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Development of the Tanzania Health Financing Strategy

Options paper Nr. 5

Inclusion of the Poor and Vulnerable into the New Health Financing Strategy

Final Report

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Abbreviations

AEO	Agricultural Extension Officer
BPL	Below Poverty Line
CBA	Community Based Approaches
CBCCT	Community Based Conditional Cash Transfer
CCTMC	Community Cash Transfer Management Committee
CDO	Community Development Officer
CHF	Community Health Fund
DED	District Executive Director
DHS	Demographic and Health Survey
DMO	District Medical Officer
FGD	Focus Group Discussion
FY	Financial Year
GDP	Gross Domestic Product
GOI	Government of India
GT	Geographical Targeting
HBS	Household Budget Survey
HDI	Human Development Index
HPSS	Health Promotion and System Strengthening
HSF	Health Services Fund
IHI	Ifakara Health Institute
IMCI	Integrated Management of Childhood Illnesses
ISC	Inter-Ministerial Steering Committee
LGA	Local Government Authority
MDGs	Millennium Development Goals
MKUKUTA	Mkakatiwa Kukuza Uchumina Kupunguza Umaskini Tanzania
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MPI	Multi-dimensional Poverty Index
MVC	Most Vulnerable Children
MT	Means Testing
NBS	National Bureau of Statistics
NGOs	Non-Governmental Organizations

NHA	National Health Accounts
NHIF	National Health Insurance Fund
NPS	National Panel Survey
NSGRP	National Strategy for Growth and Reduction of Poverty
NSPF	National Social Protection Framework
NVF	National Village Fund
OOPs	Out of Pocket Expenditure
O&OD	Opportunities and Obstacles to Development
OPD	Out Patient Department
PAA	Project Area Authority
PER	Public Expenditure Review
PHDR	Poverty and Human Development Report
PMT	Proxy Means Testing
PRA	Participatory Rural Appraisal
PSSN	Productive Social Safety Net
PWP	Public Work Program
PWR	Participatory Wealth Ranking
RSBY	Rashtriya Swasthya Bima Yojna
SWO	Social Welfare Officer
TASAF	Tanzania Social Action Fund
TDHS	Tanzania Demographic and Health Survey
TMU	TASAF Management Unit
TzPPA	Tanzanian Participatory Poverty Assessment
TZS	Tanzanian Shilling
UNDP	United Nations Development Programme
URB	Unified Registry of Beneficiaries
USD	United States Dollar
UTM	Unified Targeting Mechanism
URT	United Republic of Tanzania
VC	Village Council
VEO	Village Executive Officer
VoP	Views of People
WFP	World Food Program

Executive Summary

Tanzania shows strong commitment to progressively move towards universal coverage of health care services. According to Household Budget Survey data, poverty is pervasive, especially in rural areas. 34% of the households in Mainland Tanzania live under the basic needs poverty line defined as having an income of less than USD 1 per day per capita (USD 0.30 cent – 500 TZS) and 16.6% live below the food poverty line (USD 0.22 cent – 365 TZS) and can be considered as extreme poor. This segment of the population is too poor to contribute via income taxes or health insurance premiums to the costs of seeking health care. Further, there are groups in the society that have to be considered as vulnerable due to various demographic, health or life cycle conditions. They require financial support for accessing health care. Removing the financial barriers for accessing health care - implicit in direct payment systems – has the potential to improve their situation.

Although the Community Health Fund (CHF) has a provision to exempt the poor, this has not been enforced in most districts and if done, the process is haphazard. The situation varies in each district with regard to whose responsibility it is to identify the poor and vulnerable, what guidelines or criteria are used to identify them, and if these practices are being implemented at all. Thus, development of comprehensive, adequate and feasible reform strategies / options for the *Inclusion of the Poor and Vulnerable* in the Tanzanian Health Financing Strategy is a crucial step for ensuring financial protection of poor and vulnerable people towards accessing health care services. This report looks at the following questions:

1. How to define and identify the poor and vulnerable groups in Tanzania
2. How to remove their financial access barriers to health services and provide them with health insurance protection, and
3. How much subsidizing the inclusion of the poor into health insurance would cost.

Both primary and secondary sources of information were used in addressing the key issues in this study. Relevant literature on how poverty and vulnerability has been conceptualized internationally and in the local context, experiences on the identification of the poor and vulnerable and their inclusion in development projects, and health financing status and strategies for financing health care for the poor and vulnerable groups has been analysed. Between April and June 2013 key informant interviews were conducted with various stakeholders such as the government, non-government and UN organizations to solicit information on how various organizations define the poor and vulnerable groups in the Tanzanian context and how these groups have been identified and included in various interventions. Field visits in selected districts (Chamwino, Lindi, and Magu in Dodoma, Lindi and Mwanza regions respectively) were conducted. These districts were sampled based on on-going activities in identification and inclusion of the poor in various development projects.

In order to reach the segments of the population which are most in need and at the same time use resources efficiently, government agencies and development organisations currently apply various methods to identify households in poverty. The most accurate method to reflect a household's ability to meet basic needs is using information about income and consumption and a verified means test is generally regarded as the gold-standard of targeting. However, in developing countries the vast majority of the population works in the informal sector and/or makes a living from subsistence farming. Therefore data on income is

often either poor or not available. Thus, other identification methods can be applied such as proxy means tests (defined observable indicators to reflect a household's income); geographic targeting (targeting an area with high prevalence of poverty); demographic targeting (supporting groups with similar characteristics, e.g. women, ethnical minorities, elderly, etc.); community-based approaches or a combination of several methods.

Findings from conducted field visits show that in Tanzania communities are highly involved in activities of targeting the poor. Thus, community-based approaches in all varieties are predominantly used. The majority of interviewed organisations combine community-based approaches with other methods, in particular geographic targeting. Interviewees agreed that involving the entire community provides good results for identifying households in need. However, there seems to be a lack of coordination between stakeholders in conducting identification processes and thus, these are sometimes replicated for different purposes.

Challenges include identifying households that move in and out poverty (fluctuant poor) as well as casual labourers (kibarua) and migrant workers. In fact, poverty is a very dynamic issue and the temporal dimension plays an important role. Identifying the poor will therefore need to be a continuous process to achieve sustainable results.

None of the methods for identifying the poor is perfect due to the multi-faceted and complex nature of poverty. The understanding of poverty may vary significantly in the local context and due to gender, age or socio-economic factors. Additionally there is always a trade-off between accurateness of identification and transaction costs. The challenge is to balance affordability and accurateness of the targeting processes.

The National Health Accounts 2010 show that out-of-pocket payments (OOP) in the meanwhile form the single largest contribution to health financing in Tanzania (31.9%), larger than the contributions of the MoHSW (17.6%) or of NGOs (25%). Out of pocket payments in Tanzania amounting to TZS 741 billion, or approximately USD 443 million per year (2009/10) constitute a sincere financial barrier to accessing health services, especially for the poor. In 2007 the poorest 20% of the population had to spend a mean amount of TZS 858 per month out-of-pocket for medical expenses (approximately 0.5 US Dollar). Factors such as seasonal poverty aggravate the situation for the poor.

When Tanzania implemented a user fee policy in the health sector in the early 1990s, exemption and waiver mechanisms were introduced with the aim to protect the poor and vulnerable groups of the society and enable them free access to health services. Exempted from paying user fees are pregnant mothers and children under the age of five, people suffering from chronic diseases, and the elderly above 60 years. These exemptions can be handled relatively easily as the belonging to such a demographic group is not too difficult to verify. At the same time, the implementation of the need-based waivers, which should be provided to the poor according to Government policy, faces much more problems. Studies conducted on waivers for accessing health services in Tanzania agree that this mechanism is ineffective and prone to misuse. Principle alternatives to the present policy of providing waivers to the poor are either abolishing user fees and provide "free" health care, or protecting the poor through subsidized health insurance membership.

For protecting the poor from financial access barriers to health care we recommend a targeting approach for providing subsidized health insurance coverage over giving "free" health care for two major reasons: Firstly, for using resources efficiently because a "free" health care system also subsidizes those persons who can afford paying a contribution (the

non-poor), and secondly for creating a voice mechanism of health care users where the health insurance organisation from a crucial size onwards will be in a position to effectively lobby for improving quality of health services to be provided to its members. Such a voice mechanism would get lost when abolishing health insurance schemes.

Health insurance schemes also have the further advantage that they are able to address other financial access barriers as well, apart from the fees of health care providers: they may be designed in a custom-tailored way to address specific problems of the target group. A health insurance scheme may e.g. provide a comprehensive mother-child care package which compensates also for transport costs or pays for the services of a maternal waiting home (Chigonella).

At present, health insurance schemes cover only 9% to 14% of the population of Tanzania. They do not have an effective mechanism in place for enrolling the poor and subsidizing their membership contributions (premiums). Some few district and municipal councils do foresee "pro-poor" budgets for providing free CHF cards to the poor. However, these budgets are too small to enrol more than a few hundred households, and are thus completely inadequate for substantially improving access of the poor to health services in Tanzania.

In order to set up a financing mechanism for implementing pro-poor health subsidies a move away from budget funding of health services to contributions to health insurance is required. Modalities how to share the costs of such contributions should be worked out among the different potential institutions: central level government, district / municipality, village government, and insurance organisations such as the National Health Insurance Fund (NHIF) and the National Social Security Fund (NSSF). The channelling of funds from the financing sources to the insurer (e.g. CHF) would allow different modalities, from increasing matching funds to CHF up to establishing a central level equalisation fund.

Model calculations for this report show that financing health insurance coverage for the poor seems to be in feasible dimensions if the present level of CHF premiums is taken as a basis. It would cost the Government between TZS 43 billion and TZS 49 billion (26 to 29 million US Dollars) to provide all poor households in Tanzania with a CHF card in the value of TZS 10,000, depending on which degree of own contributions is asked from the poor households.

Likewise, even if the CHF premiums are doubled to a level of TZS 20,000, the funding of this amount should still be in a feasible dimension for the Government. This option would require an amount of TZS 93 billion to TZS 98 billion (USD 56 million to USD 58 million) for providing all poor households in the country with health insurance coverage. Even in the case of a full subsidizing of a premium of TZS 30'000 per household, with an additional TZS 30'000 per household as central government matching funds, the overall total Government contribution to CHF cards for the poor would not exceed TZS 150 bn or USD 88 (at the rate of 1 USD = 1650). This amounts to approximately 20% of the MoHSW budget.

Subsidizing health insurance for the poor up to a level of premiums which is currently available for government employees, on the other side, looks unrealistic in the present situation. The NHIF presently has about 13 times as much funding available from premiums as the CHF (including matching funds).

The following table shows the funds required for subsidizing health insurance for the poor in Tanzania under different assumptions:

Government funding required for subsidizing health insurance for the poor as compared to MoHSW budget and health sector budget

	Government Subsidy (million TZS)		Government Subsidy (million USD)		% of Tanzanian MoHSW budget		% of Tanzanian Health Sector budget	
Premium per household	min.	max.	min.	max.	min.	max.	min.	max.
TZS 10,000 (present average level in Tanzania)	43,232	48,733	26	29	5.73%	6.46%	2.89%	3.26%
TZS 20,000 (doubling of the present level)	93,595	97,457	56	58	12.42%	12.93%	6.25%	6.51%
TZS 30,000 (level of max. revenue but still affordable by majority of population)	140,251	146'200	84	88	18.60%	19.39%	9.37%	9.77%
TZS 287,853 (level of health insurance for govt. employees - NHIF)	753,493	789,183	451	473	99.95%	104.69%	50.33%	52.72%
Approved MoHSW budget for the fiscal year 2013/2014 (million TZS)	753,850							
Health sector budget for the fiscal year 2013/2014 (million TZS)	1,497,000							

However, these calculations do not answer the question which premium level would be optimal for financing the costs of a minimum benefit package.

In order to allow for monitoring and evaluation as well as tracking the development of the households identified and provided with services, ideally the establishment of a databank for the identified households would save the country from repeated targeting exercises for various service provision purposes. Establishing such a databank, however, will come with high initial costs. As the Tanzanian Social Action Fund (TASAF) presently plans to implement such a database it can be made available for several organisations and institutions involved in development activities in order to avoid replicating processes. One of the questions to be addressed in the process is how to ensure a required degree of confidentiality while at the same time making data available for development programmes.

A multi-criteria approach is recommended in order to capture various aspects of poverty. Furthermore, it is crucial that the databank is updated periodically in order to address

fluctuant poverty as good as possible. The observation of the assessment team is that TASAF is presently in the process of building up such a data bank for registering poor households comprehensively in the whole country.

Monitoring and evaluation will have to be done also on the follow-up of which services have been provided for poor households. As discussed above subsidizing health insurance coverage for the poor is one major option for providing them with access to health services. In such an approach, a strong Health Insurance Management Information System would be the instrument to capture the enrolment of the poor and the payment for their premium, i.e. the subsidy by a third party. Such a third party could be the Government along different levels such as central government, district council, and village, plus additionally NGOs / private charities. Further, a health insurance could provide and monitor benefit packages addressing other major access barriers apart from user fee costs (transport, time delays, foregone income, etc.), depending on the financial means available in the health insurance fund.

1 Context, objectives and methodology

Poverty is a multidimensional and complex phenomenon and therefore difficult to define.[1] Much has been written about the meaning of poverty but, because of its complexity, many authors feel safer stating its causes or manifestations rather than analysing what it is. Variations in definitions complicate the design of poverty measurements and poverty reduction programs as well as the assessment of the impacts of policy on poverty.

What is found in the literature and through frequent visits to poor communities is that poverty deprives people of their security and well-being; prevents people from having access to basic services including education, health care, safe water, adequate food, clothing and shelter; takes away people's rights and their freedom, dignity and peace of mind; puts people's lives in danger; and robs them of their future.[2]In its broadest sense, poverty is defined as *the inability to attain a minimum standard of living, that is, an individual is considered poor if the income level falls under a specific minimum level to meet the basic needs*.[3]It is caused by a lack of adequate resources and capabilities to acquire basic human needs.

Tanzania remains one of the poorest countries in the world, and poverty reduction has been one of its main national development challenges. Poverty in Tanzania is a phenomenon primarily in rural areas, where the majority of the population lives. Thus, since independence in 1961, the government of Tanzania has been preoccupied with combating especially rural poverty. Nevertheless, evidence from various studies, including the National Strategy for Growth and Reduction of Poverty (NSGRP) known in Kiswahili as Mkakatiwa Kukuza Uchumina Kupunguza Umaskini Tanzania (MKUKUTA) progress reports, reveals little progress (if any) in poverty reduction in the area of income poverty. Furthermore, there are significant disparities across social groups, by gender and by geographical location.

For poor households, once a person recognizes symptoms of an illness and decides to initiate treatment, access becomes a critical issue. Five dimensions of access influence the course of the health-seeking process: Availability, accessibility, affordability, adequacy, and acceptability of health services.[4] What degree of access is reached along these five dimensions depends essentially on the interplay between the health care services and the broader policies, institutions, organizations, and processes that govern the delivery of services; and the livelihood assets people can mobilize and transform in a particular vulnerability context. Poor households have to mobilize financial and other resources to access health care, and in the course of doing this, treatment seeking is delayed. When they fail to access the required resources, treatment seeking is not initiated.[5]Thus, development of a comprehensive framework for inclusion of the poor and vulnerable in the health care financing framework is a crucial step for ensuring financial protection of poor and vulnerable people towards accessing health care services.

The overall objective of this study is to develop comprehensive, adequate and feasible reform strategies / options for the *Inclusion of the Poor and Vulnerable* in the health financing framework to be presented to the Inter-ministerial Steering Committee (ISC) for feeding into the Tanzanian Health Financing Strategy.

[1]Laderchi et al. (2003)
[2]Kessy et al. (2006)
[3]Jehu-Appiah et al (2010): p. 167f
[4]Obrist et al. (2007)
[5]*ibid*. (2010)

The main areas looked at are the following:

1. How to define and identify the poor and vulnerable groups in Tanzania
2. How to remove their financial access barriers to health services, and
3. How to finance such a mechanism.

Methodology applied:

1. Review of relevant literature on how poverty and vulnerability has been conceptualized internationally and in the local context; experiences on the identification of the poor and vulnerable and their inclusion in development projects; the health financing status in the country; and strategies for financing health care for the poor and vulnerable groups.
2. Key informant interviews with various stakeholders in the government, non-government and UN organizations to solicit information on how various organizations define the poor and vulnerable groups in the Tanzanian context and how these groups have been identified and included in various interventions.
3. Field visits in selected districts (Chamwino in Dodoma, Lindi in Lindi and Magu in Mwanza). The justification of this selection is based on the on-going activities in identifying the poor by the council and various organizations;
    a. Tanzania Social Action Fund (TASAF) and Health Promotion and System Strengthening (HPSS) project are involved in identification of the poor in Chamwino district for targeted conditional cash transfers and provision of Community Health Fund (CHF) cards respectively.
    b. Save the Children in Lindi district is involved in the identification of poor households for unconditional cash transfer targeting.
    c. In Magu district, identification of old people by the council authorities and old people forums and organizations such as Magu Poverty Focus on Older People Rehabilitation Centre (MAPERECE) and provision of health insurance cards is on-going. Annex 2 shows the list of organizations interviewed during phase one.

2 Definitions: Who are “the poor” and who are “the vulnerable groups”?

2.1 Theoretical framework applied at international level

As mentioned above, poverty is a multifaceted and a complex issue. It is challenging to distinguish who is poor and who is better-off in particular in countries where poverty is widely prevalent. Furthermore, the poor are far from being a homogenous group with some households considered to be “extremely poor”, and others “moderately poor”, or even “fluctuant poor.” Globally, a widely accepted common approach to measure poverty is the monetary (welfare) approach. A household or individual is usually considered as poor, when they do not have enough resources or abilities to meet their daily needs.[6]Also the understanding of “needs” may vary but can be interpreted in terms of minimum specified quantities of items such as food, clothing, shelter, water and sanitation that are necessary to prevent ill health and undernourishment.[7]

Under welfare approach, an individual or household is considered poor if the income level falls under a specific minimum level to meet the basic needs. Two standard approaches for defining poverty exist[8]:

1. **Absolute poverty lines**, which are often based on estimates of the costs of basic food needs and non-food needs. The most common one are the internationally defined poverty lines of US$1income per day per capita (extreme poor) and US$ 2 per day per capita (poor).
2. **Relative poverty lines**, which are defined in relation to the overall distribution of income or consumption in a country, e.g. the bottom 50% of the population is classified as poor by any national poverty line.

There are various limitations with monetary measures including difficulties in measuring income. Furthermore, poverty is not only limited to the financial dimension but also embraces social and political components such as taking part in the social life of a community, political liberty, civil rights,[9] health, education and intra-household distribution[10] and so forth. Also discrimination by gender, age, kinship or social status within a household is largely ignored by monetary methods.[11] Therefore monetary measures might only provide a *static* concept and provide only a limited picture of a households’ situation.[12]

In order to address the difficulty of applying monetary measures of poverty as well as to take local specificities into account, governments, Non-Governmental Organizations (NGOs) and development organisations have applied a couple of alternative methods to monetary measures. The capability approach is one of the non-income measures, which find its origin

[6]Coudouel et al. (2002)
[7]Streeten et al. (1981)
[8]Coudouel et al. (2002); Zeller (2004)
[9]Sen (2000)
[10] Zeller (2004)
[11] *Ibid*.
[12]Falkingham and Ceema (2002)

in the work of the well-known economist Amartya Sen.[13] In this approach, poverty is seen as a failure to achieve certain minimal basic capabilities to function within society with minimal adequacy. Poverty as capability deprivation entails the inability of an individual to secure an adequate quality of life. In terms of measurement, the capability approach tends to focus on actual outcomes such as life expectancy, morbidity, literacy and nutrition levels. The UNDP Human Development Index (HDI) draws from this concept. It measures the average achievements in three basic dimensions of Human Development[14]:

- **A long and healthy life**, measured by life expectancy at birth.
- **Knowledge**, measured by mean years of schooling for adults aged 25 yearsand expected years of schooling for children of school entering age[15].
- **A decent standard of living**, as measured by Gross Domestic Product (GDP) per capita.

Poverty has also be seen as vulnerability resulted from social exclusion[16]; the inability to protect oneself against impoverishment due to exposure to shocks, stress and risks because of prevalent exclusionary measures. Social exclusion occurs rather among groups than individuals, but more often and even more importantly between groups within a society. Social exclusion rather occurs among groups within a society than between individuals. Therefore, social exclusion, is a *relational* concept – it cannot be understood as a characteristic of an individual or even of a group, but only as a product of social relations. Matters of distribution and of redistribution are central to its concerns. Finally, social exclusion is multidimensional in scope since exclusionary processes can be at work in different directions (dimensions).

The last concept in the global literature is on poverty as powerlessness – the lack of voice and political rights. In order to antagonise this powerlessness of local populations, decentralised processes have been established in various contexts. The distinctive feature of participatory approaches is that they try to get away from defining poverty as an externally imposed standard. Instead the approach seeks to enlist the participation of local populations in defining what poverty means – that is, to identify what constitute the circumstances of the poor.[17]In principle at least, the definition of poverty is seen to spring from the way poor people analyse their own reality. As such, these approaches are invariably multidimensional in nature and generally include processes, causes and outcomes, as perceived by the poor.

Income and capabilities approaches have widely accepted measurement indicators and they can give a benchmark over the poverty situation in general in a country, a region or worldwide. In contrast, other non-welfare approaches focus on indicators of poverty such as social relations, cultural aspects, personal security etc. Restrictions are the difficulty in measuring and quantifying poverty with non-welfare measures.**[18]** They may also be regarded as biased measures, which are not objective enough.

[13]Sen (2000)
[14]UNDP Website (2013)
[15] Until 2010, the used measure for education in the HDI was “adult literacy rate (with two-thirds weighting) and the combined primary, secondary, and tertiary gross enrolment ratio (with one-third weighting).”
[16]*ibid.*
[17] Robert Chambers is the pioneer of participatory approaches; participatory approaches have been applied in participatory poverty assessments.
[18] Jehu-Appiah et al. (2010)

2.2 Measuring poverty in Tanzania

2.2.1 Theoretical Framework

The MKUKUTA II provides the framework for defining and measuring poverty in Tanzania.[19] MKUKUTA II is a medium term mechanism to achieve the Millennium Development Goals (MDGs) and the aspiration of Tanzania's Development Vision 2025 of transforming Tanzania into a middle income country characterized by (i) high quality livelihood, (ii) peace, stability and unity, (iii) good governance, (iv) a well-educated and learning society, and (v) a strong and competitive economy. MKUKUTA II translates the Vision 2025 aspirations and MDGs into measurable broad outcomes organized under three clusters:

- Cluster I: Growth for reduction of income poverty
- Cluster II: Improvement of quality of life and social well-being
- Cluster III: Governance and accountability.

Thus, Cluster I operationalize the income poverty approach while Cluster II deals with non-income measures. Cluster III introduces governance issues given that good governance and accountability are fundamental components to shaping a favourable environment for economic growth and poverty reduction. While income and capability measures are very much embraced in the Cluster I and Cluster II of MKUKUTA, the vulnerability of individuals and households and participation aspects of poverty are echoed in Cluster II and III respectively.

Data for measuring poverty are sourced mainly from the Household Budget Surveys (HBS), National Panel Surveys (NPS) and Demographic and Health Surveys (DHS). These sources provide data on income measures of poverty and access to social services including health, water and sanitation and education services. The Tanzania Participatory Poverty Assessment (PPA) was conducted in 2002/2003 with the main objective of getting people voices in what constitute poverty in their own context (how poverty manifests itself); what are the forces that drive people into poverty; what makes people move out of poverty and; what makes people stay poor despite their best efforts.[20] The participatory approaches to defining poverty have also been reflected in the series of the Views of People (VoP), which address the same questions as PPA.[21]

Various policies and frameworks have defined vulnerable groups in terms of life course, health, and economic conditions (Table 1). The draft National Social Protection Framework (NSPF) seeks to reach those who are generally at risk of the impact of natural disaster, poverty, ill-health, social marginalization, and unemployment. Some social protection interventions to address generalized vulnerability include, assuring basic income for individuals, strengthening their capabilities to absorb shocks, and enhancing their ability to sustain livelihoods.

Cluster II of MKUKUTA reflects the need to provide social protection and rights to the vulnerable and groups in need. The specified groups are vulnerable children such as orphans, children outside family care, people with a disability, eligible adults such as elderly

[19] United Republic of Tanzania [URT] (2010a)
[20] URT (2004)
[21] URT (2007a); URT (2013)

and people living with HIV and AIDS. These groups need to be covered with social protection measures including social health insurance. Ensuring equity in accessing public resources and services is also echoed in this Cluster.

Table 1: Vulnerable groups as defined in various national documents

Source	Vulnerable groups
Tanzanian Health Policy 2003[22]	Food and nutrition shocks: children, pregnant and breastfeeding women, adolescents, the elderly, the sick, those in disaster situations and institutions Vulnerable to malaria: Young children and pregnant women
Primary Health Services Development Program – MMAM 2007-2017[23]	Malaria: children under 5 and pregnant women are most vulnerable to malaria due to their particular immunity status.
Health Sector Strategic Plan III 2009-2015[24]	Chronically ill, HIV and AIDS, disabled
Draft National Social Protection Framework[25]	Extreme vulnerable groups • Most disabled children/Most Vulnerable Children • People with disabilities • Elderly • People living with long Illnesses including HIV and AIDS • Extremely vulnerable women • People who finish serving prison sentences • People who became disabled by war conflicts and military training • Economic vulnerable groups

2.2.2 Population and income poverty

Tanzania has a population of about 43 million people. The population is predominantly rural – 75% of the population lives in rural areas – earning their living from small-scale, rain-fed farming. Poverty is pervasive, especially in rural areas. About 33.6% of the households in Mainland Tanzania live under a basic needs poverty line which is well under USD 1 per day (USD 0.30 cent – 500 TZS) and about 16.6% lives below the food poverty line (USD 0.22 cent – 365TZS)and can be considered as extreme poor.[26]Measuring poverty using composite indicators such as Multi-dimensional Poverty Index (MPI)which uses 10 indicators to measure poverty in three dimensions: education, health and living standard shows even higher levels of poverty; 36.7% of Tanzanians are poor based on this measure.[27]

Poverty incidence varies by areas of residence and rural households are poorer than the urban households (Table 2). Rural poverty did not change from 1990/91 to 2007 and income

[22]URT (2003a)
[23]URT (2007b)
[24]URT (2009a)
[25]URT (2010b)
[26] URT (2009b); the calculations on USD per capita per day is based on the poverty lines per adult equivalent per 28 days.
[27]Alkire& Santos (2010).

disparities have grown over the last two decades both between rural and urban households and among urban households.

These findings have implications on identification and inclusion of the poor in accessing quality health services. If 34% of the households are poor in terms of accessing basic needs, the implication is that members from these households will face difficulties in accessing health care. This means that about 14.6 million Tanzanians are not able to access health care without difficulty. Household food security is a strong measure of poverty – that is agreed globally. If a household cannot afford even a basic meal, it is unlikely that it will be able to afford health care (estimated 7.2 million of Tanzanians live below the food poverty line).

Table 2: The incidence of poverty in Tanzania[28]

	Year	Food Poverty Rate (%)	Basic Needs Poverty Rate (%)
Dar es Salaam	1991/92	13.6	28.1
	2001	7.5	17.6
	2007	7.4	16.4
Other Urban	1991/92	15	28.7
	2001	13.2	25.8
	2007	12.9	24.1
Rural	1991/92	23.1	40.8
	2001	20.5	38.7
	2007	18.4	37.6
Mainland	1991/92	21.6	38.6
	2001	18.7	35.7
	2007	16.6	33.6

2.2.3 Non-income measures of poverty

The Poverty and Human Development Report (PHDR) of 2011 provides the status of various non-income measures ranging from education, health, and water related outputs/outcomes.[29] Information is also provided on vulnerability measures based on MKUKUTA indicators. Examples of indicators from the health sector include the proportions of births attended by a skilled health worker and deliveries at health facilities. In 2010 Demographic and Health Survey (DHS), skilled birth attendance was estimated at 50% in comparison to 47% in 2004/05. The same is observed with assisted deliveries (marginal increase from 46% in 2004/05 to 51% in 2010).[30]

There are substantial declines in infant and under-five mortality over the past 10 years. Under-five mortality rates have dropped by 45%, from 147 deaths per 1,000 births in 1999 to 81 deaths per 1,000 births in 2010.[31] An in-depth analysis of child survival gains between 1999 and 2004 found that the declining trend in child mortality is largely due to improvements in Tanzania's health system. For example, the percentage of districts implementing Integrated Management of Childhood Illnesses (IMCI) increased from 19% to 73% (between

[28] URT (2009b)

[29] URT (2012a)
[30] NBS and ICF Macro (2011)
[31] *Ibid.*

1999 and 2004), which facilitated improved diagnosis, prevention and treatment of malaria, the biggest single cause of death among children.[32]

The 2003 Tanzania Participatory Assessment (TzPPA) narrated the impoverishing factors, which result to sudden and unexpected shocks to households(Table 3).[33]The most important shocks and stresses as identified by community members participating in the TzPPA span the six categories presented in Table 3.

Table 3: Impoverishing factors34

Category	Description
Environment	• These include shocks (like flooding) and stresses (as in the case of gradually degrading forests, soils, fisheries and pastures). Environment-related impoverishing forces not only affect people's material wellbeing, but also their health and sense of confidence in future wellbeing.
Macroeconomic conditions	• National macro-economic decisions (such as the privatisation of para-statal industries, the elimination of subsidies for agricultural inputs, the introduction of cost-sharing into the health care system and a reduction of agriculture/livestock extension officers) impact on employment levels, the profitability of rural livelihoods, the cost of accessing crucial services, etc. • As a result of globalisation, macroeconomic decisions made by other countries (such as their choice to subsidise local agricultural production) are increasingly being felt by ordinary Tanzanians as shocks and stresses.
Governance	• Many impoverishing forces are directly linked to the responsibilities of Government and the practice of governance. These include shocks (such as extortion and other forms of corruption) and stresses (like stifling taxation and political exclusion).
Ill-health	• Malnutrition, injury, disease (especially HIV and AIDS) and other forms of physical and/or psychological ill-health often undermine people's material, bodily and social wellbeing.
Lifecycle-linked conditions	• People experience some types of ill-health, health risks, social marginalisation, diminished personal security, etc. *as a direct result of their place in the life-cycle.* Thus, for example, the reduced strength and energy of old age is a lifecycle-linked impoverishing force. Childhood diseases and maternal welfare are also lifecycle-linked issues.
Cultural beliefsand practices	• Some impoverishing forces are the result of cultural traditions/norms that, amongst other things, diminish people's freedom of choice and action. These forces are widespread but highly differential in impact. Many forces privilege men over women and adults over children and youth.

While pregnant women are vulnerable to reproductive health problems in their life cycle, under-fives are vulnerable to various childhood diseases. Elderly people face various vulnerabilities due to physical change, which can lead to social and economic difficulties. These include the reduced ability to be economically active which in the absence of safety

[32]Masanja et al. (2008)
[33]URT (2004)
[34]*Ibid.*

nets leads to poverty. HBS2007 found that one-third of all elderly in Tanzania lived below the basic needs poverty line[35] and VoP found that 14% "always/often did not have enough to eat.[36] The evidence on food deprivation including lack of access to protein rich food indicates that the elderly who live alone or just with their spouse are worse off than the average elderly person and worse off than the average Tanzanian.[37]Frequent and prolonged diseases are a common feature among many older people. This condition calls for a continuous professional care.[38]

Thus, while the government is intensifying measures to improve maternal health, efforts have to be made to sustain the gains made in child survival and further reduce the rates, thusincreasinglife expectancy of Tanzanians. This demands an inclusive health financing framework that addresses the needs of vulnerable households that have been impoverished by various shocks including economic shocks and life cycle related vulnerabilities.

2.2.4 Barriers to access to health care

There is limited quantified evidence on the barriers communities face in accessing health services. In the 2000s, communities reported barriers to uptake of services that included distance from health facilities, transport costs, shortfalls in medicines, medical supplies and laboratory tests and unavailable health workers. Households facing cost barriers reported borrowing from friends, family members or moneylenders and having to sell assets or delay care.[39]

The 2010 DHS collected information from women on problems faced in obtaining health care for themselves. This information is particularly important in understanding and addressing the barriers women may face in seeking care during pregnancy and, particularly at delivery. Problems in accessing health care are felt most acutely by rural women; older women; women with a larger family; divorced, separated, or widowed women; women not working for cash, and women with no education or in the lower wealth quintiles (

[35]URT (2009b)
[36]URT (2007a)
[37]Mboghoina and Osberg(2010)
[38]URT (2003b)
[39]Obrist et al. (2010); Macha et al. (2012)

Table **4**). Lack of financial access is consistently high among the various categories of women.

Studies on street children show that majority of children living on the streets do not have access to health care services. The cost of services coupled with unfriendly attitudes by health workers are the barriers to access most often cited by children. They normally opt for self-medication, purchasing drugs from local shops and pharmacies, because it is cheaper and saves time to dedicate to income-earning activities. Children go to the hospital only when they are very sick (38%), or when advised by a friend (32%). Only 30% regard hospital services as effective.[40]This group has also to be identified and included in the health care financing framework.

[40]Amury and Komba (2005)

Table 4: Problems faced by women in accessing health care[41]

Background characteristic	% of women who reported to have problems in accessing health care when they are sick by type of problem			
	Getting permission to go for treatment	Getting money for treatment	Distance to health facility	Not wanting to go
Age (20-34 years)	2.8	21.9	19.4	10.4
Age (35-49 years)	2.1	30.6	21.5	11.0
Number of children (5+)	2.3	31.7	26.1	12.5
Never married	1.9	21.2	14.1	8.8
Married and living together	2.8	22.6	21.1	11.3
Divorced/separated/ Widowed	1.2	38.9	19.5	9.7
Not employed	3.1	22.9	14.2	10.3
Employed not for cash	2.4	29.3	24.1	12.4
Urban	1.8	14.1	8.5	6/0
Rural	2.6	28.1	23.4	12.3
No education	3.3	35.7	28.6	14.8
Lowest wealth quintile	3.5	42.1	30.3	14.6

In a recent study on inclusion of persons with a disability in the health financing system in Tanzania, the main barriers mentioned by interviewees are a lack of financial resources, transportation problems, inadequate information on how to improve their situation, unfriendly infrastructure at health facilities, long distances, lack of persona assistance and unfriendly staff.[42]

Tanzania has taken various measures to reduce service availability barriers. With 90% of Tanzanians living within five kilometres of a primary health care facility, the government has prioritized ensuring resources and health workers at this level and maintaining the quality of service at these facilities.[43] The Primary Health Service Development Program (PHSDP/MMAM) strategy aims at providing a health centre in every ward and a dispensary in every village as well as to improve outreach services. The program commitments require constructing and rehabilitating 8,100 health centres and dispensaries, 62 district hospitals and 128 training institutions. This is a huge investment, which will reduce transport cost tremendously.

[41] NBS and ICF Macro (2011)
[42] Ifakara Health Institute IHI (2013)
[43] USAID (2011)

Thus there are multiple issues when talking about barriers to access to health care and they can by far not be limited to the financial component only. Issues on transportation as pointed out before, have to be addressed in order to reach universal coverage, as well as efficient medicine supply management and fighting corruption in the health system to mention only a few. However, the biggest challenge might be in the cultural aspects of health care barriers. Those cannot be solved with raising or channelling funds or capacity building but need a lot of engagement on a community level – and time. Such cultural components include for example women who are prohibited to seek health care by their husbands and families, the stigmatisation of people with a disability among other factors. Concluding, there are a lot of diverse areas that need to function in order to remove access barriers and to provide universal coverage.

3 Identification of the poor (Targeting)

3.1 Overview of methods for identifying the poor: Approaches applied in low and middle income countries

Generally, the most accurate method to reflect a household's ability to meet basic needs is using information on income and consumption. A verified Means Test is also regarded as the gold standard of targeting[44]. However, in developing countries the vast majority of the population works in the informal sector or makes a living from subsistence farming. Consequently, data on income is often of poor quality or simply not available.[45] In order to address the difficulty of applying monetary measures of poverty as well as to take local specificities into account, alternative methods can be applied. In Table 5 below, an overview of possible methods to identifying the poor is presented and each method is discussed separately thereafter.

3.1.1 Means Testing

Is a monetary measurement that aims at collecting complete information about a household's income and/or wealth (if verified against independent sources, it is regarded as "gold standard" of targeting).[46]

Strengths/Applicability:[47]

- Appropriate where declared incomes are verifiable and administrative capacities are high.
- Generally few exclusion errors.

Weaknesses/Limitations:[48]

- Detailed and accurate data required (costly, complex, often not available).
- High level of literacy and documentation of economic transaction required.
- Conventional means testing is challenging due lack of verifiable records in many developing countries.

[44] Coady et al. (2004)
[45] J-PAL Policy Briefcase (2013); Robertson et al. (2012)
[46] World Bank (2013); Coady et al. (2004)
[47] *ibid* (2004); Jehu-Appiah et al. (2010)
[48] *Ibid* (2010); World Bank (2013); Alatas (2012)

Table 5: Overview of methods to identifying/targeting the poor

Method	National criteria / poverty lines	Means-Testing (MT)	Proxy-means Testing (PMT)	Geographic Targeting (GT)	Categorical/ demographic targeting	Participatory Community-based approaches	Community-based approach (local leaders)	Self-targeting	Post identification	Hybrid methods
Description *(examples, tools)*	Monetary approach – defining a line under which people are considered as poor *(Example: (Below Poverty Line (BPL)in India)*	Monetary approach collecting complete information on a households' income A verified means test is the gold standard of targeting	Non-monetary approach to define poverty and eligibility for a service. E.g. use of household durables *(Example: CASHPOR House Index (CHI or Progress out of Poverty)*	Targeting a geographic area of predominant poverty	Targeting disadvantaged groups with same social economic characteristics (e.g. ethnicity, gender, family status, disability, etc.)	Using the communities' knowledge about who is poor *(Example: Participatory wealth ranking, lists of criteria developed/provided by local committee)* *Tools: Mapping Drawing Scoring Focus Groups*	Consulting communities leader who provide lists of the poor	The poor choose the offered service e.g. public work programs, subsidized food, basic health care, etc.)	People are registered once they consult, e.g. a health facility, service centre, etc.	Combination of 2-3 methods

Method	National criteria / poverty lines	Means-Testing (MT)	Proxy-means Testing (PMT)	Geographic Targeting (GT)	Categorical/ demographic targeting	Participatory Community-based approaches	Community-based approach (local leaders)	Self-targeting	Post identification	Hybrid methods
Strength / Applicability	Serve as a good bench-mark	Few exclusion errors Appropriate when incomes are verifiable When verified declared as gold standard	Requires less information than MT Good for programs to address chronic poverty	Generally pro-poor allocation of resources Cost efficient Generally few exclusion errors	Administratively simple Cost efficient Useful if specific characteristics and welfare are correlated	Often appreciated by community (especially in rural areas) Cost efficiency Conceptually simple tool	Can be efficient depending on honesty and knowledge of community leaders about their community	The poor can decide themselves	Can be an additional way to capture beneficiaries	Combination of advantages of several approaches Cross-checking confidence in tools can increase Process runs through a couple of stages
Weakness / Limitation	Inclusion/ exclusion errors	Detailed data required, requires high level of literacy and documentation of economic transaction	Indicators may be unable to capture recent shocks or can be manipulated Risks of inclusion/exclusion errors can be high	Robust data required Poor and non-poor might live in close proximity (inclusion errors)	Characteristics may only weakly correlate with poverty Robust data needed, e.g. for age proof	Up-scaling to regional/national level is limited Elite capture, inclusion/exclusion errors possible Self-exclusion of the poor	Risk of elite capture Inclusion and exclusion errors	Stigma can be considerable The poor might be reluctant to participate	Passive method and generally not promising The poor are often reluctant to use services	Evidence from literature is mixed on whether the results will be better

3.1.2 Proxy Means Testing (PMT)

Is a non-monetary measurement that uses indicators of observable characteristics of a household (e.g. location, ownership of durable goods, demographic structures, education, occupation, etc.). Scores are given to each indicator, which can also be weighted.[49]

Strengths/Applicability:[50]

- Requires less information than MT but is yet objective.
- Is applicable for programs that address chronic poverty in stable situations.
- Appropriate if administrative capacities are reasonably high.

Weaknesses/Limitations:[51]

- Requires large body of literate and (computer-trained) staff.
- Insensitive to quick changes in welfare or shock.
- Indicators/assets might be manipulated (e.g. underreporting education, hiding durable goods, missing birth certificates).
- Results about inclusion and exclusion errors vary.[52]

3.1.3 Geographic Targeting

Areas within a district, community or in urban areas with a high incidence of poverty are identified and the entire population benefits from an intervention.[53]

Strengths/Applicability:[54]

- Evidence shows generally a pro-poor allocation of resources (few exclusion errors).
- Easy to administer, less costly than MT and PMT.
- Comparably easy to monitor and little influence of households to manipulate data.

Weaknesses/Limitations:[55]

- Timely and robust data is required.
- Poor and non-poor might live in close proximity (which can lead to inclusion errors).

3.1.4 Categorical/Demographic Targeting

Groups of people with social characteristics (e.g. same ethnicity, gender, family status, persons with a disability, etc.) are targeted to benefit from an intervention.[56]

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[49] Ahmed and Bouis (2002): p. 7ff; Sharif (2009)
[50] Coady et al. (2004)
[51] Alatas (2012); Kidd and Wylde (2011a)
[52] *ibid* (2011a); Veras et al. (2007); Kidd et al. (2011b); Johannsen (2006); Robertson (2012); Houssou et al. (2007)
[53] Bigman and Fofack (2000); Van Domelen (2007)
[54] Aryeetey (2012); Simler and Nhate (2005)
[55] Van Domelen (2007); Simler and Nhate (2005)

Strengths/Applicability:[57]

- Administratively simple and very low cost targeting method.
- Useful if a social characteristic (e.g. age, gender, disability) and welfare is highly correlated.
- Suitable for countries in which a specific part of the population is harder affected by poverty than others.

Weaknesses/Limitations:

- Poor approach when age or other demographic characteristics are only weakly correlated with poverty.
- Robust data required in terms of age proof when targeting the elderly or young children.

3.1.5 Community-based Approaches (CBA)

This term is widely used in the literature and approaches vary. Generally, it encompasses selection processes delegated from the Central government to the communities. The process can be participatory (drawing, mapping, discussing in an open community meeting, wealth rankings, focus groups discussions etc.)[58]or involve only community leaders/authorities (providing lists of respective poor families).

Strengths/Applicability:[59]

- Aims at using existing information and is based on community's own definition and perception of poverty – generally appreciated by communities.
- Marginalized groups can be captured (e.g. orphans, street children, poor living in new settlements).
- Participatory processes can generate an increased understanding of livelihoods and consequences of poverty.
- Trust among villagers and open participation is key for achieving good results.
- Comparably inexpensive, results are immediately available and require minimal materials.
- Consideration of local contexts and structures is important.
- Well trained and knowledgeable facilitators are needed for participatory approaches.

Weaknesses/Limitations:[60]

- Up scaling to regional or national level is limited; no information given about the absolute poverty levels.
- Unlikely to work when community ties are weak.

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[56]Coady et al. (2004); Lavalee (2010)

[57]*ibid.* (2010)

58 Narayan (2000)

[59] Ridde et al. (2009); Alatas et al. (2012); Jehu-Appiah et al. (2010); Simanowitz et al. (2000); Marsden (2011); Souares et al. (2010)

[60] Simanowitz et al. (2000); Ridde et al. (2011); Falkingham and Namazie (2002); Souares et al. (2010); Yusuf (2010); Marsden (2011); IFAD Cambodia (2010)

- Local actors may have other incentives than good targeting; elite capture in selection processes.
- Selection committee or responsible persons might be put under pressure to favour individuals, friends or family members.
- Tendency of self-exclusion of the poor in the selection process and group discussions.
- Local definitions and welfare can make evaluation processes more difficult and ambiguous.
- Reviewed studies showed varieties in degree of errors of inclusion/exclusion.[61]

3.1.6 Self-targeting

Under this approach service providers create incentives in order to encourage beneficiaries to select themselves for a service. Most commonly used in public work programs or in food subsidizing programs.[62]

Strengths/Applicability:[63]

- The poor can decide themselves to join a program as well as on the quality of service.
- Administrative costs of targeting are low.

Weaknesses/Limitations:[64]

- Stigma can be quite considerable.
- Approach is not much in use for health programs according to the literature.

3.1.7 Post-targeting

Post-identification occurs, when a person already needs and requests a service.[65] For the health sector this means that patients are registered once they come to the health facility.[66]

Strengths/Applicability:

- It can be an additional channel to register persons in conjunction with pre-identification processes.

Weakness/Limitations:

- It is a passive method and not promising to target the poor.
- Data collection is important but health providers might be overloaded with other work.

[61] Jehu-Appiah et al. (2010); Feulefack et al. (2006); Alatas et al. (2012); Ridde et al. (2011)
[62] Van de Walle (1998); Weiss (2005)
[63] Coady et al. (2004)
[64] *ibid*.
[65] Morestin et al. (2009)
[66] Men and Meessen (2008)

3.1.8 Hybrid Methods

This is used in order to combine advantages from several approaches and collecting information from a number of different perspectives.

Strengths/Applicability:[67]

- Through crosschecking confidence in reliability can increase and applying a mix of tools, can minimize targeting errors.

Weakness/Limitation:[68]

- According to several studies, hybrid methods do not necessarily perform better than single targeting methods.

3.2 Targeting efficiency and findings from selected, international studies

Literature on targeting is plenty but tend to cover single programs in relatively small areas, so differences in outcomes of the targeting performance may not only be influenced by the method applied but also through external factors.

Generally, two types of errors might occur while identifying or targeting the poor:[69]

1. **Error of exclusion**: Excluding those who should benefit from a program/intervention (the poorest, the poor) – undercoverage.
2. **Error of inclusion**: Including those who are not intended to benefit from a program/intervention (the non-poor) - leakage

No targeting method creates either one of these extremes, but the effectiveness of a tool is sensitive to those types of errors, since they either creates undercoverage or waste of resources and might additionally cause inequality. Therefore, the aim is to keep inclusion and exclusion errors at a minimum, though it is hard to reduce one type of error without increasing the other. There is always some kind of trade-off necessary between both types of error. In practice, identification is never perfect due to the complexity and costs of mechanisms applied, due to the lack of insight into a household's poverty situation and difficulty in data collection.[70] This has been proved by several evaluations of the different methods applied and results about the accurateness of reaching the poor vary.[71]

The understanding of the meaning of poverty in the area of intervention is important in order to tailor a project/program adequately to serve the poor. The perception of poverty varies strongly in the local context and is defined differently by gender, age or other social or economic factors.[72] Targeting effectiveness could be enhanced through understanding the characteristics of (extreme) poverty and the different targeting methodologies.[73] Thus

[67]Marsden (2011)
[68]Yusuf (2010); Alatas et al. (2012)
[69]Badasu (2004); Kidd and Wylde (2011a); Mkandawire (2005)
[70]Lavallee et al. (2010)
[71]Ahmed and Bouis (2002); Feulefack, Zeller and Schwarze (2006); Veras et al. (2007); Men and Meessen (2008); Souares et al. (2010); Jehu-Appiah et al. (2010); Kidd et al. (2011b); Alatas et al. (2012)
[72]Narayan (2000)
[73] Marsden (2011)

defining a list of local criteria to describe context-specific poverty that potential beneficiaries have to fulfil in order to be eligible for a programme can be helpful.[74]

Jehu-Appiah suggests a similar approach, namely that a strategy has to be adapted to the context before implementation and that is it not advisable, to apply a single strategy across an entire country. Furthermore, the authors suggest a decision framework including the criteria of feasibility, efficiency and equity.[75]

Morestin, Grant and Ridde point out that it is crucial that the process of identifying the poor is not assigned to actors who are in conflict of interest in any kind, e.g. financial interest. Furthermore, their research found out, that the involvement of many actors is usually more effective because they allow for second validation, though this has be in balance with the costs of identification. Community identification processes must be justified by the entire community and not leading to stigmatisation of the beneficiaries. Generally, joint efforts between the community and program managers/service providers in identifying the poor respond to the above-mentioned concerns.[76]

Coady, Grosh and Hoddinott draw the conclusion from an extensive review of 122 interventions that the quality of implementation matters remarkably to the targeting outcomes. There is no clear recipe for targeting but understanding the details of the different methods is important for good results. The authors also point out that the findings of the diversity in outcomes raises the importance of creativity and experimentation in devising and implementing targeting methods as well as learning from them. This “culture of public evaluation” how the authors call it, is less prevalent in many parts of Sub-Saharan Africa than in other regions such as Latin America or Eastern Europe.[77]

Social control mechanisms can be a critical component whether or not an intervention is pro-poor. It is crucial that community members are truthfully informed about processes, procedures, the roles of stakeholders, and objectives of the intervention. Transparency can constrain corruption and local elite capture. Due to the very nature of unequal power relations within a community and the resulting weakening of local social control, external controls may need to be established.[78]

Another point made by Men and Meessen is, that a targeting method is only sustainable, if the community perceives the process as fair. If the community questions the legitimacy of the applied strategy, the method will lose support and therefore no satisfying results can be achieved.[79]

Poverty is a dynamic issue and in particular in developing countries, many households are vulnerable to poverty, if they are not actually in poverty. Therefore, the proportion of people who have ever experienced poverty is larger than the population who is identified as poor at one time.[80]The temporal dimension plays an important role and identifying the poor will need to be a continuous process.

[74]Morestin, Grant and Ridde (2009); shiree (2011); Ridde et al. (2011); Men and Meessen (2008)
[75] Jehu-Appiah et al. (2010)
[76]Morestin, Grant and Ridde (2009)
[77]Coady et al. (2004)
[78]Van Domelen (2007)
[79]Men and Meessen (2008)
[80]Yaqub (2000)

3.3 Methods applied in Tanzania for identifying the poor

One of the findings in the conducted field interviews is, that community-based identification is dominant among the approaches applied in Tanzania. All interviewed organisations involve the community in their targeting activities, though the application may vary (e.g. some involve the entire community through community assemblies while others involve only key stakeholders such as community leaders from ward to hamlet levels, or the village council). In most cases, community-based approaches are combined with other identification mechanisms, in particular with geographic targeting. In this section various approaches used in the country are presented, however, the targeting methods can theoretically be combined in other compositions.

3.3.1 Multiple Targeting Mechanisms

TASAF is one of the pioneers in community driven development approaches in the country. In TASAF phase I, communities in eight districts participated in identifying development projects, mainly infrastructural development projects have been prioritised. Community participatory methodologies were also used to identifying the poor in order to be included in the TASAF Community Based Conditional Cash Transfer (CBCCT) in three pilot districts (Bagamoyo, Chamwino and Kibaha districts).[81]

Interventions in the current phase have been designed around a Productive Social Safety Net (TASAF III – PSSN). PSSN incorporate conditional cash transfers for poor households as well as transfers linked to participation in Public Works Program (PWP)[82] among other interventions. The safety net component aims at providing transfers to all those living under the food poverty line. Under this objective the poor are identified using Unified Targeting Mechanism (UTM).

The identification process includes following elements[83]:

1. **Geographic targeting** is applied to identify and select districts, wards and villages and allocate an appropriate level of resources (the program is rolled out in phases):
    a. Determination of the order in which program is rolled out to districts
    b. Selection of villages
    c. Allocation of resources
2. **Participatory community-based targeting** is carried out to identify extremely poor and vulnerable households in selected villages:
    a. Poverty criteria are defined in an open village assembly based on the local perception of poverty.
    b. Election of members to form a Community Cash Transfer Management Committee (CCTMC), which is responsible for identification of beneficiaries and managing the cash, transfers.
    c. CCTMC select households using these pre-determined criteria; the number of beneficiary households is pre-determined with a tolerance of 20%[84]

[81] TASAF website (2013a)
[82] TASAF (2013b)
[83] *ibid.*

d. Collection of key household data to facilitate application of PMT

3. **PMT** is applied to verify selected households and to minimize inclusion errors.
   a. List of identified potential beneficiary households and key household data is entered into the database at Project Area Authority (PAA)[85]level in a Unified Registry of Beneficiaries (URB).
   b. TASAF Management Unit (TMU) applies PMT and each household receives a welfare score. Those households whose score fall below the extreme poverty line are considered eligible for the program.
   c. List of accepted households is provided to PAAs and both lists (also the one rejected by PMT) are taken to the villages for validation.
   d. The PMT indicators are a benchmark against national level indicators and are based on the National Household Budget Survey indicators. These are based on the household demographic characteristics (age, sex), marital status, for children under 18 years whether parents are alive, literacy, long term illness, disability, type of dwelling, livelihoods sources, food security measured by number of meals, type of energy used for cooking and lighting, type of toilet and main sources of water for cooking/drinking. This second level verification allows for national benchmarking and inter-regional comparison.
4. **Community validation** is done to confirm the results of the community targeting and PMT in a village assembly:
   a. The identified households are presented in the village assembly for verification.
   b. Households not listed by the CCTMC can complain directly to the PAA, the village council or the CCTMC. The village council resolves the disputes; if no solution can be found, the grievance will be submitted to the PAA director or the Principal Secretary in Zanzibar.

3.3.2 Geographical and Community Based Targeting

Experiences from the World Food Program (WFP) show a combination of both geographical targeting and community based approaches. WFP developed a Comprehensive Food Security and Vulnerability Analysis Guidelines.[86] The tool has been used by the government in collaboration with other stakeholders[87]to identify geographical areas that are affected by hunger because of various impoverishing forces including draught. The identified regions / districts / communities are then considered for targeting. Criteria for targeting are developed by community members but among others:

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[84]For very poor communities, the pre-defined number of beneficiaries can be expanded by 20% to include more households in need

[85] PAA is a generic term for Local Government Authorities (LGAs)/Zanzibar Administrative Authority or district, town, municipal and city councils used in the TASAF Operational Manual on Productive Social Safety Net (PSSN).

[86] WFP (2009)

[87]The involved government entities include the Disaster Management Department under Prime Minister's Office, the National Food Security Division, Ministry of Agriculture Food Security and Co-operatives, and Local Government Authorities. Other stakeholders include Care International, Sokoine University of Agriculture, Food and Agriculture Organization (FAO), Tanzania Food and Nutrition Centre, UNICEF, World Food Program (WFP), and World Vision.

- Households with no food, livestock, cash crops or any external support are considered for targeting.
- Businessmen/women and employed people are not eligible for buying subsidized food.

In a village assembly, a food committee is selected which is in charge to ensure that households, which fulfil agreed criteria, are identified. All villages are responsible for verifying the identified households through village assembly. Given the limited resources, it is not possible to support all the identified households. Thus, a threshold is set and the poorest of the poor are the ones that are supported.

The geographic targeting approach is followed by a participatory community-based method is also applied by NGOs such as World Vision. World Vision is working with income generation groups and households but also pay Community Health Fund (CHF) premiums for poor households. Eligibility criteria is developed by World Vision whereby the poor are defined having difficulties in accessing health services, having no shelter, and can afford only one meal per day. These criteria are adapted if needed in open village meetings. Village Executive Officers (VEOs) and a World Vision Officer facilitate the village meeting and participants of the meetings mention households, which they consider as being poor. Everybody has to agree in order to put the household on the list. Village health workers/social welfare officers facilitate the verification process and they do receive and address complaints. There is also a suggestion box at the World Vision Office where people can register complaints.

3.3.3 Household Economic Assessment Tool and Community Based Approaches

Save the Children projects in Lindi provide a good example on community-based approaches combined with a household economic assessment. This assessment allows for a livelihoods-based analysis on how people obtain food, non-food goods and services and how they might respond to changes in their environment (e.g. rise of food prices, droughts, etc.).[88]

Save the Children initiated a cash transfer program in 2007 (which has now been closed) and the households that were economically vulnerable were selected. Households were chosen which had no or little income, had lost social and financial support and thus faced extreme food insecurity. Staff from Save the Children in Dar es Salaam conducted house-to-house interviews in randomly selected households (20 households in each village) on vulnerability indicators (see Annex 3 for the indicators). In ensuing village assembly, every household held eligible for the cash transfer program had to be verified.

Due to the high costs of the house-to-house interviews, Save the Children plans to conduct a Participatory Wealth Ranking (PWR) for a recently launched nutrition project instead of house-to-house interviews. The details of the wealth ranking are currently in process. The reason for choosing this method is that in rural areas poverty is often strongly correlated to assets in agriculture (e.g. in terms of the size of a *shamba* as well as outputs in farming) and therefore suitable for a nutrition project. The piloting of the methodology will be jointly conducted with Sokoine University of Agriculture.

[88] Boudreau et al. (2008)

3.3.4 Demographic and Post Targeting

Some health facilities especially at hospital level offer exemption to various groups of people once they consult the hospital. Examples were provided from Dodoma regional hospital where categorical exemptions are offered for following groups, once they come to the hospital for treatment:

- Wazee (elderly 60+)
- Pregnant women
- Individuals with HIV and AIDS
- Children under 5
- Chronically ill
- Prisoners
- Individuals in economic hardship
- Individuals involved in an accident (delivered to hospital without relatives to pay for treatment)
- Most Vulnerable Children (MVC)
- Individuals with a disability, and
- Homeless individuals (including street children).

These are groups that are listed in various national policies, as mentioned in previous chapters. Exemptions are based on few questions on the socio-economic background of a person and occasionally home visits are conducted. The assessments are repeated during every hospital visit. Guidelines for exemptions are in place but quite open to interpretation on who is eligible for getting exempted.

3.3.5 Experiences with Community Based Approaches and supportive practices for vulnerable groups

This section reflects experiences with community-based approaches mentioned by several interviewed organisations on how to identify groups of people. The government and various organizations are applying community-based approaches, which involve community members and different governance structures in the districts. Examples are cited from the three districts that have been sampled in this study.

In Lindi rural district exemption arrangements exist for health and water services. Targeted groups are wazee (above 60), Most Vulnerable Children (MVC) and persons with a disability as stated in various national documents. Identification of possible beneficiaries is performed through Community Development Officers (CDOs) and respective Village Councils (VC) by conducting joint discussions of whom in the village should be exempted. Exemptions are also discussed in village assemblies. The elderly are provided with exemption cards to receive free health care. Support also exists in the education sector. The CDOs and VCs identify school children who cannot afford fees for secondary school due to their socio-economic status.

For identifying MVCs, the district sets criteria according to the Ministry of Health and Social Welfare (MoHSW) MVC identification guidelines. However, the villages are free to define their own criteria. CDOs supervise the process at village and ward level and double-check how the village criteria match with the criteria at district level (in most cases they overlap).

Criteria are mostly related to poor health conditions, insufficient shelter and malnutrition. After identification has been completed, the CDOs evaluate who could support those identified MVC.

Help Age International has facilitated the establishment of old people forums/councils in 8 districts and 24 wards. These forums have been instrumental in the process of identification of elderly people for exemption from paying for health services. In Magu, organizations for elderly (notably MAPERECE) have been identifying elderly people in collaboration with these forums and council authorities (District Medical Officers (DMOs), ward and village authorities). A total of 20,000 elderly have been identified and out of these about 9,000 have already been provided with CHF cards in order to access health services at the district hospital. A window for elderly has been established at the district hospital and thus elderly do not have to go through the Out Patient Department (OPD) procedures. Efforts are underway to establish the same system at health centre and dispensary levels.

In Chamwino district, households in need are identified by various acting officers, such as CDOs and AEOs (Agricultural Extension Officer) for a number of purposes. For instance, poor households are provided with fertilizers and seeds free of charge. Main criterion for a household to be eligible for this support is if it does not own any livestock (the benchmark is five chickens) or land for farming activities. A team of a CDO and an AEO visit each household in order to get a picture of the socio-economic situation. They evaluate how fertile the *shamba* and crops are and if the livestock is healthy. Based on the gathered information the village sends a request to the District Executive Director (DED) for support of villagers in need.

In addition, PRA is conducted two to three times per year, depending on the budget available. The identified households are then assisted with funds and loans, which are provided by NGOs and CBOs as well as the private sector.

3.4 Challenges in identifying the poor

The interviewed organisations that apply participatory approaches pointed out the need for involving the entire community in order to receive good results on identifying households in need. However, there seem to be a lack of coordination between the players in conducting identification processes. Every organization has own procedures in place depending on their program and purposes. This could result in a lack of interest by villagers in participating in identification and targeting exercises. A continuous and integrated identification process, which not only collects data at one time but tracking the development of households over time, could address this challenge (e.g. collecting data in a databank which could be used to provide data to development organisations and government departments whenever they need it for any intervention). Establishing such a databank, however, will come with high initial costs. One of the questions to be addressed in the process is how to ensure a required degree of confidentiality while at the same time making data available for development programmes.

Transparency is important in order to gain the trust of villagers and to achieve good results. However, there might be a risk in identifying persons for a specific reason (e.g. cash transfers, subsidies etc.) that also households aim at profiting from the intervention even

though they are not in need. This can lead to inclusion errors, waste of resources as well as to complaints and in a long term to mistrust. Harmonisation of households' identification processes could help to address this, if the identification process is not directly linked to an intervention to be followed. A unified databank could also support this.

Difficulties experienced with identifying processes by CDOs are to catch poor and vulnerable individuals, for instance, *kibarua* (casual labourer) or individuals living in a "better-off" household but are marginalized within the household. In addition, addressing fluctuation in poverty is seen as a major challenge. A household may move in and out poverty over time and if identification processes are repeated in periods of 2-3 years, these households might not be captured. For instance a family / individual might live in a decent house which was built when money was available but due to a shock the household fell into poverty and struggles to feed its members. Mechanisms will need to be established that allow households to get integrated into a program also between the identification processes.

In order to enhance a household's economic situation, interviewed CDOs furthermore attempt not only to give financial support to the poor, but also pointing out opportunities to the identified household and not to create dependencies.

A challenge mentioned by several interviewees is the cost of targeting in relation to the given benefits. The more accurate a identification process is built up, the more money it will cost which can even exceed the benefits given. It is a challenge to balance affordability and accurateness of targeting processes.

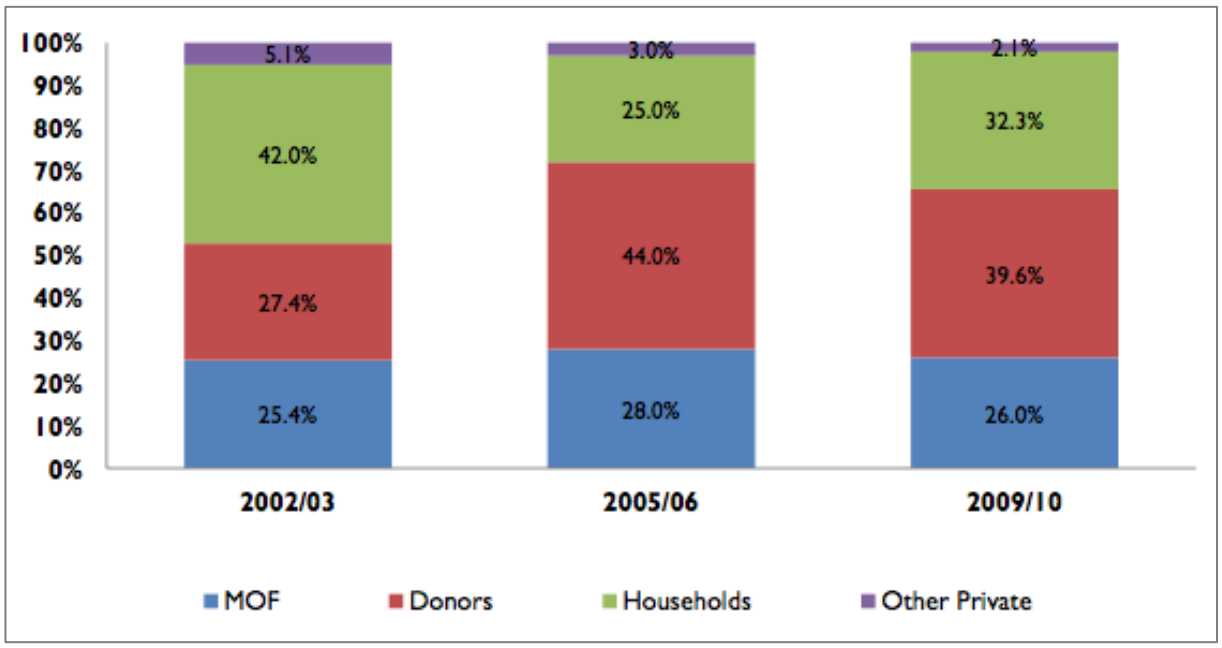
Up scaling of identification procedures can be challenging due to the multi-faceted issue of poverty, which can vary strongly among different regions in a country. Furthermore, a lot of administrative resources are required and respective structures to facilitate implementation need to be in place. Methods need to be adapted to the context. For instance, most procedures are applied in rural areas (where most of the poor live) and not much is reported on results in urban areas. Community-based approaches might be difficult to apply in a setting where neighbours do not know each other well.

4 Health financing in Tanzania and its relevance for the Poor

4.1 Who finances health care in Tanzania?

The Tanzania National Health Accounts of the year 2010 compiled by the Ministry of Health and Social Welfare (MoHSW) analyses the contributions of different financing sources to health care in Tanzania. Figure 1 shows that about a third of the health care expenditures in the country was contributed by private households in 2009/10. This share has been rising again compared to the 25% share contributed in 2005/06, after a considerable drop from 42% in the previous reporting period of 2002/03:

Figure 1: Financing Sources of the health system in Tanzania[89]



4.2 User fees / out of pocket payments

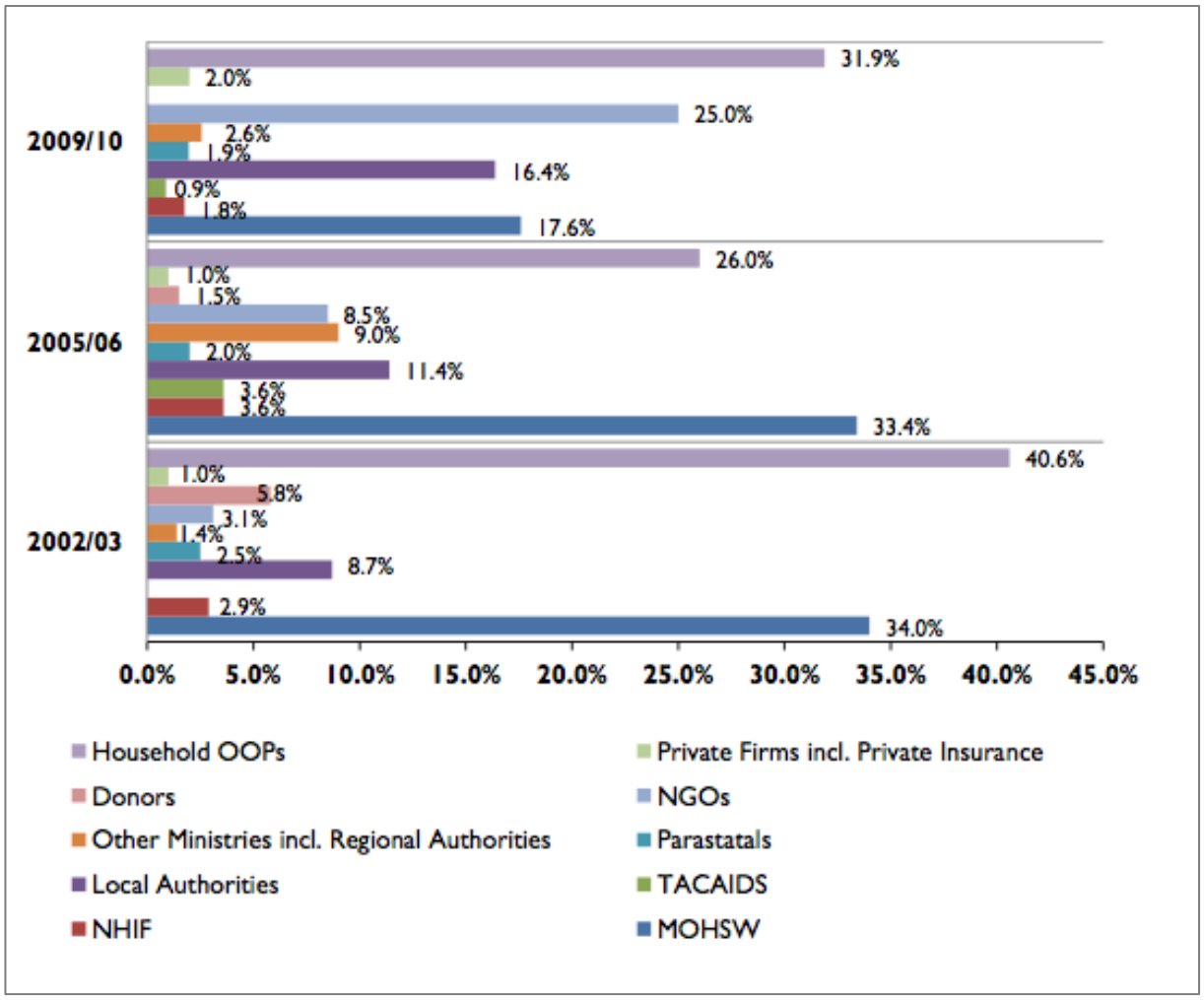
Generally, all over the world, Out of Pocket payments (OOPs) are a serious equity concern as they limit access to care for the poorest population groups.[90]

By further specifying the "financing agents" for the total health expenditures the National Health Accounts 2010 show that out-of-pocket payments (OOP) in the meanwhile form the single largest contribution to health financing in Tanzania (31.9%), larger than the contributions of the MoHSW(17.6%) or of NGOs (25%). Figure 2 illustrates this development. The absolute value of OOP payments in Tanzania comprises an amount of TZS 741 billion, or approximately USD 443 million in 2009/10 (

[89] URT (2012b): p. 8
[90] *ibid.* p. 3

Table **6**).

Figure 2: Financing agents of total health expenditures91



A study on equity implications of user fees in the health sector commissioned by REPOA in 2004, however, points out the probability of underreporting for user fee revenues:

"It is likely that the actual and projected data on user fees, CHFs and Health Service Fund (HSF) are underestimations of the real income collected at the different facility levels. This means that the Ministry of Health faces a loss of income that cannot be redistributed to the health sector. It also implies that people (both wealthy and poor) are likely to pay more than what is officially reported. The actual potential and use of the non-reported user fees are not known. The total contribution of the cost sharing schemes (excluding NHIF) to the national health resource envelope for FY03/04 is 1.67 Billion TZS. This equals a contribution of 0.6% to the overall budget for the health sector. In total, this is USD 1.56 million. Given the size of the total health budget (USD 260 million), it can be concluded that the officially reported user fees contribute a small proportion only. The actual revenue generated does not meet the initial expectations.[92]

[91] *ibid.*

[92] Schwerzel et. al. (2004)

Notwithstanding this uncertainty of the validity of reported figures, it is important to analyse in how far these out-of-pocket expenses of private households create financial access barriers for the poor.

Table 6: Absolute value of health expenditures by financing agent[93]

Financing Agent	2002/03	2005/06	2009/10	Percent Change, 2005/06–2009/10
MoHSW	263,193	594,524	408,513	-31.3%
TACAIDS	-	64,080	20,330	-68.3%
Other Ministries	10,837	160,201	-	N/A
Regional Authorities	-	-	59,625	N/A
Local Authorities	67,347	202,921	380,425	87.5%
NHIF	22,449	64,080	40,841	-36.3%*
Household OOPs	314,284	462,803	740,875	60.1%
Private Insurance	-	-	21,613	N/A
Parastatals	19,352	35,600	45,272	27.2%
Private Firms	7,741	17,800	24,517	37.7%
NGOs	23,997	151,301	580,915	283.9%
Donors	44,898	26,700	-	-100.0%
Total	**774,098**	**1,780,011**	**2,322,927**	**30.5%**

*In the previous NHA, NHIF was lumped with CHF and private insurance together. In this NHA they have been separated. This accounts for the decline in 2009/10.

Table 7 shows the mean OOP expenses for 2001 and 2007 and breaks them down for each income quintile. In 2007 the poorest 20% of the population had to spend a mean amount of TZS 858 per month out-of-pocket for medical expenses. Factors such as seasonal poverty aggravate the situation for the poor. The amounts shown in Table 7 probably do not include indirect expenses for seeking health care such as transport and food, or opportunity costs such as lost income-earning opportunities – all this adding further to the OOP expenses required from private households.

Table 7: Mean out-of-pocket medical expenses[94]

	Mean medical expenses (Tsh)			Medical expenses as a % share of total consumption		
	2001	2007	*% change*	2001	2007	*% Change*
Poorest	1057	858	*-18.8*	2.10%	2.00%	*-4.8*
2nd Quintile	1592	1251	*-21.4*	2.10%	1.70%	*-19*
3rd Quintile	1829	1618	*-11.5*	2.10%	1.90%	*-9.5*
4th Quintile	2533	2042	*-19.4*	2.50%	1.80%	*-28*
Wealthiest	3983	2759	*-30.7*	2.40%	1.70%	*-29.2*
DSM	3750	2341	-37.6	2.90%	2.00%	-31
Other Urban	2695	2006	*-25.6*	2.40%	1.90%	*-20.8*
Rural	1971	1537	*-22*	2.20%	1.80%	*-18.2*
Tanzania	2199	1706	*-22.4*	2.20%	1.80%	*-18.2*

The National Health Accounts 2010 report states as a policy recommendation: "Household OOP expenditure increased from 25% of total health expenditures in 2005/06 to 32% in 2009/10. This high percentage signifies that OOP expenditure may prevent households from accessing health services when needed or may further impoverish them since they may have

[93] *ibid*
[94] World Bank (2012)

to sell valuable assets to offset medical bills, Hence the need to accelerate pre-payment initiatives to reduce payment at the point of service.[95]

4.3 Ineffective exemption and waiver mechanisms

When Tanzania implemented a user fee policy in the health sector in the early 1990s, exemption and waiver mechanisms were introduced with the aim to protect the poor and vulnerable groups of the society and enable them free access to health services.

Exemptions in Tanzania are targeted to vulnerable groups such as:[96]

- Pregnant mothers and children under the age of five years who are in greater chance of being affected by diseases, especially communicable ones (free-of-charge medical services on essential reproductive and child health related problems);
- People suffering from diseases such as diabetes, HIV/AIDS, leprosy, TB, polio, and cancer;
- Tanzanian citizens aged 60 years and above.

While the above listed exemptions are based on categories of defined conditions, waivers are need-based. They are "a temporary relief that forgives patients who prove to be very poor and unable to pay. The government has made it clear that these have to be granted based on the experience and discretion of health workers in consultation with local (community) leaders who may officially recommend people who are too poor to afford charges at health facilities."[97]

Findings of several studies in Tanzania indicate that waiver systems, while potentially effective in principle, were ineffective in implementation. Studies have come to the conclusion that "waiving the poor and exempting the vulnerable groups has remained part of the Tanzanian government health policy but little has been done to ensure their effective implementation".[98]

A number of reasons play together to result in an ineffective implementation of the waiver system in the Tanzanian health sector:[99]

- "Lack of specification of criteria by which the poor could be identified made policy implementers at different levels to implement the policy in their own style.
- Low level of public awareness about the existence of waiver mechanisms hindered the poor to demand exemptions.
- Furthermore, fear of loss of revenue at the health facilities and ineffective enforcement mechanisms provided little incentives for local government leaders and health workers to communicate the policy to beneficiaries."

[95] URT (2012b): p. 35
[96] Mubyazi (2004)
[97] *ibid.*
[98] Gilson et. al. (1998)
[99] Idd et. al. (2013)

Mubyazi points at the difficulties created by the lack of an effective policy for identifying the poor and lists a number of reasons for ineffective waivers[100]:

- "This policy failure to define "who are the poor" or how the poor should be assessed has caused confusion among health-care providers in identifying people who are eligible for waivers. It has also been used as a loophole for some health administrators to ignore people who deserve waivers. Some people eligible for exemptions or waivers still pay either directly at the counter or indirectly under the table in order to get the better services they need.
- Other people delay or fail to contact health facilities due to lack of money or by avoiding the institutional bureaucracy in confirming who deserves a waiver.
- Some people do not benefit from exemptions because of lack of knowledge if they qualify and/or the procedures for presenting their claims.
- Meanwhile some exemptions are granted to people other than the targeted vulnerable groups.
- On the other hand, health workers hesitate to approve exemptions and waivers to avoid losing revenue on the side of their health facilities."

In conclusion, the waiver mechanism in the Tanzanian health sector is not implemented in an effective way, poor people are still facing barriers for accessing health services, and a lot of energy would have to be invested by the government to address all the associated problems listed above. Alternatively, the government could decide in investing into providing health insurance coverage to the poor.

In both alternatives for ensuring access of the poor to health care, either strengthening the waiver mechanism or introducing subsidized health insurance for the poor, the identification mechanism has to be strengthened as discussed in this assessment. However, linking such a strengthened identification process to subsidizing health insurance coverage for the poor has a number of advantages over strengthening waivers for the poor. Health insurance coverage would solve a number of problems presently faced by the poor with the waiver mechanism:

- Health insurance cards remove the stigma of being classified as "poor";
- The poor do no longer have to ask for anew waiver for every visit of a health facility, which removes the associated costs going through bureaucracy time and time again, and saves time;
- Health insurance cards create predictability on the benefit package entitlements both for the poor and the health care providers;
- The fear of loss of revenue at the health facilities is removed and replaced by certainty on revenues through health insurance payments.

Such an approach of providing the poor with CHF cards instead of waivers is already practiced in communities in Tanzania[101]

Moreover, as Mtei and Mulligan highlight, the approach of providing the poor with subsidized CHF cards has already been taken up as a policy by the Government of Tanzania, emphasized by the former President of Tanzania, Benjamin Mkapa: "District councils are

[100]Mubyazi (2004)
[101]Burns and Mantel (2006); Stoermer et. al. (2012)

expected to fully subsidize the CHF membership fees for those who have been exempted or waived. This was re-emphasised by the former Tanzanian President, Benjamini Mkapa, in his speech at the regional RMO meeting in 2005 in Mtwara: "…relevant councils should set aside funds in their budgets for purchasing CHF cards for their less fortunate constituents without the means to afford them…"[102]

4.4 Lacking protection through health insurance

As pointed out above, in a policy framework where user fees are paid for accessing health care, two principle ways of addressing the financial access barriers for the poor created through OOP expenditures are possible:

- Either, exemptions and waivers are efficiently implemented for guaranteeing free access to the poor and vulnerable sections of the population,
- or, alternatively, a health insurance mechanism provides financial protection.

In Tanzania health insurance schemes have been implemented with the Community Health Fund (CHF) for the informal sector and the National Health Insurance Fund (NHIF) for the government employees, expanding presently to other strata of formally employed persons. Both schemes are implemented countrywide since 2001. Furthermore, about 3% of Tanzanians are insured through private insurance, and 1% through the National Social Security Fund.[103]Table 8 below shows the percentage of the Tanzanian population covered by the NHIF and CHF:

Table 8: Insurance coverage in Tanzania104

	Principal Members	Dependents	Total Beneficiaries	Coverage to Total Population*
NHIF membership	468,611	2,030,309	2,498,920	5.8%
CHF membership	561,370	2,806,850	3,368,220	7.8%
Total NHIF and CHF beneficiaries	1,029,981	4,837,159	5,867,140	13.6%

*Using 2011 population projections

These figures are compiled by the NHIF. For the CHF membership they are based on the enrolment figures reported by the district councils for applying for government matching funds, administrated by the NHIF. The "Fact Sheet Inside NHIF 2001-02 to 2010-11" indicates coverage of 7.3% for NHIF (2,498,920 beneficiaries including family members of the "principle members") and coverage of 9.8% for CHF (3,368,220 beneficiaries)[105]

The World Bank arrives at lower estimates for the CHF coverage with 3.9% (Table 9) as compared to the figures of the NHIF with 7.8% (Table 8).

[102]Mtei and Mulligan (2007)
[103]URT (2012c)
[104]*ibid*
[105] National Health Insurance Fund NHIF (2012)

Table 9: Summary of prepayment plans 2010106

Plan	Number of beneficiaries	Share of pop. (%)	Revenue collected (T Sh, million)	Revenue per beneficiary (T Sh)	Benefits paid (T Sh, million)	Benefits per beneficiary (T Sh)
NHIF	1,971,251	4.6	85,826	43,539	20,057	10,175
CHF[a]	1,678,734	3.9	3,009	1,792	2,106	1,792
SHIB[b]	51,306	0.1	1,200	23,389	1,200	23,389
Total	3,701,291	8.6	90,035	24,325	24,266	6,556

Source: Author's calculations.
[a] Revenue collected is kept and used at the district; there is no direct payout of benefits; 30 percent is assumed to be used for administration (per CHF guidelines).
[b] SHIB is funded out of the general NSSF contribution, so no revenue is specifically attributed to the program.

A recommendation in the Health Sector Public Expenditure Review 2010/11 states that "efforts to promote enrolment of households in the CHF are evident at different levels. Lessons from best-performing districts and programs such as Tanzanian German Program to Support Health and the Swiss Development Cooperation funded CHF Strengthening program in Dodoma should be harnessed and applied nationwide".[107]

The German development cooperation (TGPSH / GIZ) supports an NGO in a public-private partnership approach to combine the organisational structures of a Community-based health insurance scheme with the functions of the CHF in two districts of Mbeya Region. The scheme supported by the French NGO "International Centre for Development and Research" (CIDR) builds the organisational structure on organising the members and pursuing a self-governance approach, being a "hybrid mutual and CHF organisation".[108]

The "Health Promotion and System Strengthening Project" (HPSS), implemented by the Swiss Tropical and Public Health Institute (Swiss TPH) on behalf of the Swiss Government (SDC) and the Tanzanian Government (MoHSW) pursues a different approach of re-organizing the CHF in seven districts of Dodoma Region. The key feature of this "CHF Iliyoboreshwa" is the introduction of a strong "Insurance Management Information System" (IMIS)[109] which provides the CHFs with a comprehensive solution for data management, including membership enrolment using mobile phone technology, contribution management, claims processing and payment, as well as collection of member feedback. The CHFs are also embedded into new governance structures in order to ensure an optimal monitoring and support system and a provider/payer split.[110]

Health insurance schemes do have the advantage over "free health care" (i.e. tax-funded health care provided without user fees at the point of delivery) that the government contributions can be targeted to the poor, leaving the better-off with the task of paying part of their health bill. While tax-financed budget funding (i.e. "direct supply of services") provides free health care also to the better off, health insurance provides the government with an instrument to target the scarce resources to those most in need. The Public Expenditure

[106] Haazen (2012): p. 18
[107] URT (2012c). p. xvi
[108] http://factsreports.revues.org/1826
[109] http://www.swisstph.ch/news-archive/news/news/launch-of-the-re-designed-community-health-funds-in-dodoma-region.html
[110] Stoermer, Manfred; Radermacher, Ralf; Vanderhyden, Mackenzie: 2011

Review (PER) 2011 in this line of thinking arrives at the recommendation to further build up health insurance in the country with a more pronounced subsidizing of the poor.

Tanzania has made progress on health indicators where cost barriers are not an issue (child deaths) but not on indicators where they are (maternal deaths). Suggested measures include switching public subsidies from insurance schemes for the top 10% of earners and from direct supply of services, toward subsidies to improve access to financial health protection and/or demand side financing schemes that target the majority or the poor. Targeted grants to meet healthcare costs of poor households also merit consideration.[111] At present, only few households receive subsidized CHF grants through “pro-poor” budgets of the district and municipal councils. However, these budgets are too small to enrol more than a few hundred households, and are thus completely inadequate for substantially improving access of the poor to health services in Tanzania.

[111]URT(2011).

5 Costs of financing the access of the poor and vulnerable to health services

5.1 Funding from health insurance premiums (CHF and NHIF)

The previous chapters of the report showed the dimensions of poverty in Tanzania. It became clear that a significant number of the population, based on the HBS data, does not reach financial access to health services unless they are supported. Such support requires subsidies from the Government of Tanzania. Unless the government decides to go back to "free health care for all", which means in effect subsidizing the entire population (also the better-off), the alternative is to introduce targeted subsidies for those who need support (the poor). Providing health insurance coverage for the poor, and subsidizing membership through government funding (taxes, and donor funding) would be the technical means to implement such a targeted health financing approach.

In order to determine the funding requirements, it is useful to look at which level the premium (contribution) is presently fixed for the insurance coverage (CHF) of a household of six persons per year (household definition as per the present CHF policy). Currently the district councils decide CHF premium levels, as the CHFs are district-operated schemes. A recent review of innovative features implemented by various districts in the country in their CHF schemes showed that the premium levels generally range between TZS 5,000 and TZS 10,000 per year per household, with some few above this amount.[112]In a recent World Bank study by Haazen, a calculation shows an average revenue per beneficiary of TZS 1,792 for the CHF – with a household coverage of 6 persons - would correspond to a premium of CHF 10,752 paid per household on average.[113]Obviously with a premium of approximately TZS 10,000 per year per household the financial power of the CHF health insurance scheme is extremely low.

In comparison, Haazen shows that the NHIF, the health insurance scheme covering government employees and other members of the formal sector, has an average revenue from membership premiums of TZS 43,539 per person per year. This corresponds to revenues from premiums of TZS 261,234 for a 6-person household covered by an NHIF insurance policy.

Recent NHIF data show an even higher income from membership contributions (premiums). Calculations based on the "Fact Sheet Inside NHIF 2001-02 to 2010-11" show revenues per "beneficiary" (i.e. family members) of TZS 53,980, and per "principle member" (equivalent to the "household" insured) of TZS 287,853:[114]

[112]Stoermer et al. (2012); NHIF (2012)
[113]Haazen (2012)
[114]NHIF (2012)

Table 10: Beneficiaries and contributions income for NHIF in 2010-11

Revenues from premiums in 2010-11 (contributions income)	Beneficiaries:	Revenues from premiums per beneficiary:	Number of "principle members" (households) insured by NHIF	Revenues from premiums per "principle members" (household)	Beneficiaries per "principle member" (household)
134,890,980,000	2,498,920	53,980	468,611	287,853	5.33

The comparison between CHF income and NHIF income (from premiums only) shows the huge difference in health insurance funds available for paying for a government employee (NHIF beneficiary) versus citizens working in the informal sector (mostly rural farming population) covered by the CHF (Table 11):

Table 11: Average revenues from CHF and NHIF premiums

	Per beneficiary	Per household of 6 persons
Average CHF Revenue from premiums(TZS)[115]	1,792	10,752
Average NHIF Revenue from premiums (TZS) (WB calculations)[116]	43,539	261,234
Average NHIF Revenue from premiums (TZS) (NHIF data)[117]	53'980	287,853

Disregarding for a moment the administrative costs, the NHIF would be able to pay 27 times as much for the medical bills of its beneficiaries as compared to the CHF, or in other words, the CHF so far reaches a mere 4% of the premium income of the NHIF per beneficiary. Even if the matching funds for CHF are included in this calculation, NHIF still has 13 times as much funding available from premiums than CHF, and CHF would reach 7% of the NHIF premium income per member. This of course is due to the structure of the premium setting for the two schemes: While NHIF deducts 6% from the monthly payslip of each government employee (3% as member's contribution, 3% as employer's contribution), the CHF depends on voluntary contributions of a predominantly agricultural population. The differences in the availability of funds in the two schemes, however, shows that for increasing funding for the health insurance of the rural population political will is required for bridging this gap.

It is clear, however, that neither the amount available for the NHIF member nor the much lesser amount available for the CHF member is presently able to foot the whole medical bill. This is also not required yet, as the government will continue to finance part of the health care costs through supply side funding of health services through their budgets, outside the health insurance mechanism. However, the more funds are directed through a demand-side

[115] Calculated by Haazen (2012): p. 18
[116] Calculated by Haazen (2012): p. 18
[117] NHIF data (NHIF 2012)

financing, through a health insurance mechanism, the stronger the possibility of the health insurance to represent the interests of its members in advocating for quality health services. Furthermore, this strengthens the potential to build up a strong "voice" mechanism representing the interests of the insured members towards the health care providers (an important social accountability mechanism).

Health insurance schemes also have the further advantage that they are able to address other financial access barriers as well, apart from the fees of health services. They may be designed in a custom-tailored way to address specific problems of the target group. A health insurance scheme may e.g. provide a comprehensive "mother-child health package" by also compensating transport costs, and paying for the services of a maternal waiting home (Chigonella)[118].

5.2 Funding requirements for the government for subsidizing health insurance for the poor

The following model calculations show the requirements for funding the financial access of the poor through subsidizing their health insurance premiums, depending on the levels of the premiums and the degree of own contributions expected.

As has been shown, Tanzania uses two poverty lines for defining "the poor" and vulnerable parts of the population:

1. The Basic Needs Poverty Line, which includes an estimated 34% of the population (14,620,000 people) who are not able to fully satisfy their basic needs; and
2. The Food Poverty Line including an estimated 17% of the population (7,482,000 people) who are not able to fully satisfy their nutritional requirements.[119]

If we assume the Government of Tanzania would subsidize the poor in a targeted way and finance health insurance (CHF) coverage for them, additional financial means would have to be mobilised for footing this bill. The funds paid into health insurance for subsidizing the costs of medical treatment, however, are not "lost". A full cost – benefit analysis would show that these costs have to be offset against the savings of the Tanzanian society and economy through a reduction of suffering and of workdays lost due to illness. Moreover, the same funds may be re-allocated from the present budgets for health care providers.

How much funding will be required for subsidizing financial access of the poor to health services? There is no clear-cut answer to this question, as several factors play a role. So far health insurance in Tanzania (especially CHF) only pays for part of the real costs of medical treatment of the members. A large part of the costs are paid through supply-side financing of the health care providers by the government and donors (and by private providers, where they accept CHF clients).

For calculating required subsidies for the health insurance part of health care financing, different models can be applied. We propose the following considerations for setting up models for subsidizing the poor at various levels:

[118] http://countryoffice.unfpa.org/tanzania/drive/ChigonellaLeafletFinal.pdf
[119] URT (2009b)

1. The “very poor” (below food poverty line) are assumed to pay no financial contribution, with the reasoning that we cannot expect own financial contributions from individuals who do not have enough money to adequately feed themselves. (This assumption may be modified once the government considered public works programmes for enabling the very poor to earn additional income). The subsidy of the government to the health insurance card would be assumed to be 100% for the time being.
2. The “poor” (below basic needs poverty line, but above food poverty line) are expected to contribute some amount to paying for their health insurance card. The subsidy of the government to the health insurance card would be below 100%, ranging e.g. between 80% and 50%.

The following calculations show the requirements for funding health insurance for the very poor and the poor under different assumptions:

Option 1 is based on the present **national average** level of CHF premiums, i.e. TZS 10,752 per household of six persons, according to World Bank calculations. For easy calculation and understanding the model calculations are done with a premium of TZS 10,000 per household, reflecting the present situation in Tanzania.

This amount is of course very small for substantially contributing to the health bill of a 6-person household. However, this option represents the approach of extending the present financial protection the CHF offers in the country to the very poor and poor, though without improving the financial capacities of the CHF.

We propose to look at three variations:

1. The government taking over the whole cost of paying health insurance cards for the very poor and the poor;
2. The government taking over the whole cost for the very poor, but only 80% of the cost for the poor, thus offering them a heavily subsidized card;
3. The government taking over the whole cost for the very poor, and 50% of the cost for the poor, thus offering them a moderately subsidized card.

Table 12 shows the financial requirements for the government for financing the subsidies (including the continuation of the central government “matching fund”), and the own contributions of the poor.

Table 12: Option 1: CHF premium of 10,000 per household of 6 persons / TZS 1,666 per person – funding requirements under different assumptions

(assumed exchange rate USD 1 = TZS 1670)

Different options of subsidizing the poor	**Number of poor / very poor persons**	**Option 1a:** Subsidy very poor: 100% Subsidy poor: 100% (TZS 10'000 per hh)		**Option 1b:** Subsidy very poor: 100% Subsidy poor: 80% (TZS 8'000 per hh)		**Option 1c:** Subsidy very poor: 100% Subsidy poor: 50% (TZS 5'000 per hh)	
		TZS	USD	TZS	USD	TZS	USD
Population Below Food Poverty Line ("very poor") / subsidies for the very poor	7,482,000	12,470,000,000	7,467,066	12,470,000,000	7,467,065.87	12,470,000,000	7,467,066
Population Below Basic Needs Poverty Line, and above Food Poverty Line ("poor") / subsidies for the poor	7,138,000	11,896,666,667	7,123,752	9,517,333,333	5,699,002	5,948,333,333	3,561,876
Total poor / subsidies for the poor:	**14,620,000**	**24,366,666,667**	**14,590,818**	**21,987,333,333**	**13,166,068**	**18,418,333,333**	**11,028,942**
Additional Government payment of matching funds		24,366,666,667	14,590,818	24,545,592,533	14,697,960	24,813,981,333	14,858,671
Total Government contribution to CHF cards for the poor		**48,733,333,333**	**29,181,637**	**46,532,925,867**	**27,864,027**	**43,232,314,667**	**25,887,614**
Own contribution of the "poor"		0	0	2,558,259,200	1,531,892	6,395,648,000	3,829,729

Option 2 considers a moderate increase of the CHF premium to an amount of TZS 20,000 per year per 6-person household, and a corresponding increase of the central government matching funds to TZS 20,000. This increase could be acceptable for the rural population under the pre-condition of having an effective targeting mechanism for the poor in place, so that only the “non-poor” would have to pay this amount.

Again different options of own contributions of the poor are considered. However, in order not to overburden the poor with such a higher premium we propose to leave the own contribution of the poor at the level of TZS 2,000 per family (corresponding here to 10% own contribution) and TZS 5,000 (corresponding here to 25% own contribution), like in the model with a TZS 10,000 premium. The resulting financing requirements for the government subsidies and the amounts contributed by the poor are shown in Table 13.

Option 3 considers a CHF premium of TZS 30,000 per year per 6-person household, and a corresponding increase of the central government matching funds to TZS 30,000. Also this increase could still be acceptable for the rural population if there is an effective targeting mechanism in place to support the poor and very poor. Again, in order not to overburden the poor, the calculations are done with the proposal to leave the own contribution of the poor at the level of TZS 2,000 per family (corresponding here to 6.6% own contribution) and TZS 5,000 (corresponding here to 16.6% own contribution).

Option 1 (premium of TZS 10,000 per household), option 2 (premium of TZS 20,000 per household), and option 3 (premium of TZS 30,000 per household) in their different variations of own contributions of the poor, remain quite moderate regarding the capacities of a rural health insurance to shoulder a considerable part of the costs for providing health care to its members.

Option 4 gives an idea on the dimension of funds required if the government subsidized the health insurance for the rural population up to a level of health insurance protection of government employees. As shown in Table 11 the present average premium per member of the NHIF is TZS 53,980, which corresponds to a premium of TZS 287,853 per household of 5.33 persons(NHIF data), half paid by the employer, half by the employee. It is obvious that such high amounts in the present economic situation of Tanzania cannot be paid by the rural population as health insurance premium out of their own capacities. Option 4 therefore assumes that the premium asked from CHF members would be fixed at TZS 20,000, and the subsidies for the poor would be raised to an amount equalling revenues of TZS 287,853 for the CHF per household. The poor in this model will continue to be asked to pay either TZS 2,000 or TZS 5,000.

As the amount of TZS 287,853 already is quite high, we assume that the Government does not pay matching funds on this amount additionally. One could think about a system where normal households pay TZS 20,000 as a premium, and the government pays matching funds to this amount in order to maintain the incentive for the districts to enrol CHF members. In order to reach the overall amount of TZS 287,853 the government would re-direct funds from supply side funding of health care providers to demand-side funding of the health insurance up to this amount, without subjecting this payment to the matching fund mechanism. Table 15 shows the resulting funding requirements.

Table 13: Option 2: CHF premium of TZS 20,000 per household of 6 persons (TZS 3,333 per person) – funding requirements under different assumptions

(assumed exchange rate USD 1 = TZS 1670)

Different options of subsidizing the poor	**Number of poor / very poor persons**	**Option 2a:** Subsidy very poor: 100% Subsidy poor: 100% (TZS 20'000 per hh)		**Option 2b:** Subsidy very poor: 100% Subsidy poor: 90% (TZS 18'000 per hh)		**Option 3c:** Subsidy very poor: 100% Subsidy poor: 75% (TZS 15'000 per hh)	
		TZS	USD	TZS	USD	TZS	USD
Population Below Food Poverty Line ("very poor") / subsidies for the very poor	7,482,000	24,937,506,000	14,932,638	24,937,506,000	14,932,638	24,937,506,000	14,932,638
Population Below Basic Needs Poverty Line, and above Food Poverty Line ("poor") / subsidies for the poor	7,138,000	23,790,954,000	14,246,080	21,411,858,600	12,821,472	18,737,250,000	11,219,910
Total poor / subsidies for the poor:	**14,620,000**	**48,728,460,000**	**29,178,719**	**46,349,364,600**	**27,754,111**	**43,674,756,000**	**26,152,549**
Additional Government payment of matching funds		48,728,460,000	29,178,719	48,847,664,600	29,250,099	49,920,506,000	29,892,519
Total Government contribution to CHF cards for the poor		**97,456,920,000**	**58,357,437**	**95,197,029,200**	**57,004,209**	**93,595,262,000**	**56,045,067**
Own contribution of the "poor"		0	0	2,498,300,000	1,495,988	6,245,750,000	3,739,970

Table 14: Option 3: CHF premium of TZS 30,000 per household of 6 persons (TZS 5,000 per person) – funding requirements under different assumptions

(assumed exchange rate USD 1 = TZS 1670)

Different options of subsidizing the poor	**Number of poor / very poor persons**	**Option 3a:** Subsidy very poor: 100% Subsidy poor: 100% (TZS 30'000 per hh)		**Option 3b:** Subsidy very poor: 100% Subsidy poor: 93.3% (TZS 28'000 per hh)		**Option 3c:** Subsidy very poor: 100% Subsidy poor: 83.3% (TZS 25'000 per hh)	
		TZS	USD	TZS	USD	TZS	USD
Population Below Food Poverty Line ("very poor") / subsidies for the very poor	7,482,000	37'410'000'000	22'401'198	37'410'000'000	22'401'198	37'410'000'000	22'401'198
Population Below Basic Needs Poverty Line, and above Food Poverty Line ("poor") / subsidies for the poor	7,138,000	35'690'000'000	21'371'257	33'310'654'770	19'946'500	29'741'665'477	17'809'381
Total poor / subsidies for the poor:	**14,620,000**	**73'100'000'000**	**43'772'455**	**70'720'654'770**	**42'347'697**	**67'151'665'477**	**40'210'578**
Additional Government payment of matching funds		73'100'000'000	43'772'455	73'100'000'000	43'772'455	73'100'000'000	43'772'455
Total Government contribution to CHF cards for the poor		**146'200'000'000**	**87'544'910**	**143'820'654'770**	**86'120'153**	**140'251'665'477**	**83'983'033**
Own contribution of the "poor"		0	0	2'379'345'230	1'424'758	5'948'334'523	3'561'877

Table 15: Option 4: CHF premium of TZS 287,853 per household of 5.33 persons / TZS 53,980 per person (NHIF level of premiums) - funding requirements under different assumptions

(assumed exchange rate USD 1 = TZS 1670)

Different options of subsidizing the poor	**Number of poor / very poor persons**	**Option 4a: Subsidy very poor: 100% Subsidy poor: 100% (TZS 287,853 per hh)**		**Option 4b: Subsidy very poor: 100% Co-payment poor: TZS 2,000**		**Option 4c: Subsidy very poor: 100% Co-payment poor: TZS 5,000**	
		TZS	USD	TZS	USD	TZS	USD
Population Below Food Poverty Line ("very poor") / subsidies for the very poor	7,482,000	403,876,199,462	241,842,036	403,876,199,462	241,842,036	403,876,199,462	241,842,036
Population Below Basic Needs Poverty Line, and above Food Poverty Line ("poor") / subsidies for the poor	7,138,000	385,307,178,797	230,722,862	371,031,178,797	222,174,359	349,617,178,797	209,351,604
Total poor / subsidies for the poor:	**14,620,000**	**789,183,378,259**	**472,564,897**	**774,907,378,259**	**464,016,394**	**753,493,378,259**	**451,193,640**
Additional Government payment of matching funds		-	-	-	-	-	-
Total Government contribution to CHF cards for the poor		**789,183,378,259**	**472,564,897**	**774,907,378,259**	**464,016,394**	**753,493,378,259**	**451,193,640**
Own contribution of the "poor"		-	-	14,276,000,000	8,548,503	35,690,000,000	21,371,257

In summary, Table 16 shows the required amounts if the government subsidizes CHF health insurance coverage for the poor, at different levels of premiums and at different levels of own contributions by the poor.

Table 16: Government funding required for subsidizing health insurance for the poor as compared to MoHSW budget and health sector budget

	Government Subsidy (million TZS)		**Government Subsidy (million USD)**		**% of Tanzanian MoHSW budget**		**% of Tanzanian Health Sector budget**	
Premium per household	min.	max.	min.	max.	min.	max.	min.	max.
TZS 10,000 (present average level in Tanzania)	43,232	48,733	26	29	5.73%	6.46%	2.89%	3.26%
TZS 20,000 (doubling of the present level)	93,595	97,457	56	58	12.42%	12.93%	6.25%	6.51%
TZS 30,000 (level of max. revenue but still affordable by majority of population)	140,251	146'200	84	88	18.60%	19.39%	9.37%	9.77%
TZS 287,853 (level of health insurance for govt. employees - NHIF)	753,493	789,183	451	473	99.95%	104.69%	50.33%	52.72%
Approved MoHSW budget for the fiscal year 2013/2014 (million TZS)	753,850							
Health sector budget for the fiscal year 2013/2014 (million TZS)	1,497,000							

The amounts required for subsidizing health insurance coverage for the poor are compared to the budget of the MoHSW and the whole health sector budget. The MoHSW presented the approved budget for the fiscal year 2013/2014 in the National Assembly with an amount of TZS 753.85billion[120]. The health sector budget as a whole comprises about TZS 1.497 trillion, thereof TZS 753bn for MoHSW, and TZS 743bn for PMO-RALG[121].

The table clearly shows that subsidizing CHF cards of the poor should be feasible for the calculated premium levels of TZS 10'000, TZS 20'000 and TZS 30'000 per household of six

[120] Health Issues Corner (2013)

[121] Personal communication with MoHSW, Health Policy and Planning Department

persons. It would cost the Government between TZS 43 billion and TZS 49 billion(26 to 29 million US Dollars) to provide all poor households in Tanzania with a CHF card in the value of TZS 10,000, depending on which degree of own contributions is asked from the poor households.

Likewise, even if the CHF premiums are doubled or tripled to a level of TZS 20,000 respectively TZS 30,000, the funding of this amount should still be in a feasible dimension for the Government. The option based on a CHF premium of TZS 20'000 per hh would require an amount of TZS 93 billion to TZS 98 billion (USD 56 million to USD 58 million) for providing all poor households in the country with health insurance coverage.

Even in the case of a full subsidizing of a premium of TZS 30'000 per household (and no own contributions of the poor), with an additional TZS 30'000 per household as central government matching funds, the overall total Government contribution to CHF cards for the poor would not exceed TZS 150 bn or USD 88 (at the rate of 1 USD = 1650). This amounts to approximately 20% of the MoHSW budget.

It is obvious that subsidizing health insurance for a third of the population below the basic needs poverty line requires considerable re-allocation from funding budgets of providers to funding contributions to health insurance. Such re-allocations will directly benefit the poor and still provide funding to health services through reimbursement of health insurance claims.

Subsidizing health insurance for the poor up to a level of premiums which is currently available for government employees, on the other side, looks unrealistic in the present situation. This would require funding in a dimension of the whole MoHSW budget or about half of the health sector budget, which obviously is not feasible.

5.3 The financing mechanism for implementing pro-poor health subsidies

Much depends, however, on the preparedness of donors to invest into reaching universal coverage through health insurance. The recent approval of the health sector budget 2013/14 shows the paramount role of donor financing in the health sector: "Donor dependency for development projects has reached 92% whereby a total of TZS 471.3 billion has been set aside for development projects and the government will contribute only TZS 37billion"[122]. However, the government also finances 100% of the recurrent budget.

One example of such an approach to move partially from a budget financing of the health system to a strengthening of health insurance financing is the "Rashitriya Swasthya Bima Yojna (RSBY)" scheme of the Government of India. The RSBY is designed to be the "health insurance for the poor" covering all households identified as being "Below Poverty Line" (BPL).[123] The approach taken by the Government of India outsources the implementation of the health insurance to private insurance companies. This approach, however, requires a reasonably well developed insurance market. In Tanzania this condition would not be given, and with NHIF, NSSF, and CHF national insurance schemes are already in place, which could be further developed for providing coverage for the poor. The Indian approach has its

[122] *ibid.*

[123] Rashitriya Swasthya Bima Yojna - RSBY Website (2013)

own lessons to learn regarding the identification process of the poor (BPL), which is not without problems.

The example shows, however, that if there is political will, the government can move towards financing health insurance on a large scale. The RSBY is organized in a way that the Union Government of India and the respective State Governments share the costs of subsidizing health insurance cards for the poor: "75 percent is provided by the Government of India (GOI), while the remainder is paid by the respective state government."[124] In Tanzania, the Central Government and the LGAs (district / municipal level and village) could work out such a distribution of costs. In the case of India the own contribution of the poor is quite low with an amount of Indian Rupees 30, equivalent to approximately TZS 830 or USD 0.5. In Tanzania such an own contribution of the poor could be varied according their poverty scaling, as discussed above.

The experience of India shows that with such a re-orientation from budget funding to health insurance funding a huge number of the poor households can be provided with access to health services within a short time. As an article states in June 2013: "Where dozens of "micro insurance" and NGO pilots failed to scale up, RSBY has already [in just 5 years] provided more than 110 million people (almost 10 percent of India's population) with heavily subsidized health insurance, providing up to USD 550 annually [for a family of five] to finance secondary hospital care."[125]

For Tanzania such a policy would require negotiations on the sharing of costs between different governmental institutions, both at central, district / municipal and village level. The Health Basket Fund and the Matching Funds paid by the Government of Tanzania to supplement the funds collected through member contributions (premiums), both involving donor funding, are indispensable elements of such a cost-sharing arrangement. Further, the NHIF could be included into such a cost-sharing regulation. As the World Bank notes, the expenses of the NHIF as a percentage of total revenues over the years were fairly regular reaching 27.1% in 2008/09, with a sudden jump to 35.7% in 2009/10.[126] This expenditure pattern of staying below a third of the revenues in most years enabled the NHIF to accumulate large reserves beyond legal requirements, which could be utilised in its new role of supporting the CHF.

A recent study arrives at a similar conclusion regarding the potential of NHIF to contribute to reaching "Universal Coverage", which would include subsidizing the financial access of the poor: "Insurance contributions represent a potential source of revenue. There is currently an estimated annual revenue surplus per NHIF member of TZS 25,162. This surplus is projected to increase under the expanded and universal coverage scenarios if contribution and reimbursement levels remain as they are. Indeed, the revenue surplus alone would then be sufficient to finance the expanded and universal coverage scenarios".[127].

These are potential sources for a health insurance financing approach providing financial access to health care for the poor. The modalities of channelling the funds from the financing agent to the implementer of the scheme (e.g. CHF) could vary: Matching Funds could be increased, or a national level pooling mechanism could be installed to which various sources

[124] *Ibid.*
[125] Fan (2013)
[126] Haazen (2012)
[127] Borghi, Mtei and Ally (2012)

contribute. Such a pooling mechanism – an "equalisation fund" - could take over equalisation functions, with the tasks to re-direct subsidies to districts along need based criteria. Such criteria could be the number of poor households, the scaling of the households along national level criteria, and could also be based on the criteria already established for the distribution of the Government Block Grant.[128]

6 Options for improving the inclusion of the poor in health financing

The study team examined different options for improving the inclusion of the poor in health financing. Such options exist on different levels:

1. The policy approach. "Free" health care versus health care where contributions are asked for, either as user fee or as health insurance premium;
2. The targeting approach: How to identify the poor and the vulnerable groups in a cost-effective, specific and sensitive way;
3. The technical package offered to the poor and vulnerable: exemptions of health insurance;
4. The financing mechanism: How should the funds be provided for implementing such a technical package.

6.1 The policy approach: "Free" health care for all or health insurance for all?

In a perspective of protecting the poor from financial access barriers one option certainly is to offer free health care at the point of service delivery for everybody. Theoretically the access barriers in such a set-up are lowest. This approach has been applied in most African countries after independence, until the economic (debt) crisis of the 1980 resulting from previous oil price shocks forced the African countries into structural adjustment programmes with the objective to reduce governmental expenditures. As a consequence of this economic re-orientation the concept of "cost-sharing" and introduction of user fees was developed from 1987 onwards, both with World Bank recommendations but also from the African Ministers of Health in the Bamako Initiative in 1987.[129]

"Cost-sharing through paying user fees at the point of service delivery from the beginning had two main objectives: on the one hand, raising additional funds for a chronically underfinanced health service, and on the other hand, also empowering people by giving them a say in how such funds should be utilized. Further, the abundant "informal payments" patients had to make in the nominally "free" health services were hoped to be kept under control by formalizing such payments. Especially the Bamako Initiative formulated two objectives for community contributions / user fees: the objective of "co-funding" of health services, going alongside the objective of "co-management" of health services. In Tanzania

[128] URT (2007c); Samali and Minja (2005)
[129] UNICEF (2008)

the user fee policy was implemented in the 1990, and the objective of the co-management is institutionalized in the establishment of health facility governing committees.

After user fees have been widely established in nearly all countries worldwide, critical assessments come to the conclusion that they create financial access barriers for the poor, which further contribute to their exclusion from essential services. International organisations started advocating for the abolishment of user fees.

While this may be a valid option, it would also come along with its costs and shortcomings. Not only would the health system have to do without the financial contribution of those members of the society who can afford to pay a user fee. More importantly, an abolishment of user fees would practically also abolish any health insurance approach, especially as long as it is based on voluntary membership. Why should anybody decide to contribute to a health insurance scheme while the same services are available free of charge anyway.

With the abolishment of the health insurance option, however, the society would lose two major advantages of health insurance in comparison to a purely tax-funded system: One, health insurance allows the government to target its subsidies to the poor, instead of paying for free health services for everybody. In a health insurance system the better-off are expected to contribute to their costs, and the scare resources of the government can be targeted to subsidize health care for the poor.

The second, and even more important advantage of a health insurance system over a tax-funded one is the building up of a “voice” mechanism representing the interests of the members of the health insurance towards the health care delivery system. In such a “third party” arrangement the health insurance from a crucial size onwards will be in a position to effectively lobby for quality health care to be provided to its members. Such possibilities of asking for quality services and complaining about insufficient quality of care are hardly given for individual patients towards a health care provider, but can be taken up on a large scale by health insurance schemes.

The Government of Tanzania so far does not express an intention to go back to “free” health care, i.e. a purely tax-funded health system, but rather promotes the development of health insurance policies in recent years. Regarding the inclusion of the poor this opens up the option to establish a strong targeting mechanism for identifying the poor and to provide them with health insurance coverage, in a non-stigmatizing way.

6.2 The targeting approach: How to identify the poor and the vulnerable groups in a cost-effective, specific and sensitive way?

On the basis of the interviews conducted with various key informants the study team identified the following feasible options for identifying the poor and vulnerable groups for the new health strategy in Tanzania. The options have been described in more detail above (chapter 3), and are here summarized with the aim to identify policy options for the decision makers. The described methods do not interfere with the existing national exemption policy for old people, pregnant women and children under five years of age.

6.2.1 Option 1: Multiple Targeting Mechanism

A multiple targeting approach combines different targeting methods in order to make use of positive features of various methods and allows for cross-checking. This approach is for instance used by TASAF, among other organisations, combining geographic targeting with community-based approaches and proxy means testing (PMT).

The approach has following characteristics:

- It uses poverty criteria developed by the community
- Through PMT a welfare score is given to households which allows for benchmarking against the national level poverty score (composite poverty index) and serves as a second level verification

Approach:

1. **Identification and prioritisation of districts through geographic targeting:** Geographic targeting is applied to select districts, wards and villages with high prevalence of poverty and allocate an appropriate level of resources in order to perform the identification of the poor process.
2. **Application of participatory community-based targeting:** In an open village assembly poverty criteria are defined based on the local perception of poverty in order to identify extremely poor and vulnerable households. In the same village assembly, a community committee (consisting of 50% women and 50% men) is elected which is responsible for the identification process.
   Alternatively to the open village assembly, focus group discussions (FGDs) can be organised consisting of participants with demographic similarities, e.g. only, women, only elderly, etc. The advantage could be that people are more likely to speak up if they are among each other and may define different criteria. The criteria from the all FGDs are then discussed and compiled.
3. **Selection of households:** The community committee selects households using these pre-determined criteria of beneficiaries in the respective community.
4. **Categorisation and pre-verification of selected households through proxy means testing:** The community committee applies the proxy means testing (alternatively jointly with / or separately by an external body) to categorise household in “very poor” and “poor” in line with the poverty lines in Tanzania (basic needs and food poverty line). The proxy means test serves at a benchmark against national poverty lines, allows for inter-regional comparison and is a first verification step of the households selected through the community-based approach.
   Alternatively to applying a comprehensive proxy means test, the “progress out of poverty index”(PPI) developed by Grameen Foundation in 2005 could be applied.[130] This index consists of a total of ten questions about the household’s

[130] The scorecards are aligned to country-specific elements, by using the national household survey as a baseline. Out of the content of the household survey ten indicators are selected which are: (1) Inexpensive to collect, quickly to answer and easily to verify; (2) Strongly correlated with poverty (3) Liable to change as poverty changes over time .The PPIf acilitates targeting by setting a benchmark to the national and international poverty lines (national food poverty line, national basic needs poverty line, USAid extreme poverty line, International PPP 1.25USD/day and PPP 2.50 USD/day) - Schreiner(2012)

characteristics and assets, which are scored in order to calculate the likelihood of the household to be living below the national/international poverty line.[131]
In appendix 3, the indicators for the PPI Tanzania are included.

5. **Establishment of a database and maintenance of information:** The list of potential beneficiaries and key household data is entered into a database in order to keep track of the households' development over time.
6. **Verification of final list of beneficiaries:** In a follow-up village assembly, the selected households go through the final verification, complaints can be placed and the list is finalised.

Table 17 below shows the strengths and weaknesses as well as opportunities and threats of the approach of a multiple targeting approach. Table 18 illustrates mitigation measures to address weaknesses and threats:

Table 17: SWOT Analysis of multiple targeting mechanisms

Internal factors	**Strengths**	**Weaknesses**
	• Focuses on the multiple issues of poverty (food, housing, education, social exclusion, etc.)and includes "vulnerable" groups. • Comprehensive approach both with local criteria and benchmarking against national level. • The methodology has been tested in a pilot in three districts and, has been evaluated and adapted. • FGD may improve inclusion of women's perspectives and those of other demographic groups. • In addition to giving a benchmark against national poverty lines (food poverty line and basic needs poverty line), the progress out of poverty index (PPI) also serves as a benchmark to international poverty lines (USAID extreme poverty as well as PPP USD 1.25 and USD 2.50). • The PPI is on the national household budget survey but uses only ten indicators and is thus time efficient and straightforward to apply. • Households are registered in a databank, which allows for tracking households' progress over time.	• The approach is administratively demanding and a resource intensive process. • The PMT Questionnaire applied by TASAF is very detailed and somewhat complex and thus there is a risk that the PMT might be not appropriately applied.

[131] PPI website (2013a)

External factors	**Opportunities**	**Threats**
	• TASAF will include all villages in Tanzania in the program phase “TASAF III” • TASAF is the politically legitimized institution in Tanzania for supporting the poor. • TASAF has a strong presence in the country through own offices at district level. • Trust and understanding for each other in the communities might be well established in the vast majority of communities and thus good results can be achieved • Robust geographic data is available	• If the identification process is followed by an immediate intervention, the results can be distorted and inclusion errors might occur. • The organization and facilitation of various FGDs require more resources than an open village assembly. • TASAF may not be able to conduct identification processes in the entire country • The Grameen Foundation has developed a PPI for Tanzania but no experiences in the country so far. • There might be a lack of robust geographic data • Villagers might be reluctant to participate in the process

Table 18: Mitigation measures for weaknesses and threats – multiple targeting mechanism

Weakness /Threat	Mitigation Measure
The approach is administratively demanding and a resource intensive process.	Planning resources adequately and evaluate needs of an adequate identification process or saving resouces/costs.
The PMT Questionnaire applied by TASAF is very detailed and somewhat complex and thus there is a risk that the PMT might be not appropriately applied.	An alternative could be to apply the PPI of the Grameen Bank or attempts to streamline the PMT currently applied
If the identification process is followed by an immediate intervention, the results can be distorted and inclusion errors might occur.	The identification process is conducted by an independent body and provides the list of households to local actors and development organisations to plan their intervention accordingly
The organization and facilitation of various FGDs require more resources than an open village assembly.	Thorough evaluation if FGDs bring value to the process. This might differ in the context.
TASAF may not be able to conduct identification processes in the entire country	Other local players could come in with more resources and jointly conduct the identification processes
The Grameen Foundation has developed a PPI for Tanzania but no experiences in the country so far.	Grameen Foundation has experiences in other countries, so a well-planned collaboration could mitigate possible risk of failure
There might be a lack of robust geographic data	Conduct studies on a regular basis in order to having updated information available
Villagers might be reluctant to participate in the process	Find out reasons why villages might be reluctant – this is part of keeping the flexibility in identification processes because the environment differs greatly and has a large influence of success or failure of an identification process.

6.2.2 Option 2: Geographic and community-based targeting

This approach involves two different targeting methods and is currently applied by the government in collaboration with other actors such as WFP Tanzania, among other organisations.

The approach has following characteristics:

- Geographic data is used to identify areas, which need special support.
- Involves the community and their perception of poverty, with a special focus on food insecurity.

Approach:

1. Selection of areas with special needs in terms of food insecurity through conducting a baseline study (comprehensive food security and vulnerability analysis and mapping).
2. Selection of a food committee by village assembly, which is responsible for identifying households that fulfil locally agreed criteria.
3. No need of benchmarking with national criteria to eliminate non-poor as already poor areas are selected

Table 19 shows strengths and weaknesses, as well as opportunities and threats of a geographic and community based targeting approach. Table 20 illustrates mitigation measures to address weaknesses and threats.

Table 19: SWOT Analysis of geographic and community based targeting

Internal factors	**Strengths**	**Weaknesses**
	• Focuses on food security as the most important criterion for "poverty". • Comprehensive and participative approach with local criteria • Applied methodology on the ground • Self-limiting mechanism against over reporting (the more people reported, the less food is available)	• Includes only villages in pre-selected areas of food insecurity • Poor households in "not so poor areas" are not captured. • Re-active approach, being activated in emergency situations. • Limited approach for comprehensively registering the "poor"
External factors	**Opportunities**	**Threats**
	• The geographic data available in Tanzania might be able to capture the majority of the poor • Trust and understanding for each other in the communities might be well established in the vast majority of communities and thus good results can be achieved	• Risk of errors of exclusion due to under-reporting and limited resources. • Method may be unable to identify households threatened by food insecurity when living in good housing conditions – insufficiently capturing the fluctuant poor. • There might be a lack of robust geographic data • Villagers might be reluctant to participate in the community meeting

Table 20: Mitigation measures for weaknesses and threats– geographic and community based targeting

Weakness /Threat	Mitigation Measure
Includes only villages in pre-selected areas of food insecurity	Start with those areas in a first place and roll out the process to the entire country later on
Poor households in "not so poor areas" are not captured.	See mitigation measure to the first point
Re-active approach, being activated in emergency situations	See mitigation measure to the first point
Limited approach for comprehensively registering the "poor"	Develop a suitable databank or using same systems as other organisations
Risk of errors of exclusion due to under-reporting and limited resources.	Making adequate resources available to assist poor households to graduate from poverty
Method may be unable to identify households threatened by food insecurity when living in good housing conditions – insufficiently capturing the fluctuant poor.	A certain degree of exclusion is difficult to be avoided however, having a wide variety of indicators not only focussing on housing might help to reduce exclusion errors
There might be a lack of robust geographic data	Conduct studies on a regular basis in order to having updated information available
Villagers might be reluctant to participate in the process	Find out reasons why villages might be reluctant – this is part of keeping the flexibility in identification processes because the environment differs greatly and has a large influence of success or failure of an identification process.

6.2.3 Option 3: Participatory wealth ranking (PWR)

Participatory wealth ranking (PWR) is a commonly used community-based approach and is planned to be introduced by Save the children in Lindi district. PWR are the same in principle, ranking a village's households according to their wealth and assets, but the application and features can vary. For instance, selecting households according to pre-defined criteria or rather using a definition in the village meeting (*who is socially and economically disadvantaged and is dependent on help from relatives or neighbours*). Furthermore, the households can be ranked one after the other or collected into 3-5 piles (from "extremely poor", "poor" up to "non-poor" or "wealthy" – categories can vary as applicable).

The approach has following characteristics:

- Uses a villages own definition and perception of poverty.
- The method can be combined with precedent geographic targeting and/or PMT or PPI.

Approach[132]:

1. In an open village assembly, index cards with the name of household heads are presented by the facilitator, asking questions about each household such as occupation, assets, land holdings, general economic well-being or simply asked who in the village is dependent on relatives/neighbours, is socially and economically excluded from the village life.
2. One household after the next is compared to the prior household – the process is completed after all cards have been sorted into five piles (or less if applicable) corresponding to the poverty status. This process can either be open or anonymised, depending on the environment where the wealth ranking is conducted. An anonymous way of asking villagers on their perception of a household's poverty level could be the following: The participants of the village assembly indicating behind their back if the household belongs to pile 1-5. The facilitator jots down respective numbers and calculates the average of the votes. The household is then categorised according to the mean value of all votes[133].
3. Elected members of the community (or alternatively representatives of the LGA) visit the households from the 5th pile for a short questionnaire reviewing eligibility criteria.

   Alternatively to the questionnaire, the household head (or another eligible person) could only be asked following two questions:

   a. Do you know somebody who is *just as poor or poorer* than you but *did not receive* a subsidized CHF card /exemption letter etc.
   b. Do you know anybody who is *better-off* then you but *received* a subsidized CHF card / exemption letter etc.

Table 22 below shows the strengths and weaknesses, as well as opportunities and threats of a participatory wealth ranking approach. Table 22 illustrates mitigation measures to address weaknesses and threats.

[132] The described process contains elements of two studies, one conducted by Banerjee and Duflo (2007) in India and Men and Meessen (2008) in Cambodia as well as personal information from key persons in Tanzania

[133] Information derived from personal communication with a person responsible for CHFs in Tanzania in line with participatory approaches in O&OD (Opportunities and Obstacles to Development)

Table 21: SWOT Analysis participatory wealth ranking

Internal factors	**Strengths**	**Weaknesses**
	• Is based on the local perception on who is poor and who is better of and is generally well accepted by communities (creates ownership) • Households are directly compared with each other which can sharpen the understanding of livelihoods and poverty • Verification is fairly simple due to using resources from the community (especially with the second option asking only two follow up questions)	• The subjectivity of the approach can also be a drawback if individuals follow their personal interest and not necessarily act to support the poor • Therefore, the verification might not be objective enough • The poverty status in the community cannot be compared to national or international poverty lines (however, verification with a PMT or PPI can be added if suitable) • Limited approach for comprehensively registering the "poor"
External factors	**Opportunities**	**Threats**
	• Trust and understanding for each other in the communities might be well established in the vast majority of communities and thus good results can be achieved	• The village population might be hesitant to participate in the wealth ranking or do not give correct information • The level of trust between villagers might not be strong in some villages and thus hamper the process

Table 22: Mitigation measures for weaknesses and threats – participatory wealth ranking

Weakness /Threat	Mitigation Measure
The subjectivity of the approach can be a drawback if individuals follow their personal interest and not necessarily act to support the poor Therefore, the verification might not be objective enough	Add a suitable verification tool when there is a risk of untruthful behaviour
Limited approach for comprehensively registering the “poor”	Develop a suitable databank or using same systems as other organisations
The poverty status in the community cannot be compared to national or international poverty lines	Verification with a PMT or PPI can be added if suitable
The level of trust between villagers might not be strong in some villages and thus hamper the process	Find out reasons why villages might be reluctant – this is part of keeping the flexibility in identification processes because the environment differs greatly and has a large influence of success or failure of an identification process.

6.3 Institutionalising processes to identify the poor and include them into the health system

In section 3.4 above, difficulties of identification processes raised by the interviewed organisations have been presented. One of the main conclusions was that processes are not harmonised between players and that there is a lack of coordination, data collection and data sharing. Therefore, the project team emphasises on institutionalising processes of identifying the poor. It is important to get the backing and commitment of all institutions and ministries, who work on poverty reduction, and establishing a database with access rights to different organisations working on development issues in order not to duplicate processes.

Since a nationwide approach needs the flexibility of adapting methodologies to the local context due to the multifaceted character of poverty, we suggest developing a framework which allows for this flexibility. Applying a single, fixed method could fail in capturing the poor adequately. Still, standardised guiding procedures need to be in place. This also applies for identifying the poor in urban areas. Involving the community leaders in planning for processes and implementation is crucial – be that in rural or urban settings.

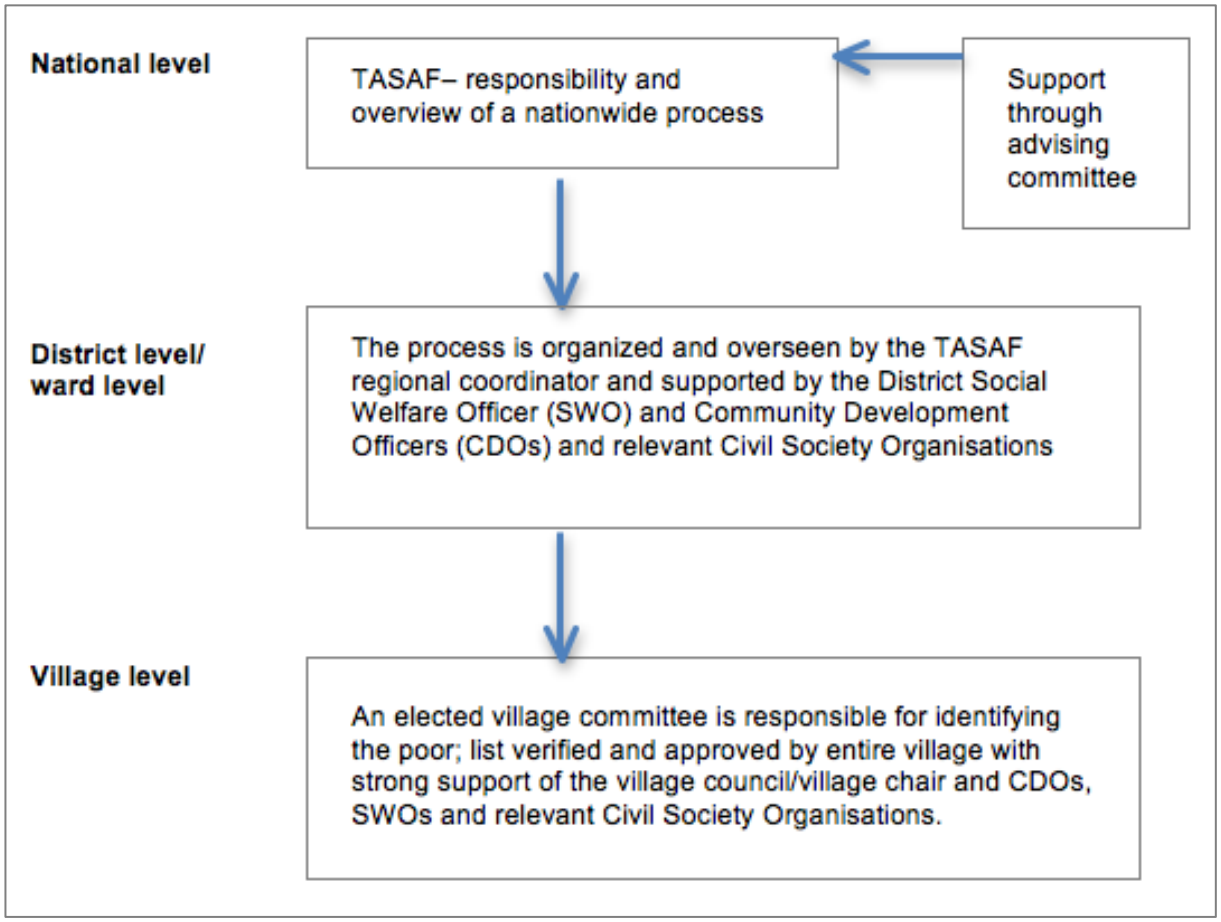
6.3.1 Option 1: TASAF to lead a nation-wide process to identify the poor

Since TASAF piloted and tested a method to identify the poor and is to date under way to cover the entire country, it seems obvious that TASAF is eligible to be leading this nationwide

approach. Furthermore, TASAF plans to track households' progress out of poverty in a database, which allows for monitoring and follow up.

However, since this is a very demanding and challenging endeavour, we recommend the establishment of a supporting committee consisting of various ministries and organisations which are dealing with supporting the poor. The committee could therefore consist of representatives of the Ministry of Health and Social Welfare, the Ministry of Finance, the Ministry of Education and Vocational Training, Prime Minister's Office – Regional Administration and Local Government (PMO-RALG), the Ministry of Water, Ministry of Community Development, Gender and Children. Additionally, representatives from multinational organisations and Civil Society Organisations could be part of the committee to ensure to join forces and pooling knowledge. TASAF can further have a leading role in mobilising resources from other ministries to implement this undertaking with the commitment of a broad range of stakeholders – which has one goal, to support the poor to progress out of poverty.

Figure 3: TASAF lead in institutionalizing a nationwide process to identify the poor

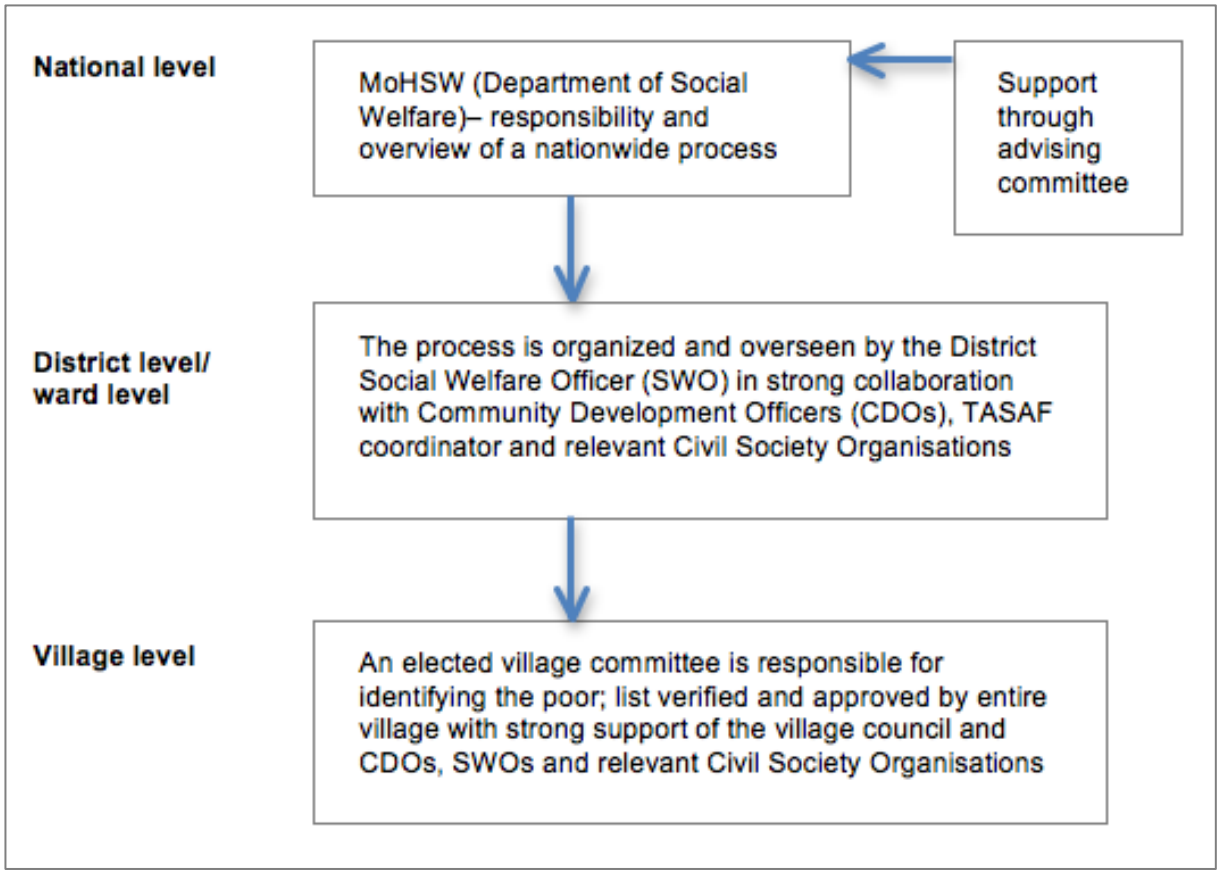


6.3.2 Option 2: The Department of Social Welfare to lead a nation-wide process to identify the poor

As an other option, the Department of Social Welfare is an entitled body to be leading such a project, initiating a nation wide process and taking over the responsibility for its implementation. This can be done in close collaboration with TASAF, since TASAF has a lot

of experience in this field, training curricula for train the trainer seminars, as well as plans to develop a database. Additionally, as in option 1, we recommend the establishment of a supporting committee consisting of various ministries and organisations dealing with supporting the poor such as TASAF, the Ministry of Health and Social Welfare, the Ministry of Finance, Ministry of Education and Vocational Training, Prime Minister's Office-Regional Administration and Local Government (PMO-RALG), Ministry of Water, Ministry of Community Development, Gender and Children as well as representatives from multi-national organisations and Civil Society Organizations to ensure join forces and pooling knowledge.

Figure 4: The Department of Social Welfare lead in institutionalizing a nationwide process to identify the poor



6.3.3 International example: The Ministry of Planning lead of a nation-wide process to identify the poor in Cambodia

A similar model is applied in Cambodia, where the Ministry of Planning is responsible for the nationwide identification of the poor processes since 2005. A working group was established at the start, chaired by the Ministry of Planning with technical support from development agencies. In the group are representatives from relevant ministries, development partners as well as national/international NGOs. The provincial department of planning oversees the entire process and the identification process in each village is conducted by a village representative group with help of a household survey. The identified households then receive

equity cards which allow them to seek different, comprehensive services and assistance. Processes are repeated every 3 years.[134]

6.4 The technical package offered to the poor and vulnerable: Waivers or health insurance?

6.4.1 Option 1: Refining exemption / waiver policy for the poor

1. Identify the poor with one of the methods described above.
2. Provide exemption in line with the national policy for vulnerable groups such as elderly (wazee), pregnant women, children under five years of age.
3. Provide waivers for individuals unable to pay for the health services.

Table 23: SWOT Analysis refining exemptions / waiver policy for the poor

Internal factors	**Strengths**	**Weaknesses**
	• Addresses groups that are vulnerable to health issues	• Treatment costs have to be paid out of the regular budget of the health services; there is no complementary reimbursement of these costs such as user fees or health insurance payments;
External factors	**Opportunities**	**Threats**
	• Builds on the present practice of providing letters for waivers	• Stigmatizes the poor through waiver letters; • Registration process is weak; no systematic data management and monitoring so far who receives exemption letters – danger of misuse is big.

[134] Ministry of Planning, Kingdom of Cambodia (2011), p. 2ff

Table 24: Mitigation measures for weaknesses and threats – refining exemptions / waiver policy

Weakness /Threat	Mitigation Measure
Treatment costs have to be paid out of the regular budget of the health services, there is no complementary reimbursement of these costs such as user fees or health insurance payments	Establish an "equity fund" which reimbursed costs; or provide the poor and vulnerable with health insurance cards and let the health insurance reimburse costs.
Stigmatizes the poor through waiver letters;	Not possible to mitigate within a waiver system; would need to provide the poor with exactly the same "identification paper" as the non-poor (health insurance card)
Registration process is weak, no systematic data management and monitoring so far who receives exemption letters – danger of misuse is big.	Establish a data management system that allows for monitoring poverty status as well as previously received waivers

6.4.2 Option 2: Enrolment of the poor into CHF

- Identify the poor with one of the methods described above.
- Provide CHF membership cards.
- Subsidize the CHF cards through third party payer (Local Government Authorities, charities etc.) for the extremely poor and poor (replacing waivers).
- Continue with exemption in line with the national policy for vulnerable groups such as elderly (wazee), pregnant women, children under five years of age.

Table 25: SWOT Analysis enrolment of the poor into the CHF

Internal factors	**Strengths**	**Weaknesses**
	• Targeting mechanism allows concentration of subsidies on individuals in need. • Scaling of subsidies is possible, e.g. for extremely poor 100% subsidy, for the moderately poor an entitlement is created to buy CHF cards for 20% or 50% of the value, and the rest is subsidized.	• Like in the case of waivers also subsidizing the poor through health insurance requires a mechanism for correctly identifying the poor households.
External factors	**Opportunities**	**Threats**
	• No stigma created (the poor get the same cards as non-poor). • Health care providers are paid by CHF for treating the poor, instead of having to pay the bills through their own budgets (in the case of waivers). • The monitoring of health insurance to the poor and associated third party payers can be easily implemented through a strong CHF data management system. • The health insurance mechanism creates a "voice" representation for the members towards health care providers, for demanding good quality; contrary to waivers, which places the beneficiaries in a powerless, "begging" position.	• If the CHF package is limited (e.g. not sufficiently covering specialized services) the poor have only limited access or are still excluded from essential services. • If the package is too large it could lead to unnecessary utilisation of services ("moral hazard").

Table 26: Mitigation measures for weaknesses and threats – Enrolment of the poor into the CHF

Weakness /Threat	**Mitigation Measure**
If the CHF package is limited (e.g. not sufficiently covering specialized services) the poor have only limited access or are still excluded from essential services.	Establish a comprehensive CHF package which allows also the poor to seek appropriate health care not only in their local dispensary.
If the package is too large it could lead to unnecessary utilisation of services ("moral hazard").	Elaborate thoroughly what an adequate CHF package includes.

6.4.3 Option 3: Enrolment of the poor into NHIF

- Identify the poor with one of the methods described above.
- Provide NHIF cards to the poor.
- Subsidize the NHIF cards through third party payer (Local Government Authorities, charities etc.) for the extremely poor and poor (replacing waivers).

- Continue with exemption in line with the national policy for vulnerable groups such as elderly (wazee), pregnant women, children under five years of age.

Table 27: SWOT Analysis enrolment of the poor into the NHIF

Internal factors	**Strengths**	**Weaknesses**
	• Targeting mechanism allows concentration of subsidies on individuals in need. • Scaling of subsidies is possible, e.g. for extremely poor 100% subsidy, for the moderately poor an entitlement is created to buy CHF cards for 20% or 50% of the value, and the rest is subsidized. • NHIF has funds available to include the poor	• NHIF is an insurance scheme for individuals working in the formal sector and contributions of the poor have to be arranged differently, not possible in form of deductions from payrolls • NHIF has no enrolment mechanism in place for enrolling the poor. Enrolling rural agricultural population needs active engagement of the Local Government Authorities • NHIF data management system is not geared towards working with informal sector population • NHIF so far has no presence at district /municipal level
External factors	**Opportunities**	**Threats**
	• Only one insurance scheme exists in the country (so-called “single payer mechanism”) • No stigma created (the poor get the same cards as non-poor – though maybe different services?). • Health care providers are paid by NHIF for treating the poor, instead of having to pay the bills through their own budgets (in the case of waivers). • As a national level organisation NHIF could monitor the district level implementation of health insurance to the poor	• If the NHIF package for the poor is limited (e.g. not sufficiently covering specialized services) the poor have only limited access or are still excluded from essential services. • If the package is too large it could lead to unnecessary utilisation of services (“moral hazard”).

Table 28: Mitigation measures for weaknesses and threats – Enrolment of the poor into the NHIF

Weakness /Threat	Mitigation Measure
NHIF is an insurance scheme for individuals working in the formal sector and contributions of the poor have to be arranged differently, not possible in form of deductions from payrolls	Establish an agreement with the district / municipal councils on politically and socially acceptable health insurance premiums and required subsidies for the poor
NHIF has no enrolment mechanism in place for enrolling the poor. Enrolling rural agricultural population needs active engagement of the Local Government Authorities	Establish an agreement with the district / municipal councils on an enrolment mechanism ensuring active enrolment in the communities under the guidance and supervision of local government authorizies
NHIF data management system is not geared towards working with informal sector population	Develop a modernized insurance management information system which is able to appropriately capture the membership of informal sector population
NHIF so far has no presence at district /municipal level	Establish district / municipal level NHIF offices for liaising with the local government authorities.
If the NHIF package is limited (e.g. not sufficiently covering specialized services) the poor have only limited access or are still excluded from essential services.	Establish a comprehensive NHIF package which allows also the poor to seek health service not only in their local dispensary
If the package is too large it could lead to unnecessary utilisation of services ("moral hazard").	Elaborate thoroughly what an adequate NHIF package includes for the poor

6.5 How to finance such improved financial access of the poor?

The model calculations presented in chapter 5 show that financing health insurance coverage for the poor seems to be in feasible dimensions if the present level of CHF premiums is taken as a basis. It would cost the Government between TZS 43 billion and TZS 49 billion (26 to 29 million US Dollars) to provide all poor households in Tanzania with a CHF card in the value of TZS 10,000, depending on which degree of own contributions is asked from the poor households. Likewise, even if the CHF premiums are doubled to a level of TZS 20,000, the funding of this amount should still be in a feasible dimension for the Government. This option would require an amount of TZS 93 billion to TZS 98 billion (USD 56 million to USD 58 million) for providing all poor households in the country with health insurance coverage. Even in the case of a full subsidizing of a premium of TZS 30'000 per household (and no own contributions of the poor), with an additional TZS 30'000 per household as central government matching funds, the overall total Government contribution to CHF cards for the poor would not exceed TZS 150 bn or USD 88 (at the rate of 1 USD = 1650). This amounts to approximately 20% of the MoHSW budget. The calculations and the assumptions

for the degree of subsidizing the health insurance cards for the poor are presented in detail in chapter 5.2.

In order to set up a financing mechanism for implementing pro-poor health subsidies a move away from budget funding of health services to health insurance funding is required. Modalities how to share the costs of such contributions should then be worked out among the different potential institutions: central level government, district / municipality, village government, and insurance organisations such as NHIF and NSSF. The channelling of funds from the financing sources to the insurer (e.g. CHF) would allow different modalities, from increasing matching funds to CHF up to establishing a central level equalisation fund. Details are discussed in chapter 5.3.

6.6 Monitoring and Evaluation

In order to allow for monitoring and evaluation as well as tracking the development of the households identified and provided with services, a databank for the identified households is recommended. The advantage is that identification processes do not have to be repeated from scratch every time a support activity for the poor is developed. Moreover, the information on the databank can be made available for several organisations and institutions involved in development activities in order to avoid replicating processes.

A multi-criteria approach is recommended in order to capture various aspects of poverty. Furthermore, it is crucial that the databank is updated periodically in order to address fluctuant poverty as good as possible. The observation of the assessment team is that TASF is presently in the process of building up such a data bank for registering poor households comprehensively in the whole country. Establishing such a databank, however, will come with high initial costs. One of the questions to be addressed in the process is how to ensure a required degree of confidentiality while at the same time making data available for development programmes. TASAF is well placed with its affiliation to the President's Office and its mandate for providing such a service accessible to other institutions. The TASAF data bank will allow easy monitoring and evaluation regarding the dimension of poverty and the scaling of poor households along national poverty indicators.

Monitoring and evaluation will then have to be done not only for the aspect of identifying who is poor, but also on the follow-up of which services have been provided for poor households. As discussed above subsidizing health insurance coverage for the poor is one major option for providing them with access to health services. In such an approach, a strong Health Insurance Management Information System would be the instrument to capture the enrolment of the poor and the payment for their premium, i.e. the subsidy by a third party. Such a third party could be the Government along different levels such as central government, district council, and village, plus additionally NGOs / private charities.

A strong data management system for CHFs would capture who has paid which contribution, and allow also for different levels of own contributions of the poor. While the Government may consider to provide the very poor (below food poverty line) with 100% subsidized cards, households a bit better off, but still below basic needs poverty line may be provided with subsidized cards, but still would be expected to pay an own contribution. In this way the two data banks, for identification and scaling of the poor on the one hand, and for CHF management on the other hand, could operate hand in hand and allow easy monitoring and evaluation.

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7 Annexes:

Annex 1 Terms of Reference: Option Paper Inclusion of the poor and vulnerable

Inclusion of the poor and vulnerable

1. Background

Tanzania is entering a new phase of health financing reforms based on the reforms undertaken since the early 1990's. The first phase of reforms moved the Tanzanian health financing system from a purely budget financed system to a mixed financing model with the hope of increasing availability and quality of care. In this first phase, user-fees (in 1993), Community Health Funds (CHFs – from 1997 onwards) and the National Health Insurance Fund (NHIF – in 1999) were introduced in order to leverage additional funds, build community ownership and create stronger accountability of service providers. The system now has countrywide coverage.

At the same time, Tanzania has gone through a period of decentralization with profound effects on the way budget financing works. Management and (partly) financing of social services, including primary and first level referral health care, moved to Local Government Authorities (LGAs) and a system of central-local intergovernmental transfers (Block Grants) was introduced, together with a pooled funding mechanism for donor funding (the Health Basket Fund).

A third development has been the overall increase in health expenditure. Total Health Expenditure (THE) increased from US$734 million in 2002/03 to US$1.75 billion in 2009/10 (National Health Accounts 2009/10). Per capita expenditure doubled from US$21 to US$41. A strong influence on this has been the large increase in donor funding, which grew from US$200 million per year to nearly US$700m per year (while the share of donor funding increased from 27% to 40%).

While these developments have helped to achieve very significant health gains by containing the HIV/AIDS epidemic, reducing Malaria and child mortality, and other successes, challenges remain. There is a large body of evidence that shows that spending from public sources, especially domestic, is still too low to finance a package of essential health services, user-fees are a barrier to access when coverage of pre-payment schemes is low, funding is not distributed equitably between and within districts, and the limited funds available are not used efficiently to achieve the maximum effect. Accountability and transparency can also still be improved.

In order to meet these challenges in an environment in which citizens demand more and better services, and in which development aid is declining, Tanzania is now embarking on a new round of health financing reforms that will build on the foundations of previous reforms, strengthen existing systems, and develop new approaches where needed.

In 2003, the Government of Tanzania adopted a *Health Policy* with the policy vision "to improve the health and well being of all Tanzanians with a focus on those most at risk […]". This vision remains still valid, and the GOT is committed to moving towards *Universal Health Coverage* and to ensure that all citizens have access to quality services and be protected from financial risk. As part of *the Health Sector Strategic Plan III*, a decision was taken to develop a Health Financing Strategy (HFS) to ensure that this vision would become reality.

Oversight for the development of the Strategy has been given to the Inter-ministerial Steering Committee (ISC), comprising of key ministries and departments, to ensure that the proposed reforms are comprehensive, accepted and supported by all stakeholders, and implemented with the support of all stakeholders. To achieve this aim, the ISC has identified key areas for reforms and requested several reports to inform the development of the Strategy. These are:

1. Minimum Benefit Package(s): options to sustainably structure access to benefits;
2. Insurance Market Structure: options for the Social and Private Health Insurance architecture;
3. Performance financing: options for linking allocations to performance of service providers;
4. Equity-based financing: options for improving the equity targeting of (esp. budget) resources;
5. Inclusion of poor & vulnerable: options for identification and financing of services for this group;
6. CHF reforms: options for the re-design of the CHF system;
7. Private sector resources: options strengthening equitable funding from the private sector;
8. Financial management: options for improving accountability and timely availability of funds;
9. Innovative financing and fiscal space: options for increasing public financing for health;

Terms of Reference (TOR) have been developed and approved by the ISC for each focus area. This set of TOR guides the assignment in the area of ***Inclusion of the poor and vulnerable.***

2. Focus Area

Tanzania is resolute about progressive movement towards universal coverage of health care services. According to Alkire et al, (2010)[135], 36.7 percent of Tanzania's are poor – based on multi-dimensional poverty index (MPI) which uses 10 indicators to measure poverty in three dimensions: education, health and living standard. These poor who in most cases live below TZS 1,600 per day (USD 1) can be considered in the category of 'poor and vulnerable'. This proportion of the population is too poor to contribute via income taxes or insurance premiums. They will need to be subsidized from pooled funds, generally government revenues. Such assistance can take the form of direct access to government-financed services or through subsidies on their insurance premiums. Removing the financial barriers implicit in direct-payment systems will help poorer people obtain care, but transport costs and lost income can sometimes be prohibitive to access than the charges imposed for the health care service. Moreover, if services are not available at all or not available close by, people cannot use them even if they are free of charge. Further, equity to health care services by the poor between districts and between urban and rural areas are an important area to address, besides ensuring the 'free-for-services are only accessed by the targeted poor and vulnerable people.

Another equally important consideration is the Community Health Fund (CHF). CHF has a

[135]Alkire, Sabina & Maria Emma Santos. 2010. Tanzania Country Briefing. Oxford Poverty & Human Development Initiative (OPHI) Multidimensional Poverty Index Country Briefing Series. Available at: www.ophi.org.uk/policy/multidimensional-poverty-index/mpi-country-briefings/.

provision to exempt the poor. The CHF Act states that the power to issue an exemption from CHF payment is vested within the Ward Health Committee upon receiving recommendations from the Village Council. The Village Council will then issue a CHF membership card to the identified households. The Act further states that “the exempting authority shall seek alternative means of compensating the Fund.” Yet in reality, the situation varies in each district in regard to whose responsibility it is to identify the poor, what guidelines or criteria are used to identify them, and if these practices are being carried out at all. In those districts where the poor households are being identified they are not being issued a CHF membership card, but instead an exemption letter which grants them free care at the health facilities. While this practice addresses the issue of supporting those who are unable to pay, it also stigmatizes the household by labelling them as poor instead of allowing them to blend in with all of the other cardholders. These and other issues related to inclusion of the poor and the vulnerable will need to be addressed in this consultancy.

3. Steering & Oversight

The commissioning body for the assignment under these TOR is the ISC. The TOR has been approved by the ISC, and the report will have to be approved by the ISC. The ISC will also approve the consultants / consultancy firm contracted under these TOR. In addition, the consultant is expected to participate during the CHF Days that will discuss major areas of CHF Reform and its vision. The consultant will be given a slot during the CHF Days from the organizers in order to present the main CHF options, and will be given feedback from the ISC. During that meeting the main options will be elaborated further in a more detailed way as recommended by the ISC. The consultant is supposed to develop 3-5 options for CHF reform, whereas the one option should focus on the present CHF design (CHF as a cost-sharing tool), while the other 2-4 options should elaborate more in detail different choices for re-design (please see specific content requirements under the section “objectives”).

All drafts will be submitted to the ISC. The TWG HF through its Stakeholder Subcommittee for the Health Financing Strategy will take on an advisory role in this process. The Subcommittee will receive draft reports and direct comments and positions on the report to the ISC. Subcommittee members may also address the ISC individually if they have minority comments and/or positions. The ISC Secretariat will act as a linkage between the two and ensure that communication between the two bodies will run smoothly. The ISC may request the Subcommittee (and/or individual members) to explain comments and positions in the ISC, and the Subcommittee (and/or individual members) may request to be heard by the ISC. Final decisions are taken by the ISC.

The financing organization will ensure that contracting and compliance with contractual obligations from both sides will be fulfilled. The ISC Secretariat will provide support on these issues. In order to ensure that contractual deadlines will be met, the contracting party will be able to request the ISC and the Subcommittee to consider work submitted within a reasonable timeframe, with a definition of “reasonable” to be agreed on a case basis.

4. Objectives and tasks

The overall objective of this assignment is to develop comprehensive, adequate and feasible reform strategies / options for the focus area *Inclusion of the Poor and Vulnerable* to be presented to the ISC for feeding into the Tanzanian Health Financing Strategy.

The specific objectives and tasks are as follows:

1) Gives option on how to identify the poor for inclusion in health care coverage services,
2) Discuss the role of vulnerable groups (as identified by Health Policy 2007) with specific health needs under various options, and how their needs can be integrated into the different health care coverage frameworks,
3) Assess the existing and potential funding sources for the scheme that provides coverage for the poor and vulnerable, including (i) government funds, (ii) contributions from the National Health Insurance Fund (NHIF), (iii) contributions from the National Social Security Fund (NSSF), (iv) Private insurances (including micro insurance schemes); and where applicable without jeopardizing access to the poor, out-of-pocket payments (e.g. token co-payments during harvest period).
4) Analyse how a good balance can be struck between the proportion of the poor and vulnerable covered; the range of services to be included in the coverage
5) Describe clearly how the targeting mechanism for the poor and vulnerable is to be administered. Provide option/specific scheme for the poor (Will their service coverage be completely free or they have to prepay token contributions that are compulsory? If they have to prepay, how much and when? What should happen to people who cannot afford to contribute financially?)
6) Fund Management Should funds be kept as part of consolidated government revenue or consolidated fund at the district level or in one or more health insurance funds, be they social, private, community or micro funds? Explore the various options for pooling that will be most beneficial, cost effective, efficient and equitable for the poor and vulnerable.
7) Purchase arrangement: Explain vividly how service providers will be paid for the 'free-for-service' access to health care by the poor and vulnerable. Analyse issues of mixed payment systems vs single payment mode, etc. In this regard, suggest approaches that can make the most use out of available technologies and health services.
8) Explore possibilities for cross-subsidization, how can available resources for supporting coverage of the poor and vulnerable be used efficiently and how the rich can be deterred from taking advantage of the 'free-for-service' subsidized coverage. Also explore how the poor can be integrating in existing insurance arrangements.
9) Establish reliable means to monitor and evaluate (M&E) progress towards inclusion of the poor and vulnerable in health care insurance coverage scheme(s).
10) Condense the above into three to five reform options / scenarios for this focal area that are specific enough to bring out differences and general enough to allow for use in a strategic document and adaptation and modification in implementation. Each of the options / scenarios is to be backed up by a SWOT analysis presenting internal strengths and weaknesses and external opportunities and threats to allow the ISC to assess the different options/scenarios and to make a choice.
11) Provide a brief summary of three (3) to five (5) pages of the recommended option (s) that may be included in the Health Financing Strategy.

5.*Scope and Methodology*

The report will rely on literature reviews and key stakeholder interviews and focus group discussion on the existing pilots on CHF. The literature review will include Tanzania (TASAF, Kfw approach etc) and other selected countries (to be proposed in the inception report).Use of secondary data sources available to explore utilization/need among different socio-economic groups and unit costs, possibly SHIELD data and HBS.

The consultant should consider international experience, especially on inclusion of the poor in health financing schemes. The consultant should link with existing and on-going/planned initiatives, such as the GIZ supported study that is planning to assess international experiences of sustaining/re-financing community based health initiatives and schemes, with a possible focus on Tanzania.

6. Timeframe and Deliverables

The suggested timeframe for this assignment is February to mid-April, based on the assumption that the selection of consultants/firms takes place before Christmas 2012. The following table shows the timing at which deliverables are expected:

#	**Deliverable**	**Weeks after signing**
1	Inception report incl. report outline	2 weeks
2	Draft report	7 weeks
3	Presentation to ISC	10 weeks
4	Final report incl. executive summary	12 weeks

7. Professional requirements

At least two consultants are required for this assignment. There will be one international-level lead consultant with significant practical experience in Health Insurance (Reform) and one national health financing and insurance specialist. This team may be composed of two individually contracted consultants (in which case the lead consultant will approve the national consultant for contracting, and clear his/her contributions for payment by contractors or by a consultancy firm.

Lead consultant	
Profile	• Masters degree in a relevant field (Health Systems, Financing, or Economics; Public Health or Medical degree with a relevant specialization). • A minimum of 10 years of work experience in health work. • Work experience on health financing reform in several low- and/or middle-income countries, especially in Sub-Saharan Africa. • Familiarity with the Tanzanian health financing system is a strong asset. • Excellent analytical skills • Excellent report writing skills.
Tasks	• Report to the ISC and the contracting party and take responsibility for work outcomes. • Coordinate the report writing and present to the ISC. • Manage and coordinate the specialist consultant. • Clear specialist consultants' contributions for payment by contractor.
National consultant Health Financing	
Profile	• Masters degree in a relevant field (Health financing, economics, public health with relevant specialization, social security). • A minimum of 5 years of work experience in a relevant field (including health insurance, regulatory bodies, MoHSW, health systems and health financing research) • Excellent knowledge of the Tanzanian health and health financing

	system and recent reforms. • Good knowledge of the Tanzanian (social) health financing system. • Connectedness in the Tanzanian health and health insurance sector. • Good organizational skills. • Good report writing skills. • Excellent command of English and Kiswahili, written and spoken.
Tasks	• Report to the lead consultant. • Assist the lead consultant in planning, managing and implementing activities, especially during interviews and stakeholder consultations. • Collect all relevant health financing documents. • Provide written inputs for the report in the field of specialisation

8. Relevant materials

Relevant materials include:

- National Health Accounts 2009/10 (MOHSW 2011)
- Health Sector PER – various editions (MOHSW 2011)
- Tanzania Health Systems Assessment (MOHSW with HS2020, 2011)
- (Draft) Health Financing System Analysis (TWG HF 2012)
- Making Health Financing Work for the Poor (World Bank 2011)
- SHIELD reports (IHI, various years)
- Household budget survey, SHIELD survey, DHS, CENSUS 2012

Relevant materials for the focus area include:

- CHF Innovations Study
- CHF Best Practices
- National Essential Health Interventions Package (MOHSW 2000)
- National Health Services Costing Study Report (GIZ 2013)
- Service Delivery Indicators Report (SDI) (WB 2012)
- Service Provision Assessment (SPA) (NBS/USAID 2012)
- Study on specific needs of people living with disabilities (GIZ 2013)
- Kamuzora P, Gilson L. (2007), 'Factors influencing implementation of the Community Health Fund in Tanzania' in *Health Policy Plan,* 2007 Mar;22(2):95-102;
- Community health fund as a complementary financing option in Tanzania, J.E. Sendoro, CHF Coordinator, Ministry of Health and Social Welfare.
- WHO (2010), 'The world health report: health systems financing: the path to universal coverage' Geneva, Switzerland.

Annex 2 List of interviewed organizations

Organisation	Contact person
World Vision Dodoma	Mr. Florian Buraye Project facilitator
Dodoma Regional Hospital	Mrs. Nkinda Shekhalaghe Social Welfare Officer
IRDP Dodoma	Mr. Andrew Komba Lecturer planning and poverty issues Dr. Omari Mzirai Head of Department Mr. Baltazar Namwata Head Rural Information Centre
TAMISEMI Dodoma	Mr. Motambi
HPSS	Prof Manoris Meshack Project Manager
Ardhi University Dar es Salaam	Prof Alphonce G. Kyessi Associate Director Dr. John Lupala Senior Lecturer
Social Security Regulatory Authority Dar es Salaam	Mr. Ansger Mushi Director of Research & Policy Development Mr. Joseph Mutashubilwa Principal Financial Analyst
REPOA Dar es Salaam	Dr Blandina Kilama Director of Programmes Support, M&E and Learning
Ministry of Finance - Poverty Eradication Division Dar es Salaam	Mr. Mudith Buzenja Assistant Director
WFP Dar es Salaam	Mr. Juvenal Kisanga Programme Officer (VAM)
TASAF Dar es Salaam	Mr. Amadeus Kamagenge Training Research & Participation Specialist Mr. Ladislaus J. Mwamanga Executive Director
UDSM Dar es Salaam	Dr. Rose Mwaipopo Director UDSM Gender Centre
UNICEF Dar es Salaam	Mr. Alejandro Grinspun Chief Social Policy

Help Age International, Dar es Salaam	Mr. Smart Daniel, Assistant Country Director Mr. Leonard Ndamugoba, Program Manager, Social Protection
Save the Children Lindi	Mr. Lugendo Msegu Regional Program Manager Mr. Bertold Mbinga Community Development Officer
Lindi District Authority	Mr. Andrea G. Chezee District Planning Officer Mr. Selemani S. Ngadaweje Acting District Executive Director Mr. Ndimibumi J. Mwakibete Community Development Officer Ms. Nuguye Tama Community Development Officer Ms. Epifania Shangali Community Development Officer Ms. Lucia Lyakurwa Community Development Officer Mr. Goodluck Hatibu CHF Coordinator
Chamwino District Authority	Mr. Mohamed O. Sume District Planning Officer Mrs. Rachel M. Lugeye Acting Community Development Officer
TASAF Chamwino Regional Office	Ms. Christina Mtwale TASAF Regional Officer
Magu District Authority	Mr. Joseph Mandago Executive Director, MAPERECE Mr. Deusdedit Mayunga District AIDS Coordinator

Annex 3 Save the children, Lindi: Profile of typically extremely poor households

	Older person headed, semi-able bodied	**'Classic' female headed, able bodied**	**Active couple, able bodied**
Household head	Semi-able bodied (old or sick) man and/or old or sick woman	Able bodied woman, sometimes widowed, often divorced	Young to middle-aged able bodied man
Typical household composition	1 – 3 people, either: • No other dependents or • With dependent children or other non-able bodied adults	2 – 3 people including 1 – 2 children and maybe an older relative	4 – 5 people, including an able-bodied adult female (wife) and 2 – 3 children (other adult dependents uncommon)
Ability to cope	Dependents are a struggle. Children may work and support the household	Struggle with 3 or more dependents	Struggle with 4 or more children
Other assets	Commonly no/few trees. Small proportion of households own more	Commonly no/few trees. Small proportion of households own more	Almost no trees or other productive assets

Annex 4 PPI Scorecard for Tanzania[136]

Indicator	Value	Points
1. How many household members are 17 years old or younger?	A. Four or more B. Three C. Two D. One E. None	0 10 15 20 30
2. Do all children ages 6 to 17 attend school?	A. No B. Yes, or no children ages 6 to 17	0 3
3. Can the female head/spouse read and write?	A. No B. Yes, but not in Kiswahili nor English C. No female head/spouse D. Yes, only in Kiswahili E. Yes, in English (regardless of any other)	0 0 0 6 13
4. What is the main building material of the floor of the main dwelling?	A. Earth B. Concrete, cement, tiles, timber, or other	0 11
5. What is the main building material of the roof of the main dwelling?	A. Mud and grass B. Grass, leaves, bamboo C. Concrete, cement, metal sheets (GCI), asbestos sheet, tiles, or other	0 8 9
6. How many bicycles, mopeds, motorcycles, tractors or motor vehicles does your household owns?	A. None B. One C. Two or more	0 3 11
7. Does your household own any radios or radio cassettes?	A. No B. Yes	0 6
8. Does your household own any lanterns?	A. No B. Yes	0 6

[136]PPI Website (2013b)