly household income	99	297000	3000	300000	34909.09	44161.367
Total household male members	99	7	0	7	2.11	1.634
Total household Female members	98	5	0	5	1.69	1.263
Number of household members who are less than 18 years of Age	99	5	0	5	1.86	1.525
Number of Household members more than 60 years of Age and above	99	4	0	4	.41	.756
Number of Children Aged under five	99	3	0	3	.77	.843
Valid N (listwise)	98					

Source: Field data (2017)

4.3 Community Perception Regarding Cost Sharing in Chemba District

Community perception on cost sharing on health services among poor communities in rural areas of Chemba district were shown in the Table 4.2.Likert scale interview was used to asses' people's perception towards cost sharing on services among poor communities of rural areas in Chemba District. The respondents were expected to show negative or positive perceptions towards cost sharing. When the respondents agree it implies that the respondents acknowledge the services under cost sharing and when they disagree means the respondent face difficulties in using health service under cost sharing.

Table below indicates that, 82% of respondents agreed that costs are unaffordable under cost sharing, which implies that majority of the household heads cannot afford to pay the health services cost which are higher in rural area while 1 percent were neutral and 17% disagree which implies that, cost under cost sharing were affordable.

83% of the respondents disagreed that cost sharing on health service provision is affordable while 1 percent were neutral and 17%agreed. 80% of respondents agreed that registration is more efficient under cost sharing while 20% disagree.80% agreed that diagnosis/physical examination is more sufficient under cost sharing while 20% disagree.59% agreed that treatment is more sufficient under cost sharing while 1% were neutral and 40% disagreed that treatment is more sufficient under cost sharing.88% agreed that cost sharing is more effective approach in improving health services while 12% disagree that cost sharing is more effective in improving health services.93% agreed that cost sharing is more acceptable because it ensures wider coverage of health services while 7% percent disagrees.52% were satisfied with cost sharing in utilization of health services while 48 percent disagreed.62% agreed that cost sharing improves overall quality of health services while 1 percent were neutral and 37% of respondents disagreed.63% of respondents agreed that cost sharing improves attention of health care professionals while 1% of respondent were neutral and 36% of respondents disagreed. 95% of respondents agreed that cost sharing improves efficiency of health care system while 1% of respondents were neutral and 4% ofrespondents' disagreed.92% of respondents agreed that, they expected cost sharing to improve health care services delivery while 2% of respondents disagreed. 34% of respondents agreed that cost sharing is appropriate for people with regular income while 66% of respondents disagreed that cost sharing is not for people with regular income.94% of respondents agreed to recommend cost sharing to others while 6% of respondents disagreed to recommend cost sharing to others.

Through FGD and individual discussion it was reveal that, cost sharing is for all the people within the study area, as its showed in the finding 94% of respondents agreed

to recommend cost sharing to others. The study discovered that, people acknowledges cost sharing on health services in rural area but the main challenge is the costs that are too expensive in the sense that majority of the household heads and other community members cannot afford based on their earning per month since depend on agricultural production which is seasonal.

The findings were similar to the study conducted by Tanzanian Demographic and Health Survey (2010) when asked about problems on health care services, about 24% said that, getting Money was a big problem, 19% complained about the geographic distance to a health facility. Those problems are more often reported by women that are poor, those who live in rural areas, older women, women with no education, and women, who are divorced, separated or widowed.

The community perceptions were in line with the aims of the MoH whereby; the moneys collected from cost sharing were expected to be used to provide quality care, ensuring adequate supplies of drug and procure medical equipment as well as human resources (Ministry of Health, 1996). However, the facts according to the study correspond with the findings by Ngelela, (2015) whereby, more than 67% people earn less than 50,000 per month and more than 10% do not attend hospital services when they become sick due to poverty.

Also, more than 58% of people are not aware about cost sharing on health service in rural areas (Ngelela, 2015). Therefore, a big proportion of cost sharing fund should be utilized to improve availability of medicines in a Drug Revolving Fund (DRF) system (MoH & SW, 2008) as expected by the community.

Table 4.3:Community Perception Regarding Cost Sharing in Chemba District

S/No	Opinions Regarding Cost Sharing	Agree	Neither	Disagree	Total
1.	Registration is more efficient	80	-	20	100
2.	Diagnosis/physical examination is more efficient	80	-	20	100
3.	Treatment is more efficient	59	1	40	100
4.	Cost sharing is more effective approach in improving health services	88	-	12	100
5.	Cost sharing is more acceptable because it ensures wider coverage of health services	93	-	7	100
6.	Satisfied with cost sharing on health services	52	-	48	100
7.	Cost of services are affordable	17	-	83	100
8.	Cost sharing improves overall quality of health services	62	1	37	100
9.	Improves attention /care of health professionals	63	1	36	100
10.	I recommend cost sharing to others	94	-	6	100
11.	Improves efficiency of health care system	95	1	4	100
12.	Could be appropriate if medicine were available	98	1	1	100
13.	Costs are unaffordable	82	1	17	100
14.	Expected to improve health care services delivery	92	-	2	100
15.	It is more appropriate for people with regular income	34	-	66	100

Source: Field Data (2017)

4.4 Effects of Cost Sharing on Health Services in Rural Communities of Chemba District

Respondents identified factors affecting cost sharing on health services in rural communities of Chemba district as;Failure to access health facilities and services, shortage or absence of drugs, lack of health professionals, lack of diagnostic tests and lack of treatment due to high and unaffordable costs.

4.4.1 Access to Quality Health Service

The study findings revealed that, 35% of the respondents have acknowledged to have received quality health services as a result of cost sharing while 65% of the respondents disagreed to have received quality health services because of cost sharing. This study is similar to the study conducted by Afrobarometer survey which indicated that, between one-fifth and one-half of their respondents have frequently (that is a few times or often) experienced each of the specified problems with their local public clinic or hospital in the last one year. Close to a half noted lack of medicines or other supplies (47%) and long waiting time (50%) to be common problems; and between a quarter and a third of the respondents mentioned absent doctors (32%), “services are too expensive/unable to pay (28%) and lack of attention or respect from staff (28%) (REPOA, 2006).

A number of studies (REPOA, 2006: Kida, 2009: Mackintosh et al., 2013) have reported consumers’ complaints on dissatisfaction of the quality and type of services provided in health facilities, both public and private. This was mainly due to shortages of health facilities and decreased availability of drugs in commercial outlets following more restrictive drug regulations.

Table 4.4: Responses on Access to Quality Health Services

Category of response	Frequency	Percentage
Yes	35	35
No	65	65
Total	**100**	**100**

Source: Field Data (2017)

4.4.2 Factors Contributing to Poor Quality of Health Services

Figure 4.5as shown summarizes the factors contributing to poor quality of health services. Findings from the study were as follows; twenty nine respondents equal to 47.5% indicated shortage or lack of health work professional, twenty two respondents equal to 36.1% shortage or absence of drugs while eight respondents equal to13.1% indicated absence of lab examination and two respondents equal to 3.3 % indicated lack of treatment due to unaffordable high costs.

These findings were in line with the findings from other studies whereby the previous studies indicated that; despite the improvements in health delivery systems, there still exist under skilled and de-motivated personnel, deficiencies in quality of care, weak and confusing management systems, lack of information provided to health consumers, and lack of access by the very poor to treatment (Whitehead *et al*., 2001). Rural public primary health facilities have persistently faced shortage of medicines and supplies. The shortages are at an average of 40% and involve very essential medicines (TGPSH, 2011).

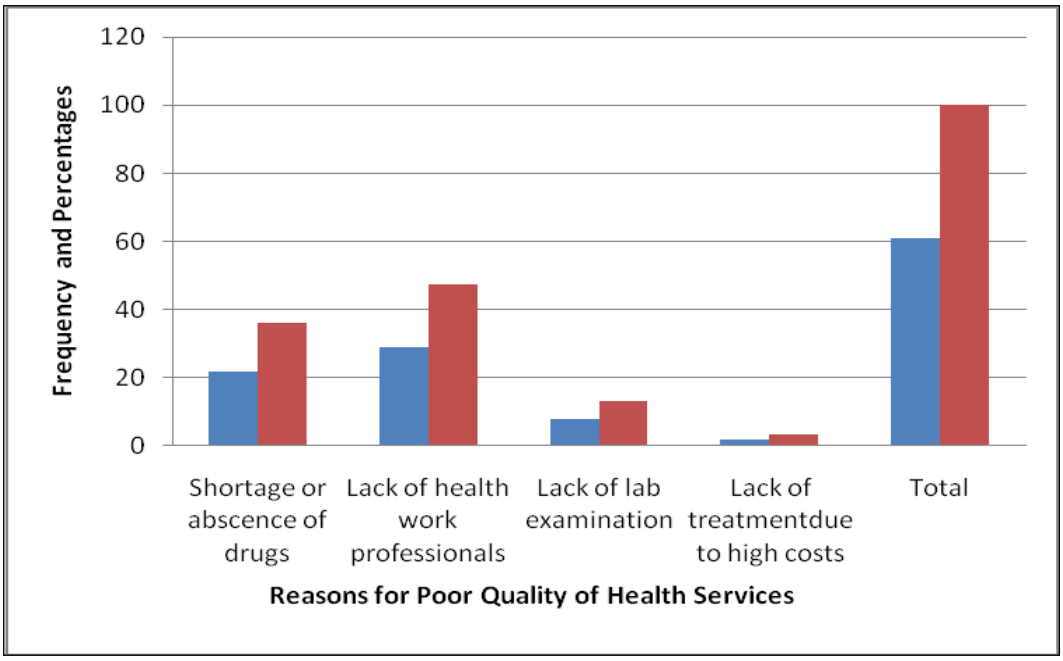

Figure 4.5: Factors Contributing to Poor Quality of Health Services

Source: Field Data (2017)

4.4.2.1 Shortage of Competent Health Work Professionals

Results from the study indicate shortage and or absence of health workers at the health facilities. These absences and shortages hinder patients from obtaining the necessary services on need and sometimes they could not get completely. For example, one respondent from Farkwa who was complemented by other respondents had this to say, There is only one health worker at the dispensary who is a doctor. Because the service provider is all alone he does only what he can. When he is not at work due to various reasons like being sick, travels on official duties or for any other excuse there happens to be no service. (FGD with a community members Farkwa ward, Chemba District in Dodoma, July 2017).

These findings are in line with the previous findings where various studies revealed that, there are some challenges associated with cost sharing, fund management and

information systems, especially in the operation at the facility level. An important question is whether facility staffs that are often left with the day to day management of the fund are capable of handling funds in addition to delivering services to patients (Mulligan, 2007). Lack of knowledge, capacity and experience in community mobilization and financial management is among the factors that have hindered the quality of services (Chee *et al*., 2002, MOH, 2006). Some studies recognized incompetence of facility and district staff in utilization of funds (Laterveer *et al*., 2004). Most of the previous literatures revealed that cost sharing fund needs to be well managed for provision of quality medical care services in all health care levels.

4.4.2.2 Shortage or Absence of Drugs

Shortages or absence of drugs was cited in this study to be high a concern to patients. Because of such absences cost sharing through CHF was considered fake. People have no trust in the system although most were forced to register with CHF out of fear of confiscation of their possessions by local government leaders. People contribute 13,000/= instead of 10,000/= set by the government. These findings were in line with the findings from the previous studies. For most Tanzanians, the quality of health care services is indicated by availability of medicine and medical supplies/equipments (Alba *et al*., 2010). Therefore, lack/shortage of essential medicines and supplies in health facilities is a major obstacle for populations to access quality health care services (MOH and SW 2009, Alba *et al*., 2012).

So far, shortages of supplies and medicines are a persistent problem in most of public health facilities. It results into communities obtaining health services below quality. Most of public health facilities often run short of medicines and supplies, situations

being worse in rural facilities. As most of councils are rural, majority of Tanzanians about (80%) live in rural areas. They get health services from rural facilities that often suffer from stock outs of medicines and other essential supplies (MoHSW, 2013). This situation results into patient dissatisfaction to quality of health services provided in most of public health facilities (Mtei *et al*., 2012). Poor communities were not convinced on the role of these insurances because most of facilities do not have adequate supply of medicines. For the community, health services in public facilities are not reliable therefore joining voluntary health insurances schemes does not have any impact to them (Chee and Smith, 2002).

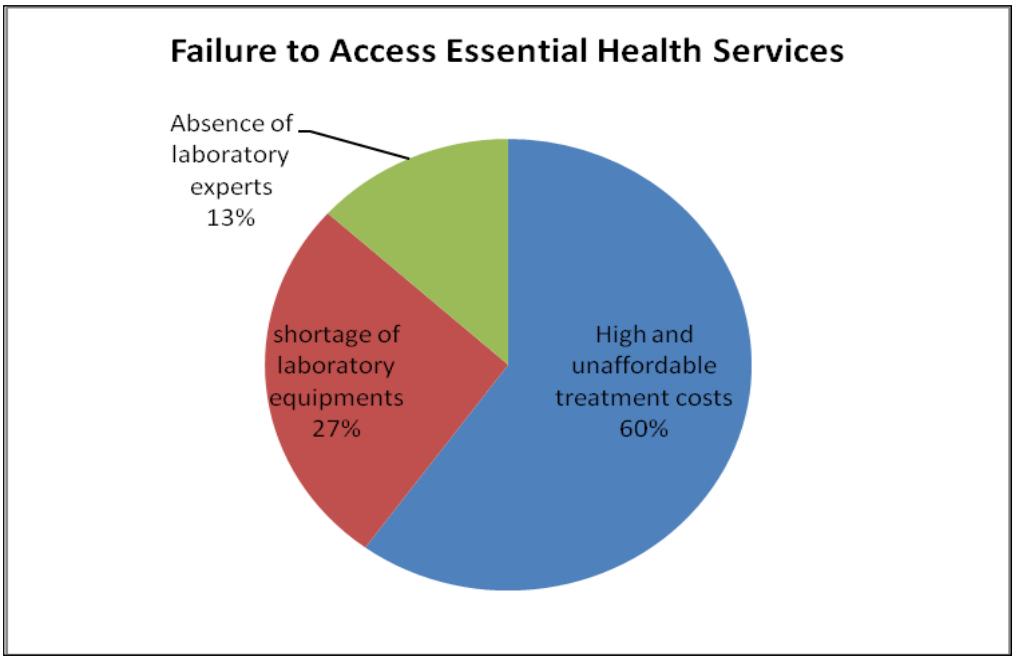

Figure 4.6: Failure to Access Health Services
Source: Field Data (2017)

4.4.2.3 Absence of lab Examination or Diagnostic Tests

Majority of respondents in all five wards under the current study indicated to have failed in most instances to access essential health services due to the following

reasons; 60% indicated high and unaffordable treatment costs, 26.70% failed to undertake laboratory diagnosis due to shortage of laboratory equipments and absence of laboratory experts while 13.30% of respondents failed to receive health services because of lack of surgery services in rural health facilities. The results were summarized as indicated in the Figure 4.6.

4.4.4 Unaffordable High Costs

During the study, the respondents were asked whether they have access to secure health services. 84% of respondents acknowledged having access to health services while 16% indicated to have failed to secure health services due to unaffordable costs and lack of proper information on cost sharing schemes. The findings were summarized in Table 4.5.

Table 4.5: Access to Health Services

Category of Response	Frequency	Percentage
Yes	16	16.0
No	84	84.0
Total	**100**	**100**

Source: Field Data (2017)

The results as shown in Table 4.6 further indicated that, the affordability was expressed in failures to pay for treatment laboratory or diagnostic tests procure medicines and pay admission costs.

Table 4 6: Failures to Afford Treatment

S/No	Reason	Percentage
1	Failure to pay treatment expenses	68
2	Failure to pay laboratory examination cost	16.8
3	Failure to procure medicines	10
4	Failure to pay admission cost	5.2
5	**Total**	**100**

Source: Field Data (2017)

The research findings further revealed that 68% which represents the majority of the respondents, failed to receive services because they failed to pay treatment expenses, 16.8% of respondents failed due to pay laboratory examination costs, 10.0% of the respondents failed to meet the costs of pharmacy (procurement of medicines) while 5.2% of the respondents failed to pay admission cost.

The results from the study were in line with the policy and service satisfaction survey of 2003 which found that 73% of respondents revealed that health care services had become less affordable which implied that are expensive, costs of treatment was ranked as most serious problem on the health sector. Therefore different studies in health systems established that 59% Tanzania rural population were in extreme poverty that 42% failed to meet the need for cost sharing in the 1990s while health services are worse in rural than urban areas (Twaweza, 2013). Henceforth; From the results mention above it was concluded that, majority of the people from Chemba District cannot afford expenses in health care which influences them to look for other alternative option of seeking traditional treatments and medicine. As one respondent narrated:

In 2015, my daughter broke her leg and I took her to Kwamtoro Health Center only to be given paracetamol. I was told to take her to Kondoa District Hospital or to Dodoma Referral Hospital for further treatment. But, because I could not afford the costs I took her to one Maasai native doctor residing in the mountains who is known for many years. He treated her for only ten thousand instead of the huge amounts of money I

was to spend had I taken her to the recommended hospitals. She is properly healed and moves swiftly so why should I waste my money with modern treatments? We grew up being treated with our practitioners and even our wives deliver from home without problems (FGD with community members Farkwa ward, Chemba District in Dodoma, July 2017).

Despite the initiatives done by Ministry of Health which institute exemption and waiver system in public facilities to accommodate the poor through Community Health Fund however this system has been alleged for being ineffective and inefficiently administered (Save the Children,2005; Kida, 2009). Shown below are the responses for access to health services according to Wards.

Table 4.7: Failure to Receive Health Services Due to Cost

S/No	Ward	Ever Failed to Receive Health service due to cost		Total
		Yes	No	
1	Chemba	1	19	20
2	Paranga	5	15	20
3	Kwamtoro	4	16	20
4	Farkwa	4	16	20
5	Kidoka	2	18	20
6	**Total**	**16**	**84**	**100**

Source: Field Data (2017)

4.4.4.1 Health Services that Need Cost Sharing

Table 4.7 summarizes the findings on health services that need cost sharing. 52 % of respondents indicated that, treatments need cost sharing while 28% of respondents revealed that laboratory examination needs cost sharing, 19% of respondents

emphasized on Diagnosis and 1% of respondents said counseling needs cost sharing. The results on services that need cost sharing are similar with the findings from the study by Heller (1982) that households are willing to pay, this implies that small fees could be introduced. This is similar to what the researcher has found through discussion with household heads they are willing to pay for the service they do not need it to be free. Majority of the household head shave requested for reduction of medical fee expenses.

Table 4.8: Health Services that Need Cost Sharing

Category of Response	Frequency	Percent
Diagnosis	19	19.0
Treatment	52	52.0
Counseling	1	1.0
Lab examination	28	28.0
Total	**100**	**100**

Source: Field Data (2017)

4.5 Effect of Failing to Secure Health Services

Out of all individuals who responded to this question 23.9% said the effect of failing to secure health service is lack of treatment which subsequently leads to severe illnesses and ultimate deaths. Another 23.9% revealed that they fall into debts while getting money for treatment hence becoming even poorer. 21.7% of respondents complained of failing to perform development activities due to ill health, time spent on taking care of the sick,lack of resources and lack of formal education.

These results are in agreement with the previous studies which established that; cost

sharing, has impact on health across socio-economic groups (Akazili *et al*., 2012) and the most at risk groups (Ataguba and McIntyre, 2012). Most of the previous literatures revealed that, cost sharing fund needs to be well managed for provision of quality medical care services in all health care levels otherwise it becomes a burden to the service users. Well managed cost sharing funds improves availability of medicines, supplies, and health facility infrastructures. It can also be used as an incentive to improve health workers motivation status (Sacca, 2000; Family and January, 2009; Khalafalla and Ali, 2009).Results from the study on effects of failing to secure health services are summarized in Table 4.9shown below.

Table 4.9: Effect of Failing to Secure Health Services

Effects	**Responses**		**Percent of Cases**
	N	**Percent**	
Lack of treatment/severe illness/death	11	23.9%	68.8%
Fail to perform development activities	10	21.7%	62.5%
Debts	11	23.9%	68.8%
Total	**46**	**100.0%**	**287.5%**

Multiple Response Results

Source: Field Data, (2017)

4.5.1 The Use of Health Services in Rural Communities of Chemba District

The findings on the challenges faced in cost sharing on health services revealed that 21.2% of respondents indicate shortage of health work professionals within health facilities, 17% of respondents said shortage of drugs/medicine, 16.2% indicate shortage of diagnostic equipment in health facilities,13.8% of respondents said lack of ambulance for transfer of patients from ones house to the heath facility or for referral most especially during emergencies 9.2% of respondents said costs are too high and

distance to the health facility while 6.8% represents challenge in lab examinations. Some diagnostic tests are not done as health professional provide medication based on the patient explanations which indicates lack of professionalism and commitment. 5.5% of respondents said lack of surgery services even minor surgery is a challenge. Information from the key informants reveals that, these challenges are due to poor management and administration on the collected fund, delays from medical stores department in supply of medicine and government priorities in re-allocation of funds.

The established challenges on cost sharing on health services are in agreement with findings of the previous studies by Manzi *et al.,* (2012), which indicated that, the shortage of health workers is more worse in rural health facilities and is further worsened by working less productively for about half of the working hours even when they are physically present in health facilities (Kwesigabo *et al*; Mackintosh *et al*., 2013).

Table 4.10: Use of Health Services in Rural Communities in Chemba District

Category of Response		**Responses**		**Percent of Cases**
		N	**Percent**	
Challenges[a]	Distance	37	9.2%	37.0%
	Very costly	37	9.2%	37.0%
	Shortage of diagnostic equipments	65	16.2%	55.0%
	Shortage of health professionals	85	21.2%	85.0%
	Lack of ambulance	55	13.8%	65.0%
	Shortage of Drugs	69	17.2%	69.0%
	Lab examination	27	6.8%	27.0%
	Lack of health center	1	0.2%	1.0%
	Lack of admission room	2	0.5%	2.0%
	Lack of surgery services	22	5.5%	22.0%
Total		**400**	**100.0%**	**400.0%**

Source: Field Data (2017)

Also, poor availability of medicine, medical supplies and medical equipment continues to plague public health facilities in Chemba District. The results correspond with reports and findings by URT (2009); Mackintosh and Muyinga (2010) respectively. The findings indicate that, Tanzania suffers from inadequacies in health facilities and health delivery systems.

4.5.2 Alternatives After Failing to Secure Health Service

Findings from this research revealed that, 37.8% of respondents use traditional medicine as an alternative after failing to secure health service, 27.0% of respondents buy medicines at pharmacies and private shops while 18.9% of respondents were registered with CHF and 16.2% borrow money for treatment, after failing to secure health service at the health centers and village dispensaries.

The study findings indicate that, majority of the population in rural areas prefer the use of traditional medicine as best alternative simply because it is affordable and accessible to many people within the community. These findings are in concurrence with the findings by Kayombo *et al*., (2012) which established that, many people in Tanzania use traditional medicine and other alternative medicine outlets for their dental and medical treatments.

Some patients agreed to often utilize both traditional and western medicine concurrently in an attempt to cure single ailment as was found in the study by Wenzel (2011). Moreover, it was estimated that about 60% of all those seeking health services

depend on some traditional health services while about 53% birth takes place at home, most with traditional birth attendants.

Table 4.11: Alternatives after Failing to Secure Service

Category of Response	Responses		Percent of Cases
	N	Percent	
Borrow money for treatment	6	16.2%	40.0%
Register with CHF	7	18.9%	46.7%
Use traditional medicine	14	37.8%	93.3%
Buy medicine without prescription	10	27.0%	66.7%
Total	**37**	**100.0%**	**246.7%**

Source: Field Data (2017)

Table 4.11 shown below indicated the accessibility of health facilities in rural community whereby 55% of respondents revealed that health facilities are far from people while 45% of respondents revealed that health facilities are nearby people. Accessibility to health facilities is determined by the number and distance.

Four health centers and 30 dispensaries are at the low side compared to the district area of 7289.7 square kilometers and a population of 235,711 people. The health sector reforms were aimed to provide health services that might result into improvement of life expectancy of the people. Both central and LGAs are to ensure availability, adequacy, accessibility and affordability of health services (inputs) in their areas of jurisdiction (Adams *et al*., 2002).

However, the facts contradict the aims as was revealed in previous studies by Sacca, 2000 who revealed that shortages of health facilities in rural areas have more impact as accessibility to alternative private medical store is limited. Regardless of the

introduction of cost sharing systems, there has been little evidence of its use in improving availability of these facilities, medicine and supplies.

Table 4.12: Accessibility of Health Facilities

Category of response	Frequency	Percent
Nearby the people	45	45.0
Far from the people	55	55.0
Total	**100**	**100.0**

Source: Field Data (2017)

4.5.3 Services that Should be Considered for Possible Exemption from Cost Sharing

As a result of challenges revealed in the study, respondents have given their views on what services need to be exempted from cost sharing. 23% of respondent request for exemption in laboratory examination fees, 20% of respondents request for exemption in screening for Malaria, 14% of respondents need exemption on registration fees as is between seven thousand to ten thousand per patient which is so expensive, 12% of the respondents when asked about the service that should be considered for possible exemption they said treatment while 7% of respondents request for exemption in medicine and 6% of respondents seek exemption in use of ambulance when given referrals and during emergencies.

Table 4.13: Services that Should be Considered for Possible Exemption from Cost Sharing

Category of Response	Frequency	Percent
Free screening for Malaria parasi	20	20.0
Lab examination	23	23.0
Typhoid	6	6.0
Treatment	12	12.0
Registration fee	14	14.0
Ambulance service	6	6.0
Drugs	7	7.0

Admission	1	1.0
None	11	11.0
Total	**100**	**100.0**

Source: Field Data (2017)

Majority of the heads of household are willing to share costs in utilization of health services though they request for reduction on costs, since they are mainly concern with laboratory tests which are so expensive in that they cannot afford to run some test due to costs which hinders effective treatments of the patients. The results finding are summarized in as shown in the Table 4.13.

4.6 General Opinions/Recommendation towards Cost Sharing on Health Services

Table4.13 reveal community opinions/ recommendations towards cost sharing on health services in rural areas of Chemba District as follows 18.2% of respondents when asked, they said there is need for increment in number of health work professionals to suit the need of facility to provide quality services on time, 12% of respondents recommend on the construction of medical facilities in each ward and village to reduce distance and costs reaching health facilities, 10% of respondents recommend on the availability of drugs on time the authority responsible should ensure that medicines are available at health facilities all the time, 9% of respondents recommend on the continuous provision of education to community on the importance of cost sharing and utilization of health services while 8.4% recommend on the reduction of medical charges and 7% and below recommend on availability of ambulance at affordable costs, availability of medical equipments, timely management of patients improve quality of health service at dispensary level by making service available for 24 hours. Government should analyze /list all CHF services provided, presence of all specialist doctors, all contributions report should put clearly, presence

of surgery services and the Government must emphasize all contributions to improve health services.

Table 4.14: General Opinions/Recommendations towards Cost Sharing on Health Services

Category of Response	Responses		Percent of Cases
	N	Percent	
Reduce cost of medical charges	42	8.4%	42.0%
Construction of medical facility on each ward and villages	60	12.0%	60.0%
Availability of ambulance and affordable cost	36	7.2%	36.0%
Continuously educate the community on the importance of cost sharing	45	9.0%	45.0%
Availability of drugs on time	52	10.4%	52.0%
Increase number of health professionals	91	18.2%	91.0%
Free screening for malaria parasite	11	2.2%	11.0%
Timely management for patients	34	6.8%	34.0%
Availability of medical equipments	13	2.6%	13.0%
Improve quality of healthy service at dispensary level by making service available for 24 hours	40	8.0%	40.0%
Improve quality of healthy service at dispensary level by making service available for 24 hours	18	3.6%	18.0%
Government should analyze /list all CHF services provided	12	2.4%	12.0%
Presence of all specialist doctors	3	0.6%	3.0%
All contributions report should put clearly	22	4.4%	22.0%
Government must emphasize all contributions to improve health services	5	1.0%	5.0%
Presence of surgery services	16	3.2%	16.0%
Total	**500**	**100.0%**	**500.0%**

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

The main objective of this study was to assess the effects of cost sharing on health services among poor communities in rural areas in Chemba District of Tanzania. Data for this study was gathered through structured questionnaire, Key Informants Interviews, Observation, Focused Group Discussion and literature reviews. Data for this study were gathered from five villages located in five wards of Chemba District namely Chemba, Farkwa, Kwamtoro, Paranga and Kidoka out of twenty six wards.

The general findings from this study indicated that, majority of the household heads failed to secure health services because of the expensive and unaffordable health service. Despite the failure to secure the services, majority of the household heads were aware of cost sharing on health service. They acknowledge cost sharing although the amount paid is too expensive for them compared to their earnings. They do not need the service to be completely free but the amount shared should be reduced since their main source of income depends on agricultural production which is very uncertain.

The community members that were involved in this study expressed their opinion and requests towards the Government to reduce the amount paid for treatment, so that the people of Chemba can afford and utilize the service effectively. Furthermore, they request for construction of medical facilities in each ward and village with enough number of health workers professionals; and ensure that, all the medical equipments

and drugs are available on time. Additional requests include free screening for Malaria parasites and continuous education regarding cost sharing and the use of Community Health Fund (CHF) should be provided so that the household heads and the community in general will be able to understand clearly the services provided by CHF and the limitation as well as the usefulness of cost sharing.

5.2 Recommendations

To address the effects of cost sharing on health services among poor communities in rural areas of Chemba Districts, the study has come up with the following recommendations to the Government and Community in general.

5.2.1 Recommendations to the Government

5.2.1.1 Community Sensitization and Awareness Creation

The government in collaboration with the other stakeholders, Non-Government Organizations, Voluntary agencies and private Institutions should make effort to encourage as well as sensitize the rural poor communities on usefulness of cost sharing and preventive measures by increasing resources on preventive programs like safe water and adequate sanitations to decrease diarrhea and other related diseases, infrastructure development to improve utilization of health services, safe food, nutrition, healthy environmental conditions and other related health education and information.

The Government should create awareness on pre-payments benefit, through CHF, the services provided through and the limitations.CHF is one of the government initiatives to ensure that even the poor are able to utilize health services when they are in need of

the health service. Since cost sharing exists among the majority of poor rural communities, the payment has limited proper use of health services.

More people need to be protected by health insurance from loss of income in situation of illness. Hence there is need for well trained, motivated and qualified health insurance personnel to provide timely mentorship to communities and health professional to make clear understanding on cost sharing to eliminate the misconception towards cost sharing and the CHF for proper use of health services.

5.2.1.2 Give Priority to Availability of Health Facilities and Services

It is urged from the study findings for the Government in collaboration with health stakeholders (such as private institutions and Non-Government Organizations) to prioritize health services by reducing health costs, increasing the number of health facilities especially in rural areas by providing at least one dispensary and health center in each ward, furnished with needed number of trained, qualified and motivated health professionals and all the necessary health facilities. Improving the quality of service and appropriate use of health services will motivate and encourage people on cost sharing.

5.2.1.3 Ensure Proper Use of Cost Sharing Revenue

The Government and health institutions should ensure that all the money collected through cost sharing are fully utilized for the purpose of improvement (development) of health facilities and the reports be published on amount collected and its usage which will promote transparency and improve quality of health services provided.

5.2.1.4 Encourage Effective Sharing of Information

The Government should conduct meetings with community members from time to time to discuss various challenges that face the provision of health services to the community members. It is through the meeting that, the Government can understand the challenges and built informed strategy to over these challenges after obtaining the information from the community and clear unnecessary doubts. It is through these meetings the community rumors, misconception and doubts regarding cost sharing on health services can be cleared.

5.2.1.5 Create Conducive Investment Opportunities

The government should promote and create conducive environment for stakeholders to invest in rural areas. Such ventures will create job opportunities where people can earn money to improve their livelihoods and manage costs of health services as their income increases.

5.2.2 Recommendation to the Local Community

5.2.2.1 Community Willingness and Right to Proper Information

The community should be willing to receive knowledge and proper information from the government leaders, motivated and qualified health personnel and other partners in the sector regarding the benefits of cost sharing, usefulness of pre-payment (CHF), the services provided by the CHF and limitations. Individuals should be informed of formal health care both preventive and curative that will increase proper use of health services.

5.2.2.2 Community to Improve Household Economies

The community should be proactive in looking for alternative ways for earning income instead of depending entirely on agricultural production. There is need for

training on improved ways of animal keeping. Encourage irrigation in agricultural production in advantaged villages whereimproved seeds will be used to increase crop yield and subsequent income.

5.2.2.3 Create Social Groups

Communities should create social groups for the purpose of economic and social endeavors. Such groups will promote economic activities aimed to increase household income and encourage other social activities that will reduce chances of illnesses.

5.3 Conclusion

The findings from this study conclude that:

The government in collaboration with other stake holders should make efforts to encourage and sensitize the poor communities in the rural areas on the aims and importance of cost sharing in provision of health services as well as preventive measures by increasing resources on preventive programs. It is through sensitization and awareness creation that dissemination of appropriate information on cost sharing will enable heads of households to make informed decisions regarding family health issues.

To improve the quality of health services provided through cost sharing. The health institutions or the management should ensure that all the money collected through cost sharing are fully utilized for the purpose of improving health facilities. Well managed cost sharing funds will improve availability of medicines, supplies, and health facility infrastructures. It can also be used as an incentive to improve health workers

motivation status (Sacca, 2000; Ali *et al.*, 2009). From time to time, reports need to be published on cost sharing revenue that was collected and its expenditure to promote transparency and clear doubts.

There is a need to enhance capabilities with focus on the poor by reducing cost of health services and promote the initiatives done by the government through Community Health Service (CHF), free screening for malaria parasite and treatment as people request for possible exemption from cost sharing. Although majority of the heads of households acknowledge cost sharing on health services, the costs involved are too expensive. The Government is urged to consider reducing thecost whereby the poor communities can afford.

Effective communication and dissemination of information on health services is needed. Proper health services when provided to the poor rural community are greatly expected to reduce the burden of diseases and serve expenditures that are directed to health services. Equity and equality in accessing quality health services will bring about development in rural areas.

5.3.1 Recommendation for Further Studies

This study has established that, majority of the households in Chemba District are registered with Community Health Funds (CHF) by force. Research results obtained from three wards namely Farkwa, Kwamtoro and Kidoka including its villages indicates that, people were forced to register with CHF by local leaders. Instead of providing proper information people were threatened by confiscating their property if

not registered with CHF. Registration fee is thirteen thousand shillings as opposed to the ten thousand shillings set by the government for six members. These people registered without being sensitized, well informed on what is CHF, how does it work, the services provided and the limitation of CHF in obtaining health services. Hence, people call CHF fake as they cannot utilize health services when provided with a referral. Further research is needed to assess the impact of CHF on the improvement of health services among poor rural communities

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APPENDIX

Appendix I: Research Questionnaire

EFFECT OF COST SHARING ON HEALTH SERVICES AMONG POOR COMMUNITITIES IN RURAL AREA

SECTION A: INTRODUCTION

I am Rufina Khumbe, a student from Open University of Tanzania pursuing Masters of Social work, with registration number PG201504934. I am conducting a research on Effect of cost sharing on health services among poor communities in rural areas. This research is for academic purpose, your assistance in providing the required information is kindly requested by completing the questioner below. Please note that information provided will be kept confidential. I thank you in advance.

SECTION B: BACKGROUND INFORMATION OF THE RESPONDENTS

1. Name of Ward

    1. Chemba

    2. Paranga

    3. Kwamtoro

    4. Farkwa

    5. Kidoka

3. Name of Village

    1. Chemba

    2. Chambalo

    3. Paranga

    4. Kelema Juu

5. Kwamtoro

6. Kurio

7. Farkwa

8. Mombose

9. Kidoka

10. Muungano

4. Date of interview……..

5. Respondent age in years……

6. Sex.....

1. Male

2. Female

7. Education level

1) No formal education

2) Primary school

3) Secondary school

4) College

8. Marital status

1) Married

2) Single

3) Divorced

4) Widow

5) Separated

9. Occupation

1) Farmer

2) Government official

3) Self-employed

4) Unemployed

5) Student

6) Retired

10. Do you have health insurance?

1) Yes

2) No

11. Household income per month……Tanzanian shillings.

12. Total household members Males…….. Females……..

13. Number of household members who are less than 18 years of age……..

14. Number of household members who are more than 60 years of age and above…….

15. Number of children aged between o to 5 years……

PART C: COMMUNITY PERCEPTION ON COST SHARING

16. What do you know about cost sharing in health services?.....
.....
.....

17. Have you ever paid for any health service provision?

1. Yes
2. No

18. Please give your opinion regarding cost sharing in the scale of 1-3

(1= disagree, 2=neither, 3= agree)

	Variable	**Disagree (1)**	**Neither (2)**	**Agree (3)**	**GIVE EXPLANTAION**
1	Registration process is more efficient with cost sharing				
2	Diagnosis/physical examination is more efficient with cost sharing				
3	Treatment is more efficient with cost sharing				
4	Cost sharing is effective approach in improving health service				
5	Cost sharing is acceptable because it ensures wider coverage of health services				
6	Overall I am satisfied with the cost sharing on health services				
7	Even with cost sharing, the cost health services are affordable				
8	Cost sharing improves overall quality of care/care				

	Variable	Disagree (1)	Neither (2)	Agree (3)	GIVE EXPLANTAION
9	Attention/care by health professional is better with cost sharing				
10	I would recommend cost sharing to others				
11	Cost sharing improves efficiency of the health care system				
12	Cost sharing could be appropriate if medical supplies were available				
13	Costs are rather not unaffordable				
14	I expected improved health service delivery with sharing of cost				
15	Cost sharing is more appropriate for people with regular income				

PART D: EFFECT OF COST SHARING ON HEALTH SERVICES

19. Have you ever received poor quality of health services because of cost sharing?

1. Yes
2. No

If yes to question 14 please explain

.....

.....

.....

.....

.....

20. Have you ever failed to receive services because of costs?

1. Yes

2. No

If yes to question 20 please explain

…….....

.....

.....

.....

21. If the answer in 20 above is yes, which service did you fail to pay for?

1. Diagnosis,

2. Treatment

3. Counseling

4. Lab examination

5. Pharmacy

6. Admission

21. What were the effects of you failing to secure health services?

1. ……

2. ……..

3. ……..

4……

22. What were your alternatives after failing to secure the services due to cost sharing?

1. ……..

2. ……..

3……

4……

PART E: CHALLENGES OF COST SHARING ON HEALTH SERVICES

23. Which health service do you think need cost sharing among the following?

1. Diagnosis
2. Treatment
3. Counseling
4. Lab examination
5. Others

24. Which health service do you think do not need cost sharing among the following?

1. Diagnosis
2. Treatment
3. Counseling
4. Lab examination
5. Others

25. How do you recommend the amount of money paid as cost sharing in health services delivery?

1. Much money
2. Moderate
3. Less money
4. I do not know

26. How do you recommend the accessibility of health centers

1. Nearby the people
2. Far from the people
3. I do not know

27. How do you recommend the health service provision by public health workers?

1. Good
2. Bad
3. Moderate
4. worse

28. What are the main challenges do you face on cost sharing on use health services?

(i)----------

(ii)----------

(iii)----------

(iv)----------

29. Are there specific services should be considered for possible exemption from cost sharing?

1. Yes
2. No

29 (b). If yes name them……..

30. What are your general opinions on cost sharing in health services?

(i)----------

(ii)----------

(iii)----------

(iv)----------

(v)----------