The Community Health Fund: Assessing Implementation of New Management Procedures in Hanang District, Tanzania

January 2004

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PHR*plus*

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Abstract

A key obstacle to the success of community-based health insurance initiatives in Africa is the dearth of well-trained health managers who can design and run the insurance schemes in a viable manner. Internal management controls are often not adequate to ensure the fund is protected from misuse and fraud carried out by members or its own staff. The Community Health Fund in Hanang district in Tanzania has introduced management procedures that help it to exercise control over revenue collection and reporting and provide management with sufficient information to assess the Fund's performance. This report looks at the implementation of the new management procedures, identifies successes and shortcomings in fulfilling record keeping and reporting requirements in particular, and recommends steps to improve record keeping at health care facilities, reporting of data to the district level, and use of the new data by the district.

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Acronyms

CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Services Board
DMO	District Medical Office
DSR	Daily Status Report
NHIF	National Health Insurance Fund
PHR*plus*	Partners for Health Reform*plus*
USAID	United States Agency for International Development

Acknowledgments

The author would like to thank Dr Massay, District Medical Officer (DMO), Hanang district, as well as members of the Council Health Services Board and the Council Health Management Team for their participation in this assessment during the training workshop and visits to various facilities. Mr Chilewa, District CHF Accountant, accompanied the author in all the facility visits and provided valuable input.

Mr Gil Cripps, USAID/REDSO/ESA Health Financing Advisor, participated in the assessment and provided very valuable input during the facility visits and in discussions with the DMO on the operations of the Fund and what support is needed to make it viable.

Executive Summary

The Community Health Fund (CHF) in Hanang district is implementing new management procedures developed with assistance from the Partners For Health Reform Project (PHR*plus*). These new procedures were introduced in August 2002 in fulfillment of one of the key recommendations from an assessment of the CHF that PHR*plus* conducted in 2001. The current assessment was intended to look at the implementaion of these management procedures and did not review details of the broader operation and design of the CHF that were covered in the earlier assessment.

Key Findings

- The new management tools are easy to understand and implement, and staff are willing to comply with the new procedures. All facilities have implemented them.
- Facility in-charges who were trained have provided some training to other members of their staff, but not all staff are able to prepare the required reports.
- Submission of Monthly Status Reports by facilities has been poor. New procedures for submitting reports have been instituted and, at the time of writing this report, most facilities have submitted all their reports.
- The CHMT has not provided adequate supervision and support to the facilities to encourage better CHF management.
- Community committees have been formed. All committees are not active due to the absence of allowances for members. The District Medical Office and the Council Health Services Board (CHSB) are addressing this issue to ensure that the budget for committee allowances is passed.
- CHF membership continues to be very low (about 2.4 percent of households are enrolled) but service utilization by members is 45 percent of all outpatient visits. Of the revenue collected at the facilities, CHF membership fees (excluding the matching grant) account for about 15 percent, while user fees account for 85 percent.
- There is urgent need to review the CHF design in the district to make it a viable scheme. Premium and user-fee levels and exemption policies all need to be re-examined to encourage membership while also making services accessible to those who cannot afford the premiums.

Next Steps

PHR*plus* will assist Hanang district in the following activities.

- Assist in the review of the CHF to determine if any changes need to be done to make it a more viable and equitable scheme.
- Purchase a digital camera to assist in taking member photographs. This will be feasible

initially in Katesh, but can easily be expanded to include all facilities since the CHF Agent will visit all facilities regularly.

- The CHSB will meet in December 2003 to review progress of the community mobilization activities. PHR*plus* will follow up in January to discuss what technical or other assistance is needed.

- Continue to follow up with the DMO to ensure that reporting performance improves and stays up. Request monthly summary to be sent to PHR*plus* at quarterly intervals, starting with September 2003.

- Assist in reviewing the design of the CHF in efforts to increase both membership and access to health care.

1. Introduction

1.1 Background

The Tanzanian Ministry of Health is promoting the development of health insurance in its endeavor to make health care affordable and available to the people. Community based health insurance is one option being tried. The Community Health Fund (CHF) was created as a means to make health insurance available at the community level.

The Partners for Health Reform*plus* (PHR*plus*) project has been working in collaboration with the Commonwealth Regional Health Community Secretariat for East, Central, and Southern Africa and the Ministry of Health to strengthen the management of the CHF in Hanang district. The CHF has been in operation in Hanang district since 1998, and PHR*plus* has been involved since 2001.

At the request of USAID/REDSO/ESA and with the support of the Ministry of Health, PHR*plus* conducted an assessment of the CHF in Hanang district with a view to identifying areas that required strengthening in order to improve the scheme's sustainability. The assessment was carried out in November/December 2001[1] and subsequently new management procedures were developed.

Since the introduction of the new management procedures, the following activities have been carried out:

- Training workshops for the Council Health Management Team (CHMT) and two staff from each of the facilities where the CHF is in operation in Hanang district, i.e., all the public facilities plus a few private plantation dispensaries;
- Workshops for the Ward Health Committees to train them on their responsibilities with regard to the CHF;
- On-site follow-up to each facility to explain further about the new procedures;
- Development of a spreadsheet-based program for analyzing monthly reports submitted by facilities to the DMO.

The purpose of the current assessment was to find out how well the new procedures had been implemented and identify any areas that still needed strengthening.

[1] See Chee, Grace, Kimberly Smith, and Adolph Kapinga. July 2002. *Assessment of the Community Health Fund in Hanang District, Tanzania*. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.

1.2 Activities

The assessment consisted of facility visits plus a one-day workshop for the members of the Council Health Services Board (CHSB), a District Council committee drawn from the community and responsible for all health services in the district, and the Council Health Management Team, government employees who form the technical arm of the CHSB. The purpose of the workshop was to train these two key committees to more effectively supervise the operations of the CHF and conduct community mobilization for CHF membership.

Eight of the 17 facilities where the CHF is active were visited[2]: Stephen Musau (PHR*plus*) visited six facilities accompanied by Gil Cripps (USAID/REDSO) and Mr Chilewa (District CHF Accountant). Musau visited two more facilities with members of the CHSB and CHMT.

[2] The field visits covered the following facilities: Dawar, Bassotu Ziwani, Bassodesh, Gitting, Syrop, Endasak, and Dirma dispensaries and Katesh heath center. The tables in Annexes A and B provide details of facilities, a summary of assessment results, and contacts.

2. Facility Record Keeping and Reporting Performance

2.1 Required Reports

The primary function of the new management procedures was to ensure that there is proper internal control over the revenues generated by the CHF. The records kept and reports produced make it easy for supervisors (the CHMT and CHSB) to detect problems early and take corrective action. PHR*plus* trained two staff members from each facility in August 2002, and each facility was given a copy of the management procedures manual plus a full set of the necessary stationery.

All health facilities are required to maintain the following records:

Patient Register – All patients (CHF and non-CHF) attended to are recorded in this register. It includes a summary of the diagnosis and treatment. For CHF purposes, the register was modified to include details of the mode of payment for the treatment: User fee (record receipt number); CHF member (record membership number); National Health Insurance Fund (NHIF) member (record membership number); No payment (for those who show up with no money); Exempt.

CHF Member Cards – A card is issued for each family, showing details of family members covered and expiration date. All current (unexpired) cards are filed in numerical order.

CHF Membership Register – This register lists all CHF members, showing enrollment date, expiration date, amounts paid, unpaid balances, etc.

Receipt Books – An official receipt is issued to patients and CHF members for all cash received. A copy of the receipt remains in the facility and is used to check the accuracy of cash surrendered to the District CHF Accountant.

CHF Daily Status Report – The purpose of this record is to summarize the "mode of payment" column that was added to the Patient Register. It ensures that cash received is reconciled to the number of patients seen at the facility that day and to make sure that a receipt was issued for all cash received.

CHF Financial Ledger – The Financial Ledger tracks the collection, use, and balance of CHF funds. All user and membership fees collected should be recorded in the ledger on a daily basis; these amounts are taken from the Daily Status Report; official receipts for amounts deposited with the district CHF Accountant; expenditures; and notifications of matching grants received.

CHF Monthly Status Report – The CHF Monthly Status Report records service utilization, CHF membership, and fee collection information on a monthly basis. The information entered into the CHF Monthly Status Report is based on the CHF Daily Status Report and the CHF Membership Register.

2.2 Record Keeping Performance

2.2.1 Capacity to Keep Records and Prepare Reports

Most of the facilities visited (six of the eight) demonstrated that they understand the new procedures and are able to maintain accurate records in a timely manner. It was clear that the new records are easy enough and do not impose an unreasonable amount of effort on the facility staff in most facilities. The failures of the two facilities are highlighted below.

The Patient Register is filled in as patients are seen and the data is transferred to the Daily Status Report (DSR) either at the end of the day or the following morning before patients arrive. The facility in-charges normally prepare the DSR but they can also delegate to any other person in the facility who has been trained.

The only errors noted were the following:

- Patient register
  - In Dawar Dispensary facility CHF membership numbers were not filled in and therefore it was not easy to audit the entry to confirm whether the patient was a valid CHF member or beneficiary.
- Daily Status Report
  - At Dawar Dispensary the DSR was not up-to-date as the facility in-charge had traveled and the assistant could only cope with keeping the Patient Register. The in-charge was in the process of updating the DSR.
- Monthly Status Report (MSR)
  - All MSRs were up-to-date to the end of August except for Dawar, which needed to finish updating its DSR in order to prepare the monthly report.
  - The Katesh MSR was not correctly done. The clerk who prepares the reports had wrongly transferred figures from the DSR and had not checked to make sure that the row for that month on the MSR added up correctly. The doctor in charge of the health center had not reviewed the monthly report either before it was submitted.
- Financial Ledger
  - Financial Ledgers were all up-to-date with the revenue collected at the facilities. Only Dawar's ledger was not up-to-date, as this can only be written up once the DSR is ready.
  - None of the ledgers had been reconciled with the DMO's office to reflect any transactions that occur at the district level, e.g., matching grants received or payments made for purchases by the facility. Failure to keep the ledger up-to-date gives a wrong picture to the Ward Health Committee and Facility Health Committee when they want to plan for improvements to the facility.

- CHF Membership Register
  - The CHF Membership Register was up-to-date in all facilities except Dawar.
- CHF Cards
  - Facilities are to keep CHF membership cards in a file, in numerical order. Most facilities did this; even where the cards were not placed in a file, they were still kept together in CHF numerical order and could easily be accessed. The exception was once again Dawar, where the cards were not filed in any order.

2.2.2 Maintaining Records in High-Volume Facilities

The review of records in the Katesh Health Center showed the potential problems that the CHF should prepare for when implemented in high-volume facilities. At the health center, the staff were not able to cope adequately with the volume of new and renewing members and were not issuing cards immediately. Patients had to come back for the card later because the staff were too busy to fill out the card, especially in the morning hours, when the registration office is very busy. New members continue to receive services using the receipt issued by the cashier as evidence of membership until the card is ready. This could easily create opportunities for fraudulent access to services by non-members. The overload on staff in the patient registration office may also have led to the errors in the MSR referred to above.

In high-volume facilities, staffing for the CHF activities will need to be regularly reviewed, to ensure that:

- Registration procedures are performed correctly and promptly,
- Records are kept accurately and are up-to-date
- Potential new CHF members are not discouraged by inefficient enrollment procedures.

This may mean creating a position of CHF clerk in such facilities whose primary responsibility would be to attend to CHF members and other CHF activities; other duties can be assigned if CHF workload permits.

2.2.3 Report Submission Performance

Although most monthly reports reviewed were up-to-date, the submission of reports to the DMO's office was very poor (Table 1). As of the date of the assessment, only four reports out of a total of 17 had been received for August 2003.

The facility in-charges all claimed to have submitted their reports. Members of the CHMT deliver some of the mail from the facilities to the DMO's office when they do their routine supervision. It is possible that CHMT members collect the reports but fail to deliver them to the DMO's secretary.

Table 1. Monthly Report Submission Performance

	2002		2003	
	No. of reports received	% of facilities reporting	No. of reports received	% of facilities reporting
January			12	70.6%
February			11	64.7%
March			10	58.8%
April			12	70.6%
May			10	58.8%
June			8	47.1%
July			9	52.9%
August	4	23.5%	4	23.5%
September	11	64.7%		
October	13	76.5%		
November	11	64.7%		
December	12	70.6%		

In order to improve the reporting performance, it was agreed with the DMO that all facilities that have radio communication capabilities would be required to radio in their reports and then follow up with the hard copy within five days after the end of the month.

2.2.4 Training

Two staff from each facility were trained in August 2002 at the launch of the new management procedures. These two were then supposed to provide training to the rest of the facility staff so that they would all be able to implement the new systems.

It appears that the on-the-job training for other staff in the facilities went only as far as the Patient Register. Most staff are able to fill in the necessary details in this register and there were no major problems noted except for the case in Dawar where the CHF numbers were not recorded. In all cases, it was the facility in-charge who was preparing the reports. In Dawar, the other staff member who was trained did not prepare the reports in the absence of the in-charge. In Gitting Dispensary, the in-charge was not present when we visited the facility, and the duty clinical officer had obviously not been trained, as he had little idea about the reports.

2.2.5 Community Health Committees

Ward health committees and/or facility (hospital, health center, dispensary) health committees are intended to be local arms of the Council Health Services Board; their duties include helping the CHSB to ensure that facility reports are submitted in a complete, accurate, and timely fashion. In Hanang, committees were formed in each ward and facility, although, in some wards, the ward health committee has been merged with the facility health committee, membership of which is drawn from all over the ward. Wards that do not have facilities were not visited.

These committees have not been very active because members are not given any incentive for their volunteer work in the committee. Members interviewed during community visits with the CHSB complained that they are not paid a “sitting” allowance for attendance at facility meetings, nor even reimbursed the cost of travel to meetings, as is normally done for volunteer workers in Tanzania. This issue will be resolved once the committees submit a request for allowances to be approved by the CHSB.

3. District Medical Office Performance

3.1 General Perception of the New Rules

Discussions with the CHF Accountant and the District Medical Officer indicate that there have been no problems with the new procedures. They have not received any complaints from staff. The District Medical Office (DMO) is happy with the new tools, and he said that they had even helped to detect fraud in one facility. In that particular case the dispensary in-charge was omitting user-fee patient names from the Patient Register and not issuing a receipt for the fees the patients paid. The reduced volume of user-fee (*Papo kwa papo*) patients reported monthly alerted the DMO to the problem.

Some members of the CHMT have done CHF supervision during their routine facility visits but most of them have not done so. This is one area that has been very weak but it is not due to a lack of comprehension of the CHF procedures on the part of the CHMT members – during community visits with the CHMT and CHSB, members of the CHMT demonstrated a good understanding of the procedures. Rather, it seems due solely to a lack of interest.

3.2 Monthly Reports to DMO

All facilities are required to submit their Monthly Status Reports to the DMO. As discussed in Section 3, only four facilities had submitted their August 2003 reports at the time of this assessment in September. Facility compliance with report submission requirements in other months was better, but still unimpressive. In the future, the facilities will try to ensure receipt by first radioing in their reports to the DMO, and following up with the hard copy. For its part, the DMO will follow up with facilities whose reports are not received.

All reports received had been promptly entered into the Excel spreadsheet. However, once the reports are entered into the computer, no further use has been made of them. It was agreed that each month the DMO's secretary should print the monthly summary and give it to the DMO for presentation to the CHMT.

4. CHF Membership and Service Utilization

Membership in the CHF continues to be very low. At the end of September 2003, only 814 households (based on the reports received; the DMO estimates that membership may be 850) were members out of about 36,597 households in the district, i.e., a membership level of only 2.2 percent. Given an average household size in 2003 of 5.6 individuals, this translates to 196,840 persons who are not covered by the CHF. A few of these will be covered by the NHIF but the number is not yet known.

4.1 Utilization of Services

Based on the CHF monthly reports received in 2003, CHF member households have consumed 45 percent of outpatient care (12,823 visits), which equates to approximately 2.7 visits per person from January to August, or about four visits per year (Table 2). Non-CHF households have utilized 15,910 outpatient visits or about 0.1 visits per person per year. This means that CHF members are over-utilizing services (DMO estimates outpatient utilization per person per year should be about three visits) and non-CHF members are grossly underserved. The reasons for the gross under-utilization of services by non-CHF members are not yet clear, but the user fee – TSh 1,000 per visit at dispensaries and Tsh 1,500 at health centers – is likely one reason. Some facilities are also not easily accessible due to poor public transport and difficult terrain.

Table 2. Service Utilization

	No. of visits Aug-Dec 2002	%	No. of visits Jan-Aug 2003	%
User-fee patients	8,178	49%	13,740	48%
NHIF members	586	4%	1223	4%
Exempt	219	1%	504	2%
No payment	268	2%	443	2%
Sub-total non-CHF	9,251	56%	15,910	55%
CHF Members	7,276	44%	12,823	45%
Total	16,527	100%	28,733	100%

4.2 Reasons for Low Membership

At the workshop of CHSB and CHMT members, the following issues were highlighted as possible obstacles to membership and ways of overcoming them:

- *NHIF competition.* The NHIF does not necessarily cover entire families (it covers only up to four dependents, which means that many families are not entirely covered), and so CHF

should still be marketed to those who have family members who are not covered by the NHIF.

- *Lack of knowledge about the CHF*. The CHSB agreed to vigorously pursue community education/mobilization on the schedule in Table 3.

Table 3: Community Mobilization Schedule

Activity	Who	When
Explain to ward and facility health committees their roles re. CHF	CHSB	September 25-26, 2003
Village meetings to be held to promote CHF	Facility/ward health committees Village administration	By 30 October 2003
Reports of village meetings submitted to CHSB	Facility Health Committee	By end November 2003
Evaluation of reports and discussion of way forward	CHSB	By end December 2003
Procure a digital camera for member pictures	PHR*plus*	By end December 2003

- *Fraudulent use of cards,* as it is difficult to always verify the identity of the user of the card. There is need to obtain picture of each person listed on the CHF card. PHRplus will assist district to acquire a digital camera.

- *Non-CHF (user-fee) patients have in some cases been preferred by providers* (facility in-charges), because the in-charges want to collect more fees. Some facility in-charges may have "borrowed" fees collected and used the money for personal purposes before they surrender it to the CHF Accountant. The CHMT will strengthen supervision of CHF procedures and especially controls over revenue.

- *CHF members have asked for privileges* in terms of services, waiting times, etc., but these have not been given. To encourage CHF enrollment, consider providing other benefits, unrelated to service (such as discounts on purchase of bed nets), to members.

- *Economic hardships* in the district. The CHF can do nothing about the general economic situation, but it can make sure to actively recruit members during seasons when people have cash, e.g., after harvest.

- *Lack of essential equipment,* especially laboratory equipment. This problem is being addressed by the DMO and hopefully will be solved.

- *Need to improve quality of services,* including attitude of providers towards patients. Providers should be given some motivation (recognition, training, allowances, etc.) to improve their service delivery as well as individual counseling if problem persist. The Quality Improvement Recognition Initiative when implemented will also address this issue.

- *Competition from non-CHF districts,* where patients can receive free treatment. This will cease to be a problem, because all the neighboring districts (Babati and Mbulu) are also starting their own CHF schemes.

- *Competition from (non-CHF) NGO facilities*. While patients must pay for NGO-provided services, they are willing to do so because the services are of higher quality. However, some NGOs may soon start accepting CHF members. (The DMO is negotiating with one.)

- *The scheme is not compulsory*. Membership should remain voluntary and community education should be increased.

- *Premium levels may be too high*. This issue will be considered after the December review. A questionnaire will be developed with PHR*plus* assistance to "listen to the customer." The package offered to CHF members will also be examined to see if there is merit in offering different packages at different prices.

Following the community mobilization work, the CHSB will review progress in December 2003 and decide whether there is need to make any changes to the CHF as it is currently designed. This may involve revising the membership and user-fee structures. The CHSB is also monitoring the number of exempt patients as this has been very low and they are concerned that poor people are being excluded from necessary health care.

4.3 Revenue Generation

A comparison of revenues from CHF membership and user fees paid by non-CHF patients in 2003 shows that user fees account for nearly 85 percent of all revenue collected in the facilities (excluding the matching grant), but nearly half (45 percent) of the consumption of the health services is by the CHF members.

Table 4: Revenue Collection

	2002 (4 months, Aug-Dec)		2003 (8 months, Jan-Aug.)	
	Tsh	**%**	**Tsh**	**%**
User fees	10,500,300	84%	18,703,000	85%
CHF Membership fees	2,029,000	16%	3,399,000	15%
Total	**12,529,300**	**100%**	**22,102,000**	**100%**

The disparity in usage of services and the revenue collections from CHF and non-CHF patients indicates that there is a serious flaw in the CHF as currently designed in the district. Questions should be asked with regard to the purpose of the fund and whether it is meeting that purpose when it appears that so many people are not able to access health care. Would a user fee-only system, with lower fees, enable more patients to access services, and would it perhaps generate even more revenue? These and other questions will be addressed in further assistance to the district in the coming months.

5. Conclusions

- The CHF in Hanang has succeeded in implementing sound management procedures that should ensure proper control over revenues and facilitate monitoring at the ward and district levels.
- The procedures are easy to apply and do not impose a big burden on staff in most of the facilities. High-volume facilities may need to have staff assigned to handle CHF members at registration in order to ensure speedy service and accurate record keeping.
- Community health committees (ward and facility) have been formed but are not fully active in some places. The main barrier appears to be the lack of allowances for the committee members.
- There is need for closer follow-up to ensure that all facilities submit their reports to the DMO on time. Submission of reports has been very poor in most cases, even though the reports are prepared and available at the facilities. The DMO's office should also act on the reports once received in order to investigate any issues that may arise.
- CHF membership continues to be very low. The CHSB and CHMT are working on community mobilization to try to raise awareness of the benefits of joining the CHF. If these efforts are not successful, the CHSB in collaboration with PHR*plus*, will explore other courses of action, which may include revising the pricing of CHF membership and user fees.
- There is a problem of access to services by the majority of people in the district. Attendance at health facilities by non-CHF members is very low and requires urgent investigation to find out what the obstacles are.

6. Next Steps

PHR*plus* will assist Hanang district in the following activities.

- Assist in the review of the CHF to determine if any changes need to be done to make it a more viable and equitable scheme.
- Purchase a digital camera to assist in taking member photographs. This will be feasible initially in Katesh, but can easily be expanded to include all facilities since the CHF Agent will visit all facilities regularly.
- The CHSB will meet in December 2003 to review progress of the community mobilization activities. PHR*plus* will follow up in January to discuss what technical or other assistance is needed.
- Continue to follow up with the DMO to ensure that reporting performance improves and stays up. Request monthly summary to be sent to PHR*plus* at quarterly intervals, starting with September 2003.
- Assist in reviewing the design of the CHF in efforts to increase both membership and access to health care.

Annex A. Summary of Facility and Committee Performance

Area Examined	Dawar Dispensary 9-17-03	Gitting Dispensary 9-17-03	Bassotu Ziwani Dispensary 9-18-03	Bassodesh Dispensary 9-18-03	Endasak Dispensary 9-19-03	Katesh Health Center 9-19-03	Dirma* 9-26-03	Sirop* 9-26-03
Patient Register	CHF numbers not filled in. Otherwise well kept	Correctly kept.	Correctly kept	Correctly kept	Well kept. In-charge writes short summary on the page at end of the day.	Well kept	Well kept	Well kept
Daily Status Report	Not up-to-date. Dispensary in-charge had traveled.	Up-to-date through Aug. 9	Up-to-date and very tidy	Up-to-date and correct	Up-to-date and well kept	Up-to-date and correct	Up-to-date and correct	Up-to-date and correct
Monthly Status Report **	Up-to-date through July. Accurate and tidy.	Up-to-date	Up-to-date and correct. August submitted to DMO	Up-to-date and correct	Up-to-date and correct	Up-to-date but not correct (numbers did not add up)	Up-to-date and correct	Up-to-date and correct
Financial Ledger	Up-to-date through July. Not reconciled with District Ledger	Up-to-date through Aug. 9. Not reconciled with District Ledger	Up-to-date but not reconciled with District Ledger	Up-to-date but not reconciled with District Ledger	Up-to-date but not reconciled with District Ledger	Up-to-date but not reconciled with District Ledger	Up-to-date but not reconciled with District Ledger	Up-to-date but not reconciled with District Ledger
CHF Membership Register	Not up-to-date	Up-to-date	Up-to-date	Up-to-date	Up-to-date	Up-to-date	Up-to-date	Up-to-date
CHF Cards	Poor filing of member cards	Cards well filed	Cards well kept though not in file	Well kept. Filed	Filed	Filed	Filed	Filed
Exemptions	No approved list	No approved list	No approved list	No approved list	No approved list	No approved list	No approved list	No approved list

Ward Health Committee	Active	Facility in-charge not available to say whether active or no.	Not active because no allowances approved	Not active	Active. Facility in-charge is also a member of the District Hospital Committee	Active	Active	Active
Facility Health Committee	Not active	Active	Not active	Active	Status not checked	Active	Active. Merged with ward committee	Active. Merged with ward committee
Other comments	No control over "No Payment" patients, i.e., those who cannot pay but promise to bring the money later	Clinical officer in-charge of dispensary was away and the assistant on duty was not knowledgeable about the CHF	Dispensary in poor state of repair. New dispensary under construction		Patient died at the dispensary during our assessment; therefore, not able to finish interview	CHF work is not well supervised and hence errors in records. Officer in-charge away during assessment	Met with Dispensary Committee members. No regular meetings. Recruitment into CHF hampered by nomadic lifestyle of community	Met with members of the dispensary/ward committee. Meets regularly and is actively involved in decision-making. Members were knowledgeable re CHF membership procedures

* Syrop and Dirma dispensaries were visited during the community visits with members of the CHSB and CHMT.
** "Up-to-date" here refers to monthly reports submitted to DMO through August 2003.

Annex B. Contacts

Contacts	Facility	Position
Daniel Mefurda	Dawar Dispensary	CO In Charge
	Gitting Dispensary	Duty Nurse
Simon Nashokigwa	Bassotu Ziwani Dispensary	CO In Charge
Martha Awe	Bassodesh Dispensary	Nurse. Deputy In Charge
Charokiwa Msangi	Endasak Dispensary	CO In Charge
Daniel S Kirumbi	Sirop Dispensary	CO In Charge
Teresia Lubuva	Katesh Health Center	Medical Recorder
Anthony Pallangyo	Dirma Dispensary	CO In Charge
Martin Kadele (Board)		Member CHSB
Petrolina Thomas (Board)		Member CHSB
A. Mjengwa (Board)		Member CHSB
Agnes Mshana		CHMT
Joshua Muna		CHMT
Pascas Isondi		CHMT
Neema Ngajilo		MOH HQ
J. B. Hussein		Chairman CHSB
R. Kiwane		Member CHSB
Julius John		CHMT
Dr E. Semali		CHMT
F. Chilewa		CHMT
Francis Gwasma		CHMT
Catherine		CHMT
Betty Tuarira		CHMT
Phesto Msongele		CHMT
Dayandi Qamata		CHMT