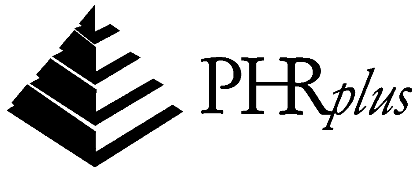

PHR*plus* Project
Abt Associates Inc.
4800 Montgomery Lane – Suite 600
Bethesda, MD 20814
www.PHRproject.com

Catalogue of Community Based Health Financing Schemes

TANZANIA

June 2006

CHeFA-EA

Community Health Financing Association for Eastern Africa

Foreword

USAID REDSO/ESA has provided ongoing support to information and technical guidance for policy makers and communities in the East and Southern Africa region in the area of health care financing, with specific focus on community based health financing (CBHF). In an effort to strengthen regional and national community based health financing associations, Partners for Health Reform *plus* (PHR*plus*) in collaboration with the Community Health Financing Association for Eastern Africa (CHeFA-EA) has produced a catalogue of CBHF schemes in four countries in the region: Kenya, Tanzania, Uganda and Rwanda. This activity was financed by USAID REDSO/ESA and carried out in 2006.

The aim of the catalogue is (i) to establish a database of existing CBHF schemes and initiatives for the use by the national and regional associations (ii) to share information with stakeholders on the CBHF movement in the region, and (iii) to demonstrate an approach to document the characteristics, and monitor the progress, of individual schemes and the national level movement, including donor involvement. Potential users of the catalogue include national and regional CBHF associations, Ministries of Health, donors, NGOs and researchers.

Data collection was carried out by regional consultants, using a structured questionnaire in Uganda, Kenya and Tanzania. In Rwanda, an existing database was made available by the Ministry of Health. The Catalogue consists of three parts: 1) a description of the national CBHF association (and the regional association contained in the Uganda volume), 2) a matrix presenting the main characteristics of the CBHF schemes, and 3) the completed questionnaires, providing detailed information on each individual scheme. It is envisaged that national associations can utilize and update essential data such as membership, service coverage, and donor assistance, on an annual basis.

An additional element of this project included providing in depth management assistance to selected schemes in two countries, Uganda and Kenya. Technical assistance included training, community mobilization, management information system development, and, in Uganda, an incentive scheme providing subsidized insecticide treated mosquito nets (ITNs).

Acknowledgement

PHR*plus* acknowledges with appreciation the contributions of regional consultants Jean Damascene Butera, who carried out the data collection and technical assistance in Kenya, Tanzania, and Rwanda, and Dr. Gloria Karungi, who carried out the work in Uganda. PHRplus staff Stephen Musau, Melinda Ojermark, Lillian Kidane and Ellie Brown contributed to the design, review and management of the project. The contributions of the following leaders and stakeholders in the regional CBHF movement were highly appreciated:

East and Southern Africa Region:
Joseph Kiggundu, Regional Coordinator of the Community Health Financing Association for Eastern Africa (CHeFA-EA)

Uganda:
Livingston Namara, Chairman, and Joy Batusa, Association Secretary of the Uganda Community Based Health Financing Association (UCBHFA)

Kenya:
Lucas Wadenya, Chairman of the Kenya Community Based Health Financing Association (KCBHFA) and Executive Chairman of the CHeFA-EA, all STIPA staff, Dr Samuel Mwenda Rukunga of CHAK and Ven. Zacchaeus I. Masake

Tanzania:
Sr. Rita Toutant: Vice Chairperson, Prof. Manoris V.Meshak: Secretary; Dr. S.A. Sheuya, Member of the TNCHF Executive Committee, Mushi Angsar, Member of the TNCHF Executive Committee

Rwanda:
Mr. Inyarubuga Hertilan, Coordinator of the Cellule Technique.

Finally we wish to thank our USAID/REDSO/ESA partners Moses Mukuna and Maria Bautista for their interest, encouragement and support throughout this project.

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Community Based Health Financing in Tanzania: Background

SUMMARY

Overview of movement

After a long period of free health care services the Government of Tanzania (GoT) reversed the policy in 1994, following a sharp decline in resources, by requiring cost-sharing by the patients. But with 51% of Tanzanians earning below the poverty level, this policy made the access to health care difficult for a large portion of the population. However, the GoT promoted other alternative funding options through health insurance, by creating the National Health Insurance Fund[1] (NHIF-1999), a compulsory health insurance scheme for public employees and their families, and the voluntary Community Health Fund (CHF-1996) initiative, which aims to cover the formal and informal sectors at district level. There are 67 districts practicing CHF.

The communities have organized themselves by creating Community Based Health Insurance Schemes, like Chawana Health Insurance, Chanika Atman Health Insurance, Manzese Atman Insurance Health Fund, Mburahati Scheme, Migahawa Micro Health Insurance Fund (MIHIFU), Yombo Atman Scheme, Sumbawanga Atman, AICT-Mkula CHF Magu District, ELCT/NWD-CBHF, and Kagera Region.

There is also a Network of 15 Self Managed Health Insurance Schemes in Mbeya, Tanzania, supported by Centre International de Développement et de Recherche (CIDR).

Government Involvement

Regarding Health Insurance Schemes, the National Health Policy (2003) states that: “Both private and public Health Insurance Schemes will continue to be encouraged. And the Government will continue to develop policy guidelines for developing different types of Health Insurance Schemes.”

Also, in order to cover the formal and informal sectors at district level, the Government of Tanzania piloted the CHF in Igunga district (1996) that is being scaled up through out the country.

1. Legislation governing CBHF

   Unlike the National Health Insurance Fund that has a legal structure (Parliamentary Act No. 8 of 1999) and the Community Health Funds (Parliamentary Act No. 2 of 2001); Community Based Health Insurance Schemes have no specific legislation and operate on trust deed and mutual arrangements basis. Some operate under the umbrella of the national network,

[1] In addition to the government programmes, there are also private health insurance companies, like Medical Express Tanzania and Air Rescue (AAR) assisting private companies and individuals in managing their health services.

Tanzania Network of Community Health Funds (TNCHF), that is registered as a NGO under Reg.No. 12137 since 5th October 2003.

2. Key contact in government (MOH) re CBHF

   Ministry of Health
   Health Sector Reforms Secretariat
   Mr Jeremiah Sendoro
   P.O.BOX 9083
   Tel +255 744 432719
   solojerry@hotmail.com

3. CBHF recognition as part of health care financing strategy

   The National Health Policy (2003) includes community contributions in the funding sources of the health sector. These contributions can either be done in the form of user fees, Community Health Fund, and Health Insurance Scheme under which fall CBHFs**.**

Donor Involvement

1. Evangelischer Entwicklungsdienst (EED)

   EED is funding some schemes, including the Self Managed Health Insurance Schemes Network in Mbeya.
   Nature of support: Financial assistance
   Amount of support and duration: Not Known

   Contact Information:
   Monica Hoffmann-Kuehnel
   Email: monika.Hoffmann-kuehnel@eed.de
   Phone: 49 228 81012363
   Fax: 49 228 8101160

2. Centre International de Développement et de Recherche (CIDR)

   CIDR is funding the Self Managed Health Insurance Schemes Network (SMHIS) in Mbeya. There is no direct support to the schemes, but CIDR helps them to start their activities by providing them with a set of furniture, a cell phone for ambulance calls and the first year's rent for their office. In addition, CIDR provides allowances (0.8USD/person) for every Board meeting (one every two month). These allowances will be transferred soon to the SMHIS management.

   Nature of support: Financial and Technical support assistance

   Amount of support and duration: Not Known

   Contact Information:

   Mr Fahdi Dkhimi
   Programme Manager
   Milowo-Mbozi District
   Address: Po Box 2827 Mbeya - Tanzania
   Telephone: _(+255) 746 515 480
   Email:_cidrtanzanie@yahoo.fr

TANZANIA Network of Community Health Funds (TNCHF)

BACKGROUND

The Tanzania Network of Community Health Funds (TNCHF) was registered on 5th October 2003 under Reg. No. 12137. The organizations involved in its creation include:

- Faith based initiatives (ACT, AICT, ELCT, RC-TEC)
- The informal sector (VIBINDO)
- MoH representatives

The main objective of TNCHF is to act as a national, legal, autonomous, non-profit organ ization dedicated to promoting Community Health Financing for the people of Tanzania while respecting the policies and priorities set by the Ministry of Health.

Objectives

- To liaise with the relevant authorities concerned with health in Tanzania and all donor agencies in the field of health financing in view of promoting collaboration between all participating health actors.
- To facilitate research, feasibility studies, evaluations, training activities and workshops on Community Health Financing schemes and related topics.
- To provide general technical and financial assistance as requested to individual Community Health Financing schemes.
- To foster the exchange of ideas and experience among institutions and organizations involved in Community Health Financing, mainly through the organization of periodic workshops, seminars, symptoms, conferences, courses and meetings.
- To encourage the establishment of an appropriate regulatory framework for institutions and organizations running Community Health Financing Schemes.
- To promote Community Health Financing through publication of books, papers, articles, newsletters and items in the electronic media on Community Health Financing schemes, their activities, and those of their members.

Membership Categories:

- Founding members:
- Voting members: includes the founding members and any other additional institutions or organizations admitted as voting members
- Associate members: Individuals sharing a common purpose with the objectives of the Network may apply to the Annual general Meeting.
- Affiliate members: Organizations and networks sharing a common purpose with the TNCHF may become affiliate members
- Honorary members: These could be individuals or organizations whose resources contribute in setting up or improving the Network.

The network has the following components:

- Annual General Meeting
- Executive Committee
- Secretariat

The Executive committee is the governing body and is comprised with:

- Chairperson
- Vice chairperson
- Secretary
- Treasurer
- Three elected member drawn from the voting membership of the network

The TNCHF has so far been receiving support from ILO, SIDO-GTZ, Tujenge Pamoja Project, the Tanzanian German Programme to Support Health (TGPSH), the GoT and EED**.**

Contact Information:

NIC House
P.O.BOX 7146
10th Floor, Office No 6
Samora Avenue, Dar es Salam
Tel: 00255-22-2122063
Fax: 00255-22-2122123
Email: network@tnchf.or.tz
Website: www.tnchf.or.tz

Contact Person:

Sr. Rita Toutant
TNCHF Vice Chairperson
Cell: +255.744.085 283
Email: msoladar@intafrica.com, Toutant40@yahoo.fr
Web: www.tnchf.org.tz

Prof. Manoris V.Meshak
Secretary TNCHF
Dir: +255.22.277 544 7
Gen: +255.22.277 750 04
Cell: +255.0741.240 261
Email: meshack@ucc.ac.tz, Meshack@uclas.ac.tz

Services provided:

- Promotion of MHIS/ CBHIs/ CHFs in Tanzania
- Lobbying CHFs and MHIs in negociations on their funding and legislation
- Training and skills development to members and staff of MHIS/ CBHIs/ CHF
- Technical management and organizational support
- Provision of up-to-date information on health issues to members
- Capacity building support
- Research and documentation
- Advocacy in support of granting the poor access to health services

Annual budget: TBD

Number of CHBF schemes registered under the association:

- Affiliate Members (12)
  - Community Based Health Insurance Schemes (e.g. ELCT, Sumbawanga, Chawana) (7)
  - Other organizations (e.g. Vibindo, CSSC etc.) (5)
- Individual members (18)

Donor assistance provided: ILO, SIDO-GTZ, Tujenge Pamoja Project, The Tanzanian German Programme to Support Health (TGPSH), The GoT , and EED

Catalogue of CBHF Schemes - TANZANIA		
1.	**Name of the Scheme**	**AICT- Mkula CHF Magu District**
	Contact Details	Dr. Joseph Ibambasi, AICT Health Director P.O. BOX 905 Mwanza, +255-028—2500302, +255-744-303878, +255-741-412447 aicthede@hotmail.com Or Dr. Kidando i/c, Mkula Hospital, Box 213, Magu, 0748 363488, spekebay@africaonline.co.tz
	Year established	July 2001
	Purpose of establishment	To provide affordable health care services in Mkula division
	Activities	Community Based Health Financing in Mkula Hospital catchment population.
	Coverage /benefit package	The number of people covered by the Scheme is 1008 in total belonging to 53 households. The Catchment area of the scheme is 150,000 people. The premium is paid in advance once a year and is collected through out the year and our premium differs from group to group: i. Children < 5 years pay 3,600/= per year, ii. Adults pay 7,000/= per year, iii. Households pay 20,000/= per year, iv. Cost sharing of Tshs 200/= when a member comes for treatment to avoid misconduct of the member. The ceiling is 60,000/= for the individual members The following are not accepted to join the scheme: i. All people with chronic diseases e.g. diabetes, cancer, ii. Epidemics, iii. Cosmetic operation, iv. Prosthesis, Spectacles, and Dentures. All this was discussed and accepted by the members
	Initiator	AICT
	Ownership	The community owns the scheme and therefore have elected the Chairperson, Se cretary, and Accountant
	Health Care Provider	Mkula Hospital. The community can also select other providers.
	Other Stakeholders	Financial support is very much needed despite the seed money given by ICCO in the year 2002. In Feb. 06, TNCHF has granted T shs 700,000 for awareness raising.
	Brief Background	The scheme is not growing as intended and is not sustainable yet. A maximum of 10,000 members would make this scheme sustainable. Right now there are only limited funds for marketing.
2.	**Name of the Scheme**	**Bima ya Afya ya Dr. Atiman Sumbawanga (BAAS)**
	Contact Address	Sr. Helena Katebera, Medical Secretary, Diocesan Health Board P.O. Box 34, Sumbawanga, 025-2802621, 0744304082, dhb@muchs.ac.tz
	Year established	The scheme started in 2001
	Purpose of establishment	To an improve access and quality of health to the whole community using health services of Sumbawanga Catholic Diocese.
	Activities	? A mini study was done in order to assess the community willingness to enroll into the scheme. The results showed people appreciated and were ready to register into the scheme.

		? Upgrading of the health facilities was done in order to assure the quality care. New staff were hired and allocated to the piloting areas ? The design of the scheme was developed involving all key stakeholder from the community the district and regional authority in the health sector. ? Management tools, sensitization and awareness creation strategies and materials were designed and used to promote the scheme at all levels ? Continued sensitization activities carried out. Strengthened collaboration with the government and have been allocated operation wards for BASS and Community health Funds.
	Coverage /benefit package	Target population 97,000. Money collected from registration forms – 200,000. The scheme has 200 members. Premium collected – Tshs 1,000,000 Basic Health care services at Dispensary and Health Centres as per the ministry of health (MOH) guidelines: Consultations, Laboratory tests, Minor surgeries Drugs, Deliveries, MCH services, Health Education
	Initiator	Diocesan Health Board, Sumbawanga Catholic Dioceses
	Ownership	Community
	Health Care Provider	Sumbawanga Catholic Diocese Health Facilities in two wards.
	Other Stakeholders Brief Background	Government Challenges: Lack of initial capital to ensure drug availability at health facility level. Delay of reimbursement by NHIF for its members weakened the portfolio for running the scheme. The government has delayed to approve staff salary grant. Way forward: To continue negotiation with the government to release staff salary. Look for development partners to support the scheme take off and improve drug revolving fund. Formulate and strengthen the functioning of the health committees at health facility and village level. Reinforce sensitization and activities at community level.
3.	**Name of the Scheme**	**Bima ya Afya ya Kujiwezesha (BAK) /Self Managed Health Insurance Schemes (SMHIS), CIDR, Itumpi**
	Contact Address	Chairperson: Also: c/o Mr. Laurent Lushinge, P O Box 3668,Mwanjelwa, Mbeya, Tz, Cell: 0744 606228; laurentlushinge@yahoo.com; cidrtanzanie@yahoo.com
	Year established Purpose of establishment	July 2003 To meet the health needs of people in Itumpi Village, Mbozi District
	Activities / role of SMHIS	Charging preferential prices to the insured. Special reception area & wards. AIDS prevention & “treatment” Transport
	Coverage /benefit	812 members.

	package	in patient treatment including surgery/complicated delivery & C/S maximum 2/52 thereafter negotiations transport to hospital only transport from hospital-dead body or referral
	Initiator	CIDR
	Ownership	Scheme members
	Health Care Provider	Mbozi Mission Hospital
	Other Stakeholders	EED, French Cooperation
	Brief Background	Population: Mbozi District 515,270(Census 2002). Economy mainly depends on agriculture and livestock. Av. annual income / person is Tshs 73,300 & family income Tshs 513,100 Cost of hospitalization: Transport costs 7020 (41%), Hospital 6730 (39%), Food 2440 (14%), others 1010 (6%) Constraints to health care; PHYSICAL Accessibility: distance, lack of vehicles & bad roads. FINANCIAL Accessibility: problem of marketing & seasonal nature of income. The problem of finance corresponds to rainy season during which cases of malaria and pneumonia are most frequent. Advantages of SMHIS: services improved due to availability of funds to buy drugs, equipment, reagents etc.; time to seek medical care minimized & therefore morbidity/mortality decreased; economy improved; « Peace of mind »
4.	**Name of the Scheme**	**Bima ya Afya ya Kujiwezesha (BAK) /Self Managed Health Insurance Schemes (SMHIS), CIDR, Lungwa**
	Contact Address	Mr. Julius Twizi, Chairperson, BAK Lungwa, P.O. Box 166, Mbozi Cell: 0748 23759 Also: c/o Mr. Laurent Lushinge, P O Box 3668,Mwanjelwa, Mbeya, Tz., Cell: 0744 606228; laurentlushinge@yahoo.com; cidrtanzanie@yahoo.com
	Year established	July 2003
	Purpose of establishment	To meet the health needs of people in Lungwa Village, Mbozi District
	Activities / role of SMHIS	Charging preferential prices to the insured. Special reception area & wards. AIDS prevention & "treatment" Transport
	Coverage /benefit package	342 members. in patient treatment including surgery/complicated delivery & C/S maximum 2/52 thereafter negotiations transport to hospital only transport from hospital-dead body or referral
	Initiator	CIDR
	Ownership	Scheme members
	Health Care Provider Other Stakeholders	Mbozi Mission Hospital EED, French Cooperation
	Brief Background	Population: Mbozi District 515,270(Census 2002). Economy mainly depends on Agriculture and livestock. Av. annual

		income / person is Tshs 73,300 & family income Tshs 513,100 Cost of hospitalization: Transport costs 7020 (41%), Hospital 6730 (39%), Food 2440 (14%), others 1010 (6%) Constraints to health care; PHYSICAL Accessibility: distance, lack of vehicles & bad roads. FINANCIAL Accessibility: problem of marketing & seasonal nature of income. The problem of finance corresponds to rainy season during which cases of malaria and pneumonia are most frequent. Advantages of SMHIS: services improved due to availability of funds to buy drugs, equipment, reagents etc.; time to seek medical care minimised & therefore morbidity/mortality decreased; economy improved; « Peace of mind »
5.	**Name of the Scheme**	**Bima ya Afya ya Kujiwezesha (BAK)/Self Managed Health Insurance Schemes (SMHIS), CIDR, Mshikamano Isansa**
	Contact Address	Mr. Mbishe Mwampashe, Mwenyekiti, BAK Mshikamano Isansa P.O. Box 2827, Mbeya, Tz. Cell: 0745 33 7159 Also: c/o Mr. Laurent Lushinge, P O Box 3668,Mwanjelwa, Mbeya, Tz., Cell: 0744 606228; laurentlushinge@yahoo.com; cidrtanzanie@yahoo.com
	Year established	July 2003
	Purpose of establishment	To meet the health needs of people in Lungwa Village, Mbozi District
	Activities / role of SMHIS	Charging preferential prices to the insured. Special reception area & wards. AIDS prevention & "treatment" Transport
	Coverage /benefit package	566 members. in patient treatment including surgery/complicated delivery & C/S maximum 2/52 thereafter negotiations transport to hospital only transport from hospital-dead body or referral
	Initiator	CIDR
	Ownership	Scheme members
	Health Care Provider	Mbozi Mission Hospital
	Other Stakeholders	EED, French Cooperation
	Brief Background	Population: Mbozi District 515,270(Census 2002). Economy mainly depends on Agriculture and livestock. Av. annual income / person is Tshs 73,300 & family income Tshs 513,100 Cost of hospitalization: Transport costs 7020 (41%), Hospital 6730 (39%), Food 2440 (14%), others 1010 (6%) Constraints to health care; PHYSICAL Accessibility: distance, lack of vehicles & bad roads. FINANCIAL Accessibility: problem of marketing & seasonal nature of income. The problem of finance corresponds to rainy season during which cases of malaria and pneumonia are most frequent. Advantages of SMHIS: services improved due to availability of funds to buy drugs, equipment, reagents etc.; time to seek medical care

		minimised & therefore morbidity/mortality decreased; economy improved; « Peace of mind »
6.	**Name of the Scheme**	**Bima ya Afya ya Kujiwezesha (BAK)/Self Managed Health Insurance Schemes (SMHIS), CIDR, Muungano Group Isansa**
	Contact Address	Mr. Rasron Nyondo, Mwenyekiti, BAK Muungano Group Isansa, P.O. Box 132, Isansa Mbozi, Mbeya, Tz. Cell: 0745337158 Also: c/o Mr. Laurent Lushinge, P O Box 3668,Mwanjelwa, Mbeya, Tz., Cell: 0744 606228; laurentlushinge@yahoo.com; cidrtanzanie@yahoo.com
	Year established	July 2003
	Purpose of establishment	To meet the health needs of people in Lungwa Village, Mbozi District
	Activities / role of SMHIS Coverage /benefit package	Charging preferential prices to the insured. Special reception area & wards. AIDS prevention & "treatment" Transport 570 members. in patient treatment including surgery/complicated delivery & C/S maximum 2/52 thereafter negotiations transport to hospital only transport from hospital-dead body or referral
	Initiator	CIDR
	Ownership	Scheme members
	Health Care Provider	Mbozi Mission Hospital
	Other Stakeholders	EED, French Cooperation
	Brief Background	Population: Mbozi District 515,270 (Census 2002). Economy mainly depends on Agriculture and livestock. Av. annual income / person is Tshs 73,300 & family income Tshs 513,100 Cost of hospitalization: Transport costs 7020 (41%), Hospital 6730 (39%), Food 2440 (14%), others 1010 (6%) Constraints to health care; PHYSICAL Accessibility: distance, lack of vehicles & bad roads. FINANCIAL Accessibility: problem of marketing & seasonal nature of income. The problem of finance corresponds to rainy season during which cases of malaria and pneumonia are most frequent. Advantages of SMHIS: services improved due to availability of funds to buy drugs, equipment, reagents etc.; time to seek medical care minimized & therefore morbidity/mortality decreased; economy improved; « Peace of mind »
7.	**Name of the Scheme**	**ELCT/NWD –CBHF, Kagera Region**
	Contact Address	Mr. Joseph Lulinga, CBHF -Coordinator, ELCT/NWD Diocese Box 98 Bukoba, Tz. 028-2220027; Res. 028- 2220214; Cell: 255 741 - 503828; jlulinga@hotmail.com ; jlulinga@yahoo.co.uk
	Year established	2001

Catalogue of CBHF Schemes - TANZANIA		
	Purpose of establishment	The initial motive was to enable communities in service areas of ELCT/NWD to access health care and as means of generating income to sustain ELCT Health facilities financially.
	Activities	Enabling community members to perceive and understand their responsibility for their health. Improving quality of health services. Reducing cost of health services to the client. Ensuring sustainability of health services in health units. Encourage people's (community) participation in health care services. Encourage people to be a caring community and contribute to the medical care of their fellow human beings through the solidarity mechanism pf members' fees (premium).
	Coverage /benefit package	Coverage depends on premium: Tshs. 40,000. per member, ceiling for treatment is Tshs. 150,000 per member per year (Private). Tshs. 10,000/= per member, ceiling for treatment is Tshs. 100,000/= per member per year. Tshs. 5,000/= per member, ceiling for treatment is Tshs. 50,000/= per member per year. Co-payment Tshs. 300/= for outpatients and Tshs. 500/= for inpatients paid by the members for each visit to the health facility. Covers medications and services which are routinely available and on site at 24 ELCT/NWD and Roman Catholic Hospitals, Health Centres and Dispensaries. This includes the following services. Outpatient Department; Inpatient wards – Medicine, Surgery, Obstetrics, Gynecology and Pediatrics.; Ophthalmology consulting, Labour and Delivery; Surgical Theatre; Intensive Care Unit; General Laboratory ;General X-ray including abdominal ultra sound; Private ward for those members who pay Tshs. 40,000/= per annum. The annual maximum for total service is determined by the contribution ceiling.
	Initiator	ELCT/NWD
	Ownership	Community with own board & diocesan CBHF office & staff. The scheme has its own bank account. All cash received are recorded immediately and banked. The invoices from health units for services rendered are brought monthly at the scheme head office for thorough scrutinization and then paid accordingly. There are regular meeting of CBHF Committee at Diocesan level, at facilities level in which community participation is encouraged to discuss matters concerning the fund.
	Health Care Providers	Four Hospitals, three health centres, and fifteen dispensaries. Also the scheme has accredited one private dispensary and one Government hospital.
	Other Stakeholders	Danish ELC
	Brief Background	The scheme covers 6 out of the 8 districts of Kagera Region: Biharamulo, Bukoba Rural, Bukoba Urban, Chato, Missenyi, and Muleba. Total area of 28.694 Km^2, 73% of the region, total population of 2,038,888. Declining donor assistance in the 80s and early 90s and inability of the government to sustain health services in the country had put great stress on the church health services whose clients were mostly rural and poor. There is increase in number of renewals and registration of new members every year:

		`` 2001 2002 2003 2004 2005 Members 1536 2391 3183 3580 4120 Marketing has proved to be the backbone of this scheme. Tools: drama groups, choirs for mobilization and sentization; Brochures; calendars, newspapers; T-shirts; radios and television; Church leaders, village leaders etc; sports competition. CBHF has helped to sustain the health units as membership has reduced debts and absconding. But CBHF is a new concept, not easily understood by the rural community. The high level of poverty due to poor coffee prices in the rural community is a drawback. Also there is confusion in the community due to introduction NHIF, which started at the same time the scheme was taking off. The rural community could not easily differentiate between the two schemes. HIV/AIDS has been a threat to our scheme, since members who are infected are likely to increase the number of patients when they fall sick and therefore consume more revenue/income. HIV/AIDS has an impact on sustainability, increasing demand & expenditures.
		Way forward: To overcome poverty by promoting income generating activities in rural areas as the source of revenue to pay premium and to encourage solidarity groups for various activities of generating income. To review premiums so that they match with fluctuating costs of services.
8.	**Name of the Scheme**	**Mfuko wa Afya wa Atiman - Manzese (MAAMz), DSM**
	Contact Address	Mr. Joseph Itan'gare, Chairperson, Mfuko wa Afya Atiman-Manzese (MAAMz), P.O. Box 55095, DSM, Tz. Tel.: 022 2400119, Cell: 0744 024292 Or Sr. Rita Toutant at msoladar@cats-net.com; toutant402yahoo.fr
	Year established	Awareness raising since 2003, accessing health care since January 2005.
	Purpose of establishment	To help the parish via the already established Small Christian Communities (SCC) create their own health solidarity fund to enable members to access basic health care.
	Activities	Treasurer available at MAAMz office in Parish Community Centre every Sunday from 7.00 a.m. to 10.00 a.m. to collect fees, process ID cards & up-date records etc. Monthly monitoring of invoice & sick sheets with good collaboration from HCP. Regular meeting of members. Raising awareness to various groups.
	Coverage /benefit package	There are agreed upon Treatment Guidelines & list of medicines to treat the most common acute conditions, keeping in mind that malaria is still the top killer disease in the country.
	Initiator Ownership	Catholic Church via Atiman MHTF. Scheme members with their own leadership under the oversight of Manzese Parish Council.
	Health Care Provider	St. Claus Modern Dispensary, Manzese (private)
	Other Stakeholders	Call of the Poor, Canada; TNCHF

	Brief Background	The scheme was promoted via the parish structure with back-up from Atiman MHTF animators & others working from the TNCHF office. Since 2003 the parish health committee promoted the MHIS throughout the Small Christian Communities (SCC). Since 2005 Manzese parish has been divided to form Tandale Parish. Between them they have at least 20,000 parishioners with a total population of 200,000 people living in the area. 80% of the people in Dar es Salaam are living from hand to mouth. Registered members: 86 families with 296 beneficiaries. But the scheme is in crisis: Half of the members are not up-to date with payments. There is an increasing no. of paid up members going for services and they are happy with HCP. Members meeting in January 06 : have increased premium to Tshs 1,000 a month; decided to pay 6 months in advance before accessing treatment; selected MAAMz rep. for Tandale Parish, will do awareness raising in the markets (Big Brother, Soko la Ndizi etc) of Manzese & Tandale. Group has strong conviction that they have to try to be self – sustaining; that it is not a charity but a solidarity group.
9.	**Name of the Scheme**	**Mfuko wa Afya wa Atiman – Chanika (MAACHK), DSM**
	Contact Address	Ms. Mary Magai, Chairperson, Mfuko wa Afya Atiman-Chanika (MAACHK) Box 8068, DSM; 0748 785789, marymrope@yahoo.com Or Sr. Rita Toutant at msoladar@cats-net.com; toutant402yahoo.fr
	Year established	Chose leadership in March 2003. Not yet accessing health care.
	Purpose of establishment Activities	To help the sub- parish of Chanika create their own health solidarity fund to enable members to access basic health care. Open to all. Awareness raising. Long negotiations to reach City Council Legal Officer to get authorization to make agreement with the village government dispensary, the only good health facility nearby. Now making concrete steps with Ilala Municipality Health Secretary. In the meantime the scheme is being officially registered to comply with pre-conditions. Also, they plan to open bank account.
	Coverage /benefit package	The clinical officer i/c is also waiting for indent system to be established before making an agreement about Treatment Guidelines & list of medicines for most common acute conditions etc
	Initiator	Catholic Church via Atiman MHTF.
	Ownership	Scheme members with their own leadership who will have scheme bank account under oversight of Atiman MHITF & TNCHF.
	Health Care Provider	Chanika Village Dispensary (Government)
	Other Stakeholders	Call of the Poor, TNCHF
	Brief Background	Chanika is 30 km from the city centre. As it is taking so long to get the agreement, there has been a lowering of morale. But it expects more people to join and pay their dues once members start accessing services. There are also concurrent plans to make an agreement with Ukonga Hospital which is quite far for the people to reach, but which could be accessed as a back-up.

Catalogue of CBHF Schemes - TANZANIA

10.	Name of the Scheme	Mfuko wa Afya wa Atiman –Yombo (MAAY), DSM
	Contact Address	Mr. Camillus Haule, (Chairperson since 15th October 2005.) P.O. Box 167, DSM.
	Year established	January 1997
	Purpose of establishment	To enable a client of poor means to manage to pay for the treatment and to get the care she/he needs.
	Activities	Make people aware of the possibility to share in the health-insurance scheme so that they know they can get help when needed since they put something aside beforehand. Animation is not an easy job especially when working with volunteers. The main concern is to teach as much as possible in the Small Christian Communities. All are welcome.
	Coverage /benefit package	Since the beginning the members were receiving all available treatments, including treatment for chronic diseases. The scheme has always been in debt. Now there is an attempt to limit the benefits to acute cases so as to make it sustainable.
	Initiator	Fr. Camillus Neuray, Dutch Missionary
	Ownership	Until very recently the scheme was run by Parish Health Committee as the chairperson of who is also a nurse/midwife at the dispensary was looking at the day-to-day affairs. In spite of getting subsidized care, the scheme has been running at a loss. Now following the advice of many experts, the scheme has elected its own leaders and they are restructuring so that they will have a greater sense of ownership & decision-making. Through meetings & seminars the situation is finally improving and the debts are diminishing.
	Health Care Provider	St. Camillus Dispensary, Yombo Parish. Considering that the aim of the dispensary is service, not business, the dispensary charges the minimum price for its service.
	Other Stakeholders	Call of the Poor, TNCHF.
	Brief Background	The biggest problem is that the people do not properly understand the meaning of insurance. The dispensary was built to accommodate 200 clients & used to be very overcrowded. But, a few years with the increase of private dispensaries closer to people's homes, the number of patients has dropped to what can be handled comfortably & safely. Elected leaders, facilitated by TNCHF, have gone on a fact-finding visit to CHAWANA to see how another scheme manages to be sustainable. In 1998 540 families registered, now there are 168. Premium: Tsh.500/= for each individual member. Year / Premiums / Trtmnt Costs / Deficit 2003 / 1,318,700/= / 2,619,900/= / 1,321,200 2004 / 1,014,100/= / 1,873,000/= / 859,000/= 2005 / 522,700/= / 714,700/= / 192,000/=

Catalogue of CBHF Schemes - TANZANIA		
11.	**Name of the Scheme**	**VIMHISPRO CHAWANA MSHIKAMANO MATIBU (Chama Cha Wafanya Biashara Wa Nazi , Kariako - Coconut vendors), DSM**
	Contact Address	Mr. Rashidi Abdalah, Chairperson, VIMHISPRO, CHAWANA Mshikamano P.O. Box 15307, DSM, Cell: 0745 216238 Mr. Gaston G. Kikuwi, Exe. Sec. General, VIBINDO, P.O. 2476,DSM, gaston.Kikuwi@tnchf.org ; vibindo@hotmail.com
	Year established	May 1999 with 38 titular members.
	Purpose of establishment	To offer health care at an affordable price to people from the informal sector who are registered members & are up-to-date in their payments.
	Activities	To ensure that members get proper health care according to the agreement with the HCP and that the regulations are followed on both sides.
	Coverage /benefit package Initiator	There are agreed upon Treatment Guidelines & list of medicines to treat the most common acute conditions which are revised from time to time in collaboration with Dr. Otato at the HCP. CHAWANA Society with assistance from ILO – SSMECA Project – with DR. S.A. Sheuya & SIDO – GTZ with Mr. Lewis & MR. Joel Chidabwa.
	Ownership	Members
	Health Care Provider	MICO Mtoni Dispensary (private) with very collaborative Medical Director: Dr. Otato
	Other Stakeholders	VIBINDO Society, TNCHF
	Brief Background	The scheme has a very good chairperson who is the lifeline of the project. Members started accessing services with a private health centre near work place in 1999. Problems: Lack of guidance in monitoring and management of the scheme as activities progressed – leading to conflicts with the provider (over-prescribing and over-charging) New HCP sought as result: MICO Mtoni Dispensary Hurdles: Gaining trust of provider (VIBINDO & TNCHF intervention & formalisation of contract) Tools: a contract, detailed treatment guidelines with agreed upon costing, up-to-date membership contribution control for access to care, detailed monthly monitoring & meeting of scheme leaders with the medical doctor /coordinator of MICO Mtoni Dispensary. Helpful Factors: Reasonable prices of services Very cooperative MD in charge (sees the advantages of the scheme for the members & ready to discuss all issues with scheme members & very collaborative during monitoring activities) The VIBINDO Secretary General has been empowered to do the monitoring & prepare the reports and give general support relating to various contractual issues Success: The scheme has never been in debt and has some money in the bank. On going challenge: decrease in number of up-to-date

members & plan to increase total membership.

Year	Titular members	Dependants	Total
1999	38	178	216
2006	23	107	1 130

Inventory of CBHF Schemes Tanzania

Identification

Name of scheme **AICT-Mkula CHF Magu District**
Year established 2001/July
Purpose of establishment To provide affordable health care services in Mkula division
Name of respondent(s) Dr. Joseph Ibambas, AICT, health director
Contact information
Address P.O.BOX 905
MWANZA
Telephone +255-028-2500302, 744-303878, and 741-412447
Email aicthede@hotmail.com

Location: Rural/Urban Rural **Coverage:** Geographic/Professional
Initiator: AICT
Ownership: The community owns the schemes and therefore has elected the chairperson, secretary and accountant
Other Stakeholders: Financial support is very much needed despite the seed money given by ICCO in year 2002.In February 2006 TNCHF has 700000/= for awareness

Brief Background

The scheme is not growing as intended and is not sustainable yet. A maximum10, 000 members would make this scheme sustainable. Right now there are only limited funds for marketing.

Management

1. **What is the enrollment mode (Individual, Household)?**
   Group, Household
2. **What is the size of your target population?**
   150,000 people
3. **What is the population size of your area of operation?**
   1,008 members
4. **What are the socio-economic characteristics of your current membership?**
   Community -Based Health Financing in Mkula Hospital catchment population
5. **What is the number of Members and/or Beneficiaries (FY 2003-2005)? Use the table below**

	Year 2003	Year 2004	Year 2005
Male		116	175
Female		125	197
Total	MOBILIZATION	241	372

6. **What does the benefit package include?**
7. **Health education/Prevention careV**
   a. Out patient care (including hospitalization at a health center)
   b. Inpatient care
   c. HIV/AIDS care
   d. Other services
8. **Are there specific exclusions?**
   There are only limited funds for marketing
9. **What is the premium amount?**
   Children<5years3600/=Adult 7000/=, Households 20,000/=
10. **Is the premium paid daily?**
    Yearly
11. **How are premiums collected?**
    Contributor submit contributions to treasurer

12. Are there co-payments? How much and how are they administered?

Yes, 200/=when a member comes for treatment to avoid misconduct of the member. The ceiling is 60,000 for the individual members.

13. Reasons for co-payments

No

14. What is the scheme income trend for the last three years? Refer to the table below.

No response

14. What is the scheme expenditure trend for the last three years? See table below

No response

15. What is the legal and regulatory framework of the CBHF?

a. Is the scheme registered?

Under the umbrella of TNCHF

b. What are the governing documents (specify)?

Constitution

16. Please describe the management structure of the scheme .

- Chairman
- Secretary
- Accountant

17. Is the community involved in scheme management? How?

Yes, the community owns the scheme and therefore elects the chairperson, secretary and accountant.

18. How many people work on scheme management?

5 Part-time

19. Is there a feedback mechanism for scheme members?

Yes, members are reporting to the management about the health services they get

20. Is there a waiting period?

No

21. Are there controls over moral hazard?

Yes, ID cards for members

22. Are there controls over adverse selection?

Not quite sure

23. Are there controls over Fraud?

Yes, the use of ID cards for members

24. Are there controls over cost escalation?

Yes, The use of ID cards for members

25. How are providers reimbursed for services?

HCP Deliver the invoice/cross checking/ payment

26. Are statistics on services utilization by members, membership and finances available? How Regularly are they prepared?

Yes, prepared annually

27. Are there income -generating activities that contribute to the scheme?

No

28. Are there external donor funds or support that contributes to the scheme?

Yes, EED, French cooperation

29. Are they mechanisms for enrolling indigents?

No

30. What are the scheme's major successes to date?

To gain familiarity by the society and people externally

31. What are the major obstacles to sustainability?

Poor contributions (premiums). They haven't succeeded to cover the targeted population

32. What strategies or plans are in place to address the issues above?

To overcome poverty by promoting Income generating activities in rural areas. To encourage solidarity within members

Identification

Name of scheme	**Bima ya Afya ya Atiman Sumbawanga(BAAS)**
Year established	2001
Purpose	To improve access and quality of health to the whole community using health services of Sumbawanga Catholic Diocese
Name of respondent(s)	Sr. Helena Katebera
Contact information	Medical Secretary Diocesan Health Board
Address	P.O.BOX 34 Sumbawanga,025
2802621,,0774304082	
Telephone	0748777674
Email	dhs@muchs.ac.tz

Location: Rural **Coverage**: Geographic/Professional
Initiator: Diocesan Health Board, Sumbawanga Catholic Diocese
Ownership: Community
Other Stakeholders: Government

Brief Background

Challenges include a lack of initial capital to ensure drug availability at health facility level and the delay of reimbursement by NHIF for its members. The government has delayed to approve staff salary grant

Way forward: To continue negotiation with the government to release staff salary. Look for development partners to support the scheme take off and improve drug revolving fund. Formulate and strengthen the functioning of the health communities at health facility and village level. Reinforce sensitization and activities at community level

Management

1. **What is the enrollment mode?**
   Group/ Household
2. **What is the size of your target population?**
   97000
3. **What is the population size of your area of operation?**
   200
4. **What are the socio-economic characteristics of your current membership?**
   Irregular income
5. **What is the number of Members and/or Beneficiaries for the FY 2003- 2005?**
   No response
6. **What does the benefit package include?**
   a. Health education/Prevention care
   b. Out patient care (including hospitalization at a health center) v
   c. Inpatient care
   d. HIV/AIDS care
   e. Other services v

7. **Are there specific exclusions?**
NO
8. **What is the premium amount?**
Tsh1,000,000

9. **Is the premium paid?**
   yearly
10. **How are premiums collected?**
   By collector
11. **Are there co-payments? How much and how are they administered?**
   NO
12. **Reasons for co-payments**
   No response
13. **What is the scheme income trend for the last three years?**
   No response
14. **What is the scheme expenditure trend for the last three years?**
   No response
15. **What is the legal and regulatory framework of the CBHF?**
   a. Is the scheme registered? YES
   b. What are the governing documents (specify)?
   Registration certified and constitution
16. **Please describe the management structure of the scheme.**
   Chairman
   Secretary
   Treasure
   6 committee members
17. **Is the community involved in scheme management? YES_____ How?**
   In case of demand quality of services
18. **How many people work on scheme management?**
   9 MINE
   a. Full time
   b. Part time Yes
   c. Paid/volunteer?
19. **Is there a feedback mechanism for scheme members?**
   Receipt of health services are reported to the office
20. **Is there a waiting period?**
   YES, 3 MONTH
21. **Are there controls over moral hazard?**
   YES
22. **Are there controls over adverse selection?**
   Target group are provided by identity, there is treatment guideline
23. **Are there controls over Fraud?**
   Yes, by monitoring scheme weekly/monthly
24. **Are there controls over cost escalation?**
   Yes due to high cost by health care provider there is termination of contract plan
25. **How are providers reimbursed for services?**
   Payments are made monthly after health care provider delivered the invoice
26. **Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?**
   Yes, are prepared monthly
27. **Are there income-generating activities that contribute to the scheme?**
   No
28. **Are there external donor funds or support that contributes to the scheme?**
   No
29. **Are they mechanisms for enrolling indigents?**
   No
30. **What are the scheme's major successes to date?**
   delivering health services to the members
31. **What are the major obstacles to sustainability?**

Risk pooling mechanism is not clearly understood. Premium rate is too small to cover cost of services

32. What strategies or plans are in place to address the issues above?

Educate and mobilize people to increase members

Identification

Name of scheme	**Bima ya Afya Ya kujiwezesha, Itumpi**
Year established	July 2003
Purpose	To meet the health needs of people in Itumpi village Mbozi District
Name of respondent(s)	Mr. Laurent Lushinge
Contacts information	
Address	P.O.BOX 3668 Mbeya
Telephone	0744-606228
Email	laurentlushinge@ yahoo.com

Location: Rural

Coverage: Geographic/Professional

Initiator: CIDR

Ownership Scheme members

Brief Background

Population:	Mbozi District 515270 (census 2002)
Economy:	Mainly depends on Agriculture and livestock
Avg. annual income:	Person is Tsh 73300 and family income Tsh 513100
Cost of Hospitalization:	Transport costs 7020(41%), Hospital 6730(39%), Food 2240(14%), Others1010 (6%)
Constraints to health care:	PHYSICAL Accessibility; problem of marketing and seasona l nature of income. The problem of finance corresponds to rainy season during which cases of malaria and pneumonia are most frequent

Management

1. **What is the enrollment mode?**
   Individual, Household
2. **What is the size of your target population?**
   515,270 (census 2002)
3. **What is the population size of your area of operation?**
   200 members
4. **What are the socio-economic characteristics of your current membership?**
   Agriculture and livestock,
5. **What is the number of Members and/or Beneficiaries for the FY 2003 - 2005? Use the table below.**
   No response

6. **What does the benefit package include?**
   a. Health education/Prevention care
   b. Out patient care (including hospitalization at a health center)
   c. Inpatient care
   d. HIV/AIDS care
   e. Other services
      MATERIAL SERVICES
7. **Are there specific exclusions?**
   No response
7. **What is the premium amount?**
   10000/=
8. **Is the premium paid daily?**
   Yearly

9. How are premiums collected?

Directly to the office or to the treasurer

11. Are there co-payments? How much and how are they administered?

No

12. Reasons for co-payments

No response

13. What is the scheme income trend for the last three years? Refer to the table below.

No response

14. What is the scheme expenditure trend for the last three years? See table below

No response

15. What is the legal and regulatory framework of the scheme?

a. Is the scheme registered? YES

b. What are the governing documents (specify)?

16. Please describe the management structure of the scheme .

Chairman and vice chairman

Treasurer and assistant treasurer

17. Is the community involved in scheme management?

No how? Due to the structure of the scheme, which is provider based

18. How many people work on scheme management?

a. Full time NIL
b. Part time?
c. Paid/volunteer? NIL

19. Is there a feedback mechanism for scheme members?

There is a meeting which involves all members of the scheme

20. Is there a waiting period?

No

21. Are there controls over moral hazard?

YES, ID cards for members, Billing system, Process of payments

22. Are there controls over adverse selection?

NO

23. Are there controls over Fraud?

Yes, there are ID cards for members

24. Are there controls over cost escalation?

YES, Prices are agreed before services with managing Health Provider

25. How are providers reimbursed for services?

Billing system (monthly)

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

Yes, Annually

27. Are there income-generating activities that contribute to the scheme?

NO

28. Are there external donor funds or support that contributes to the scheme?

No response

29. Are they mechanisms for enrolling indigents?

No

30. What are the scheme's major successes to date?

To be well known to people

31. What are the major obstacles to sustainability?

Poor contribution, (premium) they haven't succeed to cover the group targeted

32. What strategies or plans are in place to address the issues above?

To overcome poverty by promoting income generating activities in rural areas.
To encourage solidarity groups for various activities. To review premium so that they match with fluctuating costs

Identification

Name of scheme **Bima ya Afya ya kujiwezesha, Lungwa**
Year established July 2003
Purpose To meet the health needs of people in Lungwa village, Mbozi District
Name of respondent(s) Mr. Mbishe Mwampashe
Contact information
Address P.O.BOX 2827Mbeya OR Mr Laurent Lushinge,P.O.Box 3668
Telephone 0745337159
Email Laurentlushinge@yahoo.com

Location: Rural **Coverage:** Geographic/Professional
Initiator: CIDR
Ownership: Scheme members
Other Stakeholders: EED, French cooperation

Brief Background

Population: Mbozi District 515,70 (census 2002)
Economy: Mainly depends on agriculture and livestock.
Av. annual income: Per person is tsh 73300 and family income is 513100.
Cost of hospitalization; Transport costs 7020(41%). Hospital 6730(39%), Food 2440(14%), others1010 (6%)
Constraints to health care: PHYSICAL accessibility; distance, lack of vehicles and bad roads. FINANCIAL Accessibility; problem of marketing and seasonal nature of income The problem of finance corresponding to rainy season during which cases of malaria and pneumonia are most frequent.
Advantages of SMHIS: Services improved due to availability of funds to buy drugs, equipment, reagents etc. Time to seek medical care minimized and therefore morbidity/mortality decreased and economy improved

Management

1. **What is the enrollment mode (Group, Household)?**
   No response
1. **What is the size of your target population?**
   515270
2. **What is the population size of your area of operation?**
   556 members
4. **What are the socio-economic characteristics of your current membership?**
   Farmers, agriculture and livestock
5. **What is the number of Members and/or Beneficiaries for the FY 2003 - 2005? Use the table below.**

	Year 2003	Year 2004	Year 2005
Male		116	175
Female		125	197
Total	MOBILIZATION	241	372

6. **What does the benefit package include?**
   a. Health education/Prevention care
   b. Out patient care (including hospitalization at a health center)
   c. Inpatient care
   d. HIV/AIDS care
   e. Other services surgery, complicated delivery and c/s Transport to hospital only and Transport for deceased patients
7. **Are there specific exclusions?**
   No response
8. **What is the premium amount?**
   10000 to 40000
9. **Is the premium paid yearly?**
   No response
10. **How are premiums collected?**
   Contributor submits contributions to treasurer
11. **Are there co-payments? How much and how are they administered?**
   No
12. **Reasons for co-payments**
   No response
13. **What is the scheme income trend for the last three years? Refer to the table below.**

Income Source			
Premiums			
Co-payment Donors			
Others			
Totals			

14. **What is the scheme expenditure trend for the last three years? See table below**

Expenditure Lines		
Medical Claims Administration		
Personnel		
Others (Specify)		
Totals		

15. **What is the legal and regulatory framework of the CBHF?**
   a. Is the scheme registered? YES
   b. What are the governing documents? CONSTITUTION
16. **Please describe the management structure of the scheme.**
   Chairman and vice chairman
   Secretary and deputy secretary
   Treasurer
16. **Is the community involved in scheme management?**
   YES How? Through meetings

18. How many people work on scheme management? 5 (five)

a. Full time NIL
b. Part time? 5
c. Paid/volunteer? NIL

19. Is there a feedback mechanism for scheme members?
Yes, members are reporting to the management about the health services they get

20. Is there a waiting period?
No

21. Are there controls over moral hazard?
YES ID Cards are available for members,

22. Are there controls over adverse selection?
Not yet

23. Are there controls over Fraud?
Yes through auditing

24. Are there controls over cost escalation?
Yes there is treatment guideline

25. How are providers reimbursed for services?
Payment are made after services delivery (monthly)

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?
Yes, prepared monthly

27. Are there income -generating activities that contribute to the scheme?
Informal activities

28. Are there external donor funds or support that contributes to the scheme?
No

29. Are they mechanisms for enrolling indigents?
Yes

30. What are the scheme's major successes to date?
Good inflow of new members, delivering good services (health)

31. What are the major obstacles to sustainability?
Members do not understand the system of risk pooling; delay of services by health care provider

32. What strategies or plans are in place to address the issues above?
raising premiums rate from 500tsh to 1000tsh
To attract new active members

Identification

Name of the Scheme — **Self-Managed Health Insurance Schemes Network**

Year established — 2003

Purpose — Programme lead by a French NGO on a partnership basis with a faith based hospital

Name of respondent(s) — CIDR (Centre International de Développement et de Recherche)

Contact Information

Address — PO Box 2827 Mbeya - Tanzania
Telephone — (+255) 746 515 480
Email — cidrtanzanie@yahoo.fr

Location: Rural/Urban **Coverage:** Geographic/Professional
Initiator: Centre International de Développement et de Recherche (CIDR)
Ownership: Setting up of village based Mutual health organization - 15 schemes in 15 different locations managed by villagers supported by a specialized technical unit
Other Stakeholders:

- Moravian Church Mbozi Hospital (Faith Based Hospital – Health partner and service provider
- EED (sponsor)
- French Ministry of Foreign Affairs (sponsor for the first phase (3 years))
- European union (?)

Brief Background

The program has started 3 years ago. The first 4 schemes were launched in 2003. In 2005, there were 15 established schemes in 15 different villages and 2 school schemes which are gathering around 7 000 beneficiaries. Our strategy relies on group membership. People contribute through groups to a scheme that is managed by an executive board composed by elected people. There is also a board which is in charge of the governance and which is composed by one or two elected people from each group. The premium offered up to now covers high risks, which means hospitalization, surgery and deliveries. After a first year of working, we also added transport in our package and this decision boosted our results in terms of penetration. We also changed our strategy, which was first based on hamlet groups to include also coffee grower's group contribution. At last, thanks to a reasonable amount of accrued reserves in some schemes, we will enlarge our coverage to basic treatments for the coming year of services.

Management

3. **What is the enrollment mode (Individual, Household, Group, Institution)?**
   Group (hamlet or coffee growers group)
3. **What is the size of your target population?**
   The target population is 60 377 people in 2006.
4. **What is the population size of your area of operation?**
   The population of our area of operation is 175 000 people.
5. **What are the socio-economic characteristics of your current membership and the community served?**
   We are working in a rural area, where the main crops are as follows:
   Cash crops : coffee, tea (small proportion), Paprika (growing)
   Food crops : Beans, maize, rice

6. **What is the number of Membersand/or Beneficiaries (FY 2003-2005)? Use the table below.**

Year	2003	2004	2005
Members / beneficiaries	211 / 577	1 061 / 3 589	1 586 / 6 841

7. **What does the benefit package include?**
   a. Health education/Prevention care (specify types of preventive care, e.g. family planning, antenatal care, immunization, well child visits, etc.)
      The health education/prevention care is one of the main weaknesses of our programme. There will be an intern working on that area this summer, so that we can quickly improve it.
   b. Out patient care (including hospitalization at a health center) specify services covered
      After three years of working, some of our schemes will integrate OPD services in their cover. But up to now, the existing schemes have mainly covered IPD.
   c. Inpatient care
      IPD, surgery
   d. HIV/AIDS care
      There is no direct HIV/AIDS care, but three actions:
      Treatment of the opportunistic disease for not revealed HIV patients. In our last medical audit, we found that there were 17% of the members covered in 2005 who were suspected to be HIV infected. Training and setting up of HIV/AIDS committee in our target village. Lobbying for an access to ARV treatment at our health partner level (normally agreed for July 2006)
   e. Other services
      The premium includes transport guarantee: in case of emergency, there is an ambulance system. In other cases, payment of the bus fare to the hospital
   f. Family planning

8. **Are there specific exclusions? Please list.**
   No response
9. **How much is the premium?**
   The average contribution for this year is about 2 700 Tsh per person (2.25 USD) / year / person.
10. **Is the premium paid monthly, quarterly or yearly?**
    The premium is paid yearly.
11. **How are premiums collected?**
    Through the group leaders who collect them and transfer them to the Treasurer of the scheme.
12. **Are there co-payments? How much and how are they administered?**
    There is co-payment on transport (1/2 price in case of ambulance use)
    But a lot of difficulties to be reimbursed those co-payments for the moment. There are then becoming compulsory: they have to be paid at the scheme level before receiving any services.
    Furthermore there will be a co-payment set up in the schemes where we are going to launch new products covering OPD.
13. **Reasons for co-payments**
    To reduce the risk of adverse selection and of over consumption

14. What is the scheme income trend for the last three years? Refer to the table below

Income Source	Year 2003	Year 2004	Year 2005
Premiums		8 654 094 Tsh	14 189 070 Tsh
Co-payments		200 000 Tsh	300 000 Tsh
Donors		371 000 Tsh	549 000 Tsh
Others			
Totals		9 225 094 Tsh	15 038 070 Tsh

1 USD = 1 200 Tsh

15. What is the scheme expenditure trend for the last three years? See table below

Expenditure Lines	Year 2004/2005	Year 2005/2006 (Not finished – up to September 2006)
Services claims (medical + transport)	4 784 450 Tsh	3 365 530 Tsh
Running costs	1 330 160 Tsh	1 840 715 Tsh
Other costs		
Totals	6 114 610 Tsh	5 206 245 Tsh

16. What is the legal and regulatory framework of the CBHF? Is the scheme registered?
What are the governing documents (specify)?
The schemes are not yet officially registered. The governing documents are a constitution and an internal regulation in each scheme. There will be soon a SMHIS steering committee to design the network frame.

17. Please describe the management structure of the scheme
Elected people at the village level do the management. There is one meeting every month with the executive committee, which is in charge of the daily management, and one meeting, every two month with the board, which is in charge of the governance. Once a year members give the guidelines during the General Assembly of members. This general assembly, which is the core of the system, may be gathered in case of major problems.

18. Is the community involved in scheme management? How?
The community is managing the scheme. But as the health insurance activities are difficult, CIDR provides them with a Technical support in risk management, and accounting, membership follow up.

19. How many people work on scheme management? Full time/part time? Paid/volunteer?
The CIDR team is currently composed of 3 persons (1 programme manager, 1 coordinator, 1 Field officer) who are all employees by the NGO. In the schemes, members of the community on a voluntary basis do the work. Each board gathers in average 12 people.

20. Is there a feedback mechanism for scheme members?
During the general assemblies, the board presents its results, the financial situation of the schemes and the perspectives. Those assemblies are prepared with the support of CIDR team, who helps the board to clarify the situation and to present the right information so as to give a real feedback to the members.

21. Is there a waiting period?
The waiting period is one month.

22. Are there controls over moral hazard? (i.e. to make sure that there is no over-utilization of the scheme by members)
As we cover only high risks, a preliminary visit at the dispensary is compulsory to get a referral letter. In that case, the SMHIS executive board issues a guarantee letter, which allows the member to be covered at the hospital level.

23. **Are there controls over adverse selection? (i.e. to make sure that it is not just the sick who are joining the scheme – you need both sick and healthy people to join)**
    A household is supposed to contribute for at least 4 of his members. That precaution reduces the risk of adverse selection in our schemes.
24. **Are there controls over fraud? (e.g. to prevent non-members from accessing services through the scheme)**
    Each scheme issues membership cards with a picture of the beneficiaries. The control of those cards is done at the executive board level (issuance of the guarantee letter) and at the hospital level, which has been very cooperative since the beginning of the programme.
25. **Are there controls over cost escalation? (i.e. to make sure that the care provider, e.g hospital, does not increase costs to the scheme by over-charging or providing unnecessary care)**
    The schemes have signed a contract with the hospital, which include a range of lump sums (flat rates) for the different services. There is then no interest for the hospital to over-prescribe.
26. **How are providers reimbursed for services?**
    The services are invoiced every two months to the schemes, which are paid by bank transfer.
27. **Are statistics on service utilization by members, membership and finances available? How regularly are they prepared?**
    Yes, there is a monthly follow up and monitoring of the frequencies at the hospital level. The system is relatively easy for the moment as we are only with one health provider.
28. **Are there income-generating activities that contribute to the scheme? Please describe**
    No
29. **Are there external donor funds or support that contributes to the scheme?**
    If yes, please give name of donor and contact information.
    There is no direct support to the schemes, but CIDR helps them to start their activities by providing them
    - A set of furniture
    - A cell phone (for ambulance call)
    - The 1rst year rent for their office

    In addition, CIDR provides allowances (0.8USD/person) for every Board meeting (one every two month). These allowances will be transferred soon to the SMHIS management.
    What kind of support does the donor provide?
    The main support is then for the Technical support, the setting up of the network, the launching of new schemes in the area of intervention.
30. **Are there mechanisms for enrolling the poor? Please describe**
    There are not any procedures to help people, but at the end of the year during the general Assembly, if the results are financially speaking well, members define an amount to cover the contribution for the poorest in their community.
31. **What are the scheme's major successes to date?**
    - Membership growth
    - Services cover and the improvement of the health care system in the area.
    - Financial good situation (49% of reserves).
    - Commitment of the elected people in their structures
32. **What are the major obstacles to sustainability?**
    - Running costs of the technical support
    - Increasing costs of the health care in the faith based hospital in Tanzania
    - HIV AIDS
    - Voluntary work

33. What strategies or plans are in place to address the issues above?

- We have to pool the costs of the technical support on a large number of beneficiaries: we should then increase our membership and extend our area of intervention.
- We are lobbying to include our hospital in the national programme against HIV/AIDS so as to benefit from free treatment for infected people.
- Step by step we want to increase the level of contribution so as to grant the commitment of the board members. That may represent 5% of the members' contribution.

For the prices at the hospital level, there are not so many things we can do, except to negotiate a discount from our health partner. To strengthen the power of negotiation of our schemes, we want to set up a network, with one elected representative.

Identification

Name of scheme — **Bima ya kujiwezesha (BAK) Self managed Health Insurance Schemes (SMHIS) CIDR Muungano Group Insansa**

Year established — July 2003

Purpose — To meet Health needs of people in Lungwa village, Mbozi

Name of respondent(s) — Mr Rasron Nyondo

Address — P.O.BOX 132,Isansa Mbozi Mbeya Or Laurent Lushinge

P.O.Box 3668 Mbeya 0744606228

Telephone — 0745337158

Email — Laurentlushinge @yahoo.com

Location: Rural/Urban Rural

Coverage: Geographic/Professional_

Initiator: CIDR

Ownership: SCHEME MEMBERS

Other Stakeholders: EED. French cooperative

Brief Background

Population:	Mbozi District 515270 (census2002)
Economy:	Mainly depends on agriculture and livestock.
Av. annual income:	Per person is tsh 73300 and family income is 513100.
Cost of hospitalization;	Transport costs 7020(41%). Hospital 6730(39%), Food 2440(14%), others1010 (6%)
Constraints to health care:	PHYSICAL accessibility; distance, lack of vehicles and bad roads. FINANCIAL Accessibility; problem of marketing and seasonal nature of income The problem of finance corresponding to rainy season during which cases of malaria and pneumonia are most frequent.
Advantages of SMHIS:	Services improved due to availability of funds to buy drugs, equipment, reagents etc. Time to seek medical care minimized and therefore morbidity/mortality decreased and economy improved

Management

1. **What is the enrolment mode (Group, Household)?**
   No response
2. **What is the size of your target population?**
   515270
3. **What is the population size of your area of operation?**
   570 members
4. **What are the socio-economic characteristics of your current membership?**
   Depend on agriculture and livestock
5. **What is the number of Members and/or Beneficiaries for the FY 2003 - 2005? Use the table**

	Year 2003	Year 2004	Year 2005
Total			570

6. **What does the benefit package include? (Tick)**
   - a. Health education/Preventioncare
   - b. Out patient care (including hospitalization at a healthcenter) V
   - c. Inpatient care
   - d. HIV/AIDS care
   - e.Other services
   BED REST

7. **Are there specific exclusions?**
   Surgery, complicated delivery and c/s, transportto hospital onlyand transport for dead bodies
8. **What is the premium amount?**
   Tsh10000/=
9. **Is the premium paid yearly?**
   no response
10. **How are premiums collected?**
    Directly to the treasure of the scheme
11. **Are there co-payments? How much and how are they administered?**
    NO
12. **Reasons for co-payments?**
    NO
13. **What is the scheme income trend for the last three years? Refer to the table below.**
    No response
14. **What is the scheme expenditure trend for the last three years? See table below**
    No response
15. **What is the legal and regulatory framework of the CBHF?**
    a. Is the scheme registered? YES
    b. What are the governing documents (specify)?

16. **Please describe the management structure of the scheme.**
    Chairman and Vice chairman
    Treasurer and assistant
17. **Is the community involved in scheme management?**
    YES
18. **How many people work on scheme management?**
    - d. Full time NIL
    - e. Part time? V
    - f. Paid/volunteer?NIL
19. **Is there a feedback mechanism for scheme members?**
    No response
20. **Is there a waiting period?**
    NO
21. **Are there controls over mo ral hazard?**
    Yes, ID cards for members
22. **Are there controls over adverse selection?**
    Not sure
23. **Are there controls over Fraud?**
    YES, the use of ID cards for members
24. **Are there controls over cost escalation?**
    YES, The use of ID cards for members
25. **How are providers reimbursed for services?**

HCP Deliver the invoice/cross checking/ payment

26. Are statistics on services utilization by members, membership and finances available? How?

regularly are they prepared?

YES, anually

27. Are there income -generating activities that contribute to the scheme?

NO

28. Are there external donor funds or support that contributes to the scheme?

Yes, EED, French cooperation

29. Are they mechanisms for enrolling indigents?

NO

30. What are the scheme's major successes to date?

To get known by the society and people externally

31. What are the major obstacles to sustainability?

Poor contributions (premiums) and covering the targeted population

32. What strategies or plans are in place to address the issues above?

To overcome poverty by promoting income generative activities in rural areas. To encourage solidarity within members

Identification

Name of scheme	**ELCT/NWD-CBHF, Kagera Region**
Year established	2001
Purpose	The initial motive was to enable communities in services, areas of ELCT/NWD to access health care and as means of generating income to sustain ELCT Health facilities financially.

Name of respondent(s) Mr. Joseph Lulinga

Contact Information

Address P.O.BOX 98, Bukoba

Telephone 0741503828

Email jlulinga@ hotmail.com/ yahoo.co.uk

Location: rural **Coverage:**

Initiator: ELCT/NWD

Ownership: Community with own board and diocesan CBHF office and staff. The scheme has its own bank account. All cash received are recorded immediately and blanked. The invoices from health units for services rendered are brought monthly at the scheme head office for through scrutiny and then paid accordingly. The are regular meeting of CBHF Committee at Diocesan level at facilities level in which community participation is encouraged to discuss matters concerning the fund

Other Stakeholders: Danish ELC

Brief Background

The scheme covers 6 out 8 districts of Kagera Region; Biharamulo, Bukoba Rural, Bukoba Urban, Chato, Misenyi and Muleba. The total area covers 28.694 sq. Km, which is 73% of the region. The total population is 2,038,888. Declining donor assistance in the 80s and early 90s and inability of the government to sustain health services in the country had put great stress on the church health services whose clients were mostly rural and poor.

There is increase in number of renewals and registration of new number of new members every year.

2001	2002	2003	2004	2005
1536	2391	3183	3580	4120

Marketing has proved to be backbone of this scheme. Useful tool include drama groups, choirs for mobilization and sensitization, brochures, calendars, newspapers, t-shirts, radios and television, church leaders, village leaders, sports competition etc.

CBHF has helped to sustain the health units as membership has reduced debts and absconding. But the CBHF is a new concept and therefore not easily understood by the rural community. There is a high level of poverty due to poor coffee prices in the rural community. Also, there has been confusion since the introduction of NHIF that started at the same time this scheme was taking off. The rural community could not easily differentiate between the two schemes. HIV/AIDS has become a threat to our scheme, since members who are affected are likely to increase the number of patients when they fall sick and therefore consume more revenue /income. HIV/AIDS has an impact on sustainability due to increasing demand and expenditures.

Way Forward:

- To overcome poverty by promoting income-generating activities in rural areas as the source of revenue to pay premiums.
- To encourage solidarity groups for various activities of generating income

- To review premium s so that matches with fluctuating cost of services

Management

1. **What is the enrollment mode (group Household)?**
   No response
2. **What is the size of your target population?**
   2038888
3. **What is the population size of your area of operation? -**
   No response
4. **What are the socio -economic characteristics of your current membership?**
   AGRICULTURAL AND LIVESTORK KEEPERS
5. **What is the number of Members and/or Beneficiaries for the FY 2003 - 2005? Use the table below.**

	Year 2003	Year 2004	Year 2005
Male			
Female			
Total	3183	3580	4120

6. **What does the benefit package include?**
   a. Health education/Prevention careV
   b. Out patient care (including hospitalization at a health center)
   c. Inpatient care
   d. HIV/AIDS care
   e. Other services
7. **Are there specific exclusions?**
   NO
8. **What is the premium amount?**
   10,000 TO 40,000/=
9. **Is the premium paid daily, monthly, quarterly or yearly?**
   YEARLY
10. **How are premiums collected?**
    They are paid directly to the bank account or the officers
11. **Are there co-payments? How much and how are they administered?**
    CO PAYMENT Tsh 300 for outpatient and 500 for inpatients
12. **Reasons for co-payments**
    Covers medications and services which are routinely available on the site at 24 ELCT/NWD and Roman Catholic hospitals, Health centers and Dispensaries
13. **What is the scheme income trend for the last three years?**
    No response
14. **What is the scheme expenditure trend for the last three years? See table below**

Expenditure Lines Year 2003	Year 2004	Year 2005
Medical Claims		
Administration		
Personnel		
Others (Specify)		
Totals		

15. What is the legal and regulatory framework of the CBHF?

Community with board and diocesan CBHF office and staff

a. Is the scheme registered? Yes

b. What are the governing documents (specify)?

16. Please describe the management structure of the scheme.

CHAIRMAN and VICE CHAIRMAN

SECRETARY and DEPUTY SECRETARY

TREASURER

17. Is the community involved in scheme management?

No response

18. How many people work on scheme management?

5(FIVE)

g. Full time NIL
h. Part time? V
i. Paid/volunteer?NIL

19. Is there a feedback mechanism for scheme members?

There regular meeting of CBHF Committee at Diocesan level

20. Is there a waiting period? -

No response

21. Are there controls over moral hazard?

Yes, ID cards for members

22. Are there controls over adverse selection?

NO

23. Are there controls over Fraud?

YES, ID cards for members

24. Are there controls over cost escalation?

Yes, prices are agreed before services with managing health provider

25. How are providers reimbursed for services?

BILLING SYSTEM (MONTHLY)

26. Are statistics on services utilization by members, membership and finances available?

YES ANNUALLY

27. Are there income-generating activities that contribute to the scheme?

No

28. Are there external donor funds or support that contributes to the schemes?

YES Danish, ILC

29. Are they mechanisms for enrolling indigents?

Yes, everybody is allowed to be a member under conditions

30. What are the scheme's major successes to date?

People are aware for the scheme

31. What are the major obstacles to sustainability?

no response

32. What strategies or plans are in place to address the issues above?

To overcome poverty through the promotion of income generative activities in rural areas

To encourage the solidarity of groups for various activities

to review premium so that they match with fluctuating costs

Identification

Name of the scheme	**Aitman Manzese Insurance Health Fund**
Year established	2003
Purpose	Scheme was established after the discovery that community members were facing health problems without the income to pay for treatments.
Name of respondent(s)	CONELIA BENARD (TREASURER) DEO GABRIEL (DEPUTY SECRETARY)
Contact Information	
Address	P.O. BOX 5595 DSM
Telephone	0222400119
Email	

Location: Rural/Urban **Coverage:** MANZESE Geographic/Professional
Initiator MANZESE
Ownership MANZESE /TANDALE /MABIBO
Other Stakeholders

Brief Background

In 2003, a health meeting committee under the Catholic Church, Manzese Parish, examined problems facing the community's health systems. As a result, they decided to introduce a formal way of insuring themselves. They consulted TNCHF to conduct seminars to members and which were done clearly and effectively. In January 2004 they started to register members and by December 2004 they enrolled 36 families with 93 members with positive respond to the scheme. Launching of the scheme was April 2005 under Bishop Kilain.

Management

1. **What is the enrollment mode (Individual, Household)?**
   No response
2. **What is the size of your target population?**
   15000
3. **What is the population size of your area of operation?**
   No response
4. **What are the socio-economic characteristics of your current membership?**
   MIDDLE AND LOW INCOME EARNERS
   INFORMAL BUSSINES OPERATORS
5. **What is the number of Members and/or Beneficiaries FY 2003 - 2005? Use the table below**.

	Year 2003	Year 2004	Year 2005
Male		116	175
Female		125	197
Total	MOBILIZATION	241	372

6. **What does the benefit package include?**
   a) Health education/Prevention careV
   b) Out patient care (including hospitalization at a health center) V
   c) Inpatient care
   d) HIV/AIDS care
   e) Other services

7. **Are there specific exclusions**?

There are specific diseases selected to receive treatment

8. **What is the premium amount?**
   500 TSH Per mongh per head
9. **Is the premium paid daily?**
   No response
10. **How are premiums collected?**
    Contributors submit contributions to treasurer
11. **Are there co-payments? How much and how are they administered?**
    No
12. **Reasons for co-payments**
    No
13. **What is the scheme income trend for the last three years? Refer to the table below.**

Income Source	Year 2003	Year 2004	Year 2005
Premiums	NIL	404100	1329250
Co-payment	NIL	NIL	NIL
Donors	NIL	NIL	NIL
Others	NIL	NIL	NIL
Totals	NIL	404100	1329250

14. **What is the scheme expenditure trend for the last three years? See table below**

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical Claims	NIL	100000	1127325
Administration	NIL	78030	84770
Personnel	NIL	NIL	NIL
Others (Specify)	NIL	NIL	NIL
Totals	NIL	178030	1212095

15. **What is the legal and regulatory framework of the CBHF?**
    a. Is the scheme registered?
       Under umbrella of TNCHF
    b. What are the governing documents (specify)?
       Constitution
16. **Please describe the management structure of the scheme.**
    Chairman and vice chairman
    Secretary and deputy secretary
    Treasurer
17. **Is the community involved in scheme management? How?**
    Yes, through meetings
18. **How many people work on scheme management?**
    5 (five)
    Full time NIL
    Part time? V
    Paid/volunteer? NIL
19. **Is there a feedback mechanism for scheme members?**
    Yes, members are reporting to the management about the health services they get
20. **Is there a waiting period?**
    Yes, 3 month
21. **Are there controls over moral hazard?**
    Not yet
22. **Are there controls over adverse selection?**
    Not yet
23. **Are there controls over Fraud?**
    Yes, through auditing

24. **Are there controls over cost escalation?**
Yes, there are treatment guidelines
25. **How are providers reimbursed for services?**
Payments are made after services are delivered (monthly)
26. **Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?**
Yes, prepared monthly
27. **Are there income -generating activities that contribute to the scheme?**
Informal activities
28. **Are there external donor funds or support that contributes to the scheme?**
No
29. **Are they mechanisms for enrolling indigents?**
Yes
30. **What are the scheme's major successes to date?**
Good inflow of new members delivering of the goods services (health)
31. **What are the major obstacles to sustainability?**
Members do not understand the system and delay of services done by the health care provider
32. **What strategies or plans are in place to address the issues above?**
Raising premiums rates from 500 TSH to 1000 TSH to attract new active members

Identification

Name of the Scheme	**Chanika Atman Health Insurance**
Year established	2001
Purpose	Due to the nature of Chanika, most of the population is poor and can't afford to pay for health care services
Name of respondent(s)	Cleophance Chacha[Treasure]
Contact Information	
Address	P.O.BOX 167 Pugu Parish D.S.M
Telephone	0748546486
Email	

Location: Rural/Urban Chanika **Coverage:** Geographic/Professional
Initiator: Sister Ritta [YNCHF]

Ownership: Atman Insurance (community)

Other Stakeholders: TNCHF and MSOLADA

Brief Background

The scheme started in 2001 with 10 families and now there are 18 families with 78 beneficiaries. There is good flow of contributions from members. Now they are on the process of registering the scheme so as to start benefit with health services (public health centre contract is processed). Consultation from Sister Ritta of TNCHF contributed greatly in organising and setting up scheme.

Management

1. **What is the enrollment mode (Individual, Household)?**
   No response
2. **What is the size of your target population?**
   Open to everybody
3. **What is the population size of your area of operation?**
   No response
4. **What are the socio-economic characteristics of your current membership?**
   Agricultural and informal business operator
5. **What is the number of Members and/or Beneficiaries (FY 2003 - 2005)? Use the table below.**

	Year 2003	Year 2004	Year 2005
Male	52	51	44
Female	49	46	42
Total	101	97	86

6. **What does the benefit package include?**
   a. Health education/Prevention careV
   b. Out patient care (including hospitalization at a health center) V
   c. Inpatient care
   d. HIV/AIDS care
   e. Other services [Explain]

10. **Are there specific exclusions?**
    There are treatment guidelines

8. **What is the premium amount?**
   TSH500/= Per head per month

11. Is the premium paid daily, monthly, quarterly or yearly?
No response
12. How are premiums collected?
Members are volunteering to submit the premium to treasurer
13. Are there co-payments? How much and how are they administered?
No
12. Reasons for co-payments

13. What is the scheme income trend for the last three years? Refer to the table below.

Income Source	Year 2003	Year 2004	Year 2005
Premiums	91500	33000	2500
Co-payment Donors	NIL NIL	NIL NIL	NIL NIL
Others	NIL	NIL	64000
Totals	91500	33000	66500

14. What is the scheme expenditure trend for the last three years? See table below

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical Claims	NIL	NIL	NIL
Administration	NIL	NIL	NIL
Personnel	NIL	NIL	NIL
Others (Specify)	NIL	44000	NIL
Totals	NIL	44000	NIL

15. What is the legal and regulatory framework of the CBHF?
a. Is the scheme registered?
No, they are on process of registration
b. What are the governing documents (specify)?
Yes, there is scheme constitution
16. Please describe the management structure of the scheme.
Chairman and Vice chairman
Secretary and Deputy Secretary
Treasurer

17. Is the community involved in scheme management? How?
No
18. How many people work on scheme management?
5(FIVE)
a. Full time NIL
b. Part time? V
c. Paid/volunteer? NIL
19. Is there a feedback mechanism for scheme members?
There is feedback to the members through meetings
20. Is there a waiting period?
Yes, 3 month
21. Are there controls over moral hazard?
Yes, through awareness creation
22. Are there controls over adverse selection?
No

23. Are there controls over Fraud?
Yes, through management meeting and financial

24. Are there controls over cost escalation?
Yes, there is treatment guideline

25. How are providers reimbursed for services?
Not yet made

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?
Yes, prepared on a monthly basis

27. Are there income -generating activities that contribute to the scheme?
Yes, agricultural and small business

28. Are there external donor funds or support that contributes to the schemes?
No

29. Are they mechanisms for enrolling indigents?
Yes, everybody is allowed to be a member under conditions

30. What are the scheme's major successes to date?
Good inflow of contribution from members. Also, they are members of TNCHF

31. What are the major obstacles to sustainability?
Management system, delaying of health care delivering scheme registration problem

32. What strategies or plans arein place to address the issues above?
Training to the leaders registration process for legal identification to start delivering health services

Identification

Name of the Scheme — **Mfuko wa Afya Atman Yombo**
Year established — 1998
Purpose — Economic problems and the establishment of user fees have caused difficulty for low-income earners to afford health care services. Father Camitions established the scheme to cover medical expenses.
Name of respondent(s) — Maryciana Mwalongo [Treasurer]
Contact information
Address — P.O.BOX 9560
DSM
Telephone
Email
Location: Rural/Urban YOMBO PARISH **Coverage:** Geographic/Professional
Initiator: FATHER CAMILIANS
Ownership: YOMBO CATHOLIC PARISH

Brief Background

The scheme was established 1998 and focused on followers of Yombo Parish. Later on, other members of community [non RC] were welcomed to join the scheme provided that they meet the requirements such as payment of entrance fee, etc. All in all, the scheme was under supervision of father Camilions. In 1999, the health committee of Yombo Parish took over the responsibility of supervising the scheme. THCHF provided training to both leaders of the scheme and to the staff in the programme. It has been concluded that the best way for sustainability of the scheme is to change the system from provider-based to community-based.

Management

1. **What is the enrollment mode (Individual, Household,)?**
   No response
2. **What is the size of your target population?**
   2 wards: Yombo Kilakala and Yombo Dovya
3. **What is the population size of your area of operation?**
   No response
4. **What are the socio-economic characteristics of your current membership?**
   There are informal business operators, formal employees in minimum wage
5. **What is the number of Members and/or Beneficiaries (FY 2003 - 2005)? Use the table below.**

	Year 2003	Year 2004	Year 2005
Male	128	118	85
Female	169	157	108
Total	297	275	193

6. **What does the benefit package include?**
   a. Health education/Prevention care
   b. Out patient care (including hospitalization at a health center)
   c. Inpatient care
   d. HIV/AIDS care
   e. Other services
      MATERIAL SERVICES
7. **Are there specific exclusions**?
   Yes, surgery and circumcision

8. **What is the premium amount?**
500 Tsh per month/per head
9. **Is the premium paid daily?**
No response
10. **How are premiums collected?**
Submitting to collection point [HCP]
11. **Are there co-payments? How much and how are they administered?**
No
12. **Reasons for co-payments**
No
13. **What is the scheme income trend for the last three years? Refer to the table below.**

Income Source	Year 2003	Year 2004	Year 2005
Premiums Co-payment	1318700 NIL	1014000 NIL	760500 NIL
Donors	NIL	NIL	NIL
Others	NIL	NIL	NIL
Totals	1318700	1014000	760500

14. **What is the scheme expenditure trend for the last three years? See table below**

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical Claims	263900	1873000	887500
Administration	NIL	NIL	NIL
Personnel	NIL	NIL	NIL
Others (Specify)	NIL	NIL	NIL
Totals	263900	1873000	887500

15. **What is the legal and regulatory framework of the CBHF?**
a. Is the scheme registered?
Not registered
b. What are the governing documents (specify)?
Constitution
17. **Please describe the management structure of the scheme .**
Chairman and vice chairman
Secretary and deputy secretary
Treasurer and assistant treasure
4 executive members
17. **Is the community involved in scheme management? How?**
No, due to the structure of the scheme, which is provider-based.
18. **How many people work on scheme management?**
a. Full time NIL
b. Part time? V
c. Paid/volunteer? NIL
19. **Is there a feedback mechanism for scheme members?**
There is meeting concluded two times per year which involve all members of the scheme.
20. **Is there a waiting period?**
Yes, 1 month.
21. **Are there controls over moral hazard?**
No.
22. **Are there controls over adverse selection?**

No

23. Are there controls over Fraud?

Their ID cards

24. Are there controls over cost escalation?

Yes, they create awareness to the staff and doctors and other health care providers

25. How are providers reimbursed for services?

Paid monthly after delivery of the services

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

Statistics are prepared monthly

27. Are there income -generating activities that contribute to the scheme?

No

28. Are there external donor funds or support that contributes to the scheme?

No

29. Are they mechanisms for enrolling indigents?

No

30. What are the scheme's major successes to date?

Many people are benefiting from the scheme and programme leaders are participating for various training concerns; HIS

31. What are the major obstacles to sustainability?

Over expenditure decreasing the number of members

32. What strategies or plans are in place to address the issuesabove?

Changing the approach of the scheme from provider-based to community-based mobilizing the community about the importance and package of benefits of the scheme.

Identification

Name of the scheme **Chawana Health Insurance**
Year established 1999
Purpose To insure health services to people with irregular income
Name of respondent(s) Hamisi Mzuzuri [secretary]
Contact Information
Address P.O.BOX 15307 D.S.M
Telephone 07 8 7 41 49 36
Email
Location: Rural/Urban Kariakoo **Coverage:** Geographic/Professional
Initiator: COCONUT SELLER
Ownership Chawana society
Other Stakeholders: Vegetable sellers

Brief Background

Due to the irregular income the population earns, organizers decided to find an easy way to insure health services by sharing the risk through contributions. Health stakeholders and other organizations have influenced the presence of Chawana Health Insurance Scheme through provision of training based on maintaining stability of the scheme and educating members about health Insurance. E.g. SIDO/ILO SSMECA project and TNCH.

Management

1. **What is the enrollment mode (Individual, Household)?**
   No response
2. **What is the size of your target population?**
   To cover low income earners
3. **What is the population size of your area of operation?**
   No response
4. **What are the socio-economic characteristics of your current membership?**
   Irregular income
5. **What is the number of Members and/or Beneficiaries (FY 2003-2005)? Use the table below.**

	Year 2003	Year 2004	Year 2005
Male	50	50	50
Female	54	55	55
Total	104	105	105

6. **What does the benefit package include:**
   a. Health education/Prevention care
   b. Out patient care (including hospitalization at a health center)
   c. Inpatient care
   d. HIV/AIDS care
   e. Other service
   BED REST
7. **Are there specific exclusions?**
   No surgical services and heavy laboratory tests
8. **What is the premium amount?**
   TSH 25/= Per day per head
9. **Is the premium paid daily?**
   No response
10. **How are premiums collected?**
    There is contributions collector

11. **Are there co-payments? How much and how are they administered?**
    No
12. **Reasons for co-payments**
    No
13. **What is the scheme income trend for the last three years? Refer to the table below.**

Income Source	Year 2003	Year 2004	Year 2005
Premiums	648000	744000	763900
Co-payment	NIL	NIL	NIL
Donors	NIL	NIL	NIL
Others	NIL	NIL	40000
Totals	648000	744000	803900

14. **What is the scheme expenditure trend for the last three years? See table below**

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical Claims	399027	550164	1067985
Administration	35040	52740	99125
Personnel	NIL	NIL	NIL
Others (Specify)	NIL	NIL	NIL
Totals	434067	602804	1167110

15. **What is the legal and regulatory framework of the CBHF? Is the scheme registered? What are the governing documents (specify)?**
    Yes, Registration certificate and constitution
16. **Please describe the management structure of the scheme** .
    Chairman and Vice chairman
    Secretary and Deputy Secretary
    Treasurer and assistant
    2 Committee members
17. **Is the community involved in scheme management? How?**
    Yes, partial involved in case of substandard services, they report to management.
18. **How many people work on scheme management?**
    a. Full time NIL
    b. Part time? V
    c. Paid/volunteer? NIL
19. **Is there a feedback mechanism for scheme members?**
    Yes
20. **Is there a waiting period?**
    Yes 3 month
21. **Are there controls over moral hazard?**
    Yes, through awareness creation
22. **Are there controls over adverse selection?**
    Yes. There is treatment guideline
23. **Are there controls over Fraud?**
    Yes, through monitoring process
24. **Are there controls over cost escalation?**
    No response
25. **How are providers reimbursed for services?**
    HCP Deliver the invoice/cross checking/ payment

26. **Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?**
    Yes, prepared annually
27. **Are there income-generating activities that contribute to the scheme?**
    Yes, informal economy operators
28. **Are there external donor funds or support that contributes to the scheme?**
    No
29. **Are they mechanisms for enrolling indigents?**
    No
30. **What are the scheme's major successes to date?**
    Members they are secure with health services
31. **What are the major obstacles to sustainability?**
    Irregular income influence the poor payment of contribution
32. **What strategies or plans are in place to address the issues above?**
    Establishing the credit scheme.

Identification

Name of the scheme — **Migahawa Health Insurance Fund [MIHIFU]**
Year established — 1999
Purpose — Enhance the members of the scheme to access the health care services at an affordable price
Name of re spondent(s) — Halfan Mussa [secretary]
Contact information
Address P.O.BOX 25094
Telephone 0748777674
Email
Location: Rural / Urban ILALA MKT **Coverage:** Geographic/Professional
Initiator: Migahawa cooperative society
Ownership: Migahawa Health Insurance Fund [society]
Other Stakeholders: VIBINDO SOCIETY/ TUJENGE PAMOJA PROJECT/ TNCHF

Brief Background

The population is low-income. The members of the founding group realize the issue of heathcare as the major constraint to their development. The ILO SSMECA project provides information about the insurance system and introduced the risk pooling mechanism as a way to tackle this problem. The members of Migahawa have agreed to establish the health insurance scheme in collaboration with Vibindo /ILLOSSMECCA project/SIDO GTZ. TUJENGE PAMOJA project conducted a training on organising and setting up the scheme.

Management

1. **What is the enrollment mode (Individual, household)?**
   No response
2. **What is the size of your target population?**
   Open to everybody in the society
3. **What is the population size of your area of operation?**
   No response
4. **What are the socio-economic characteristics of your current membership?**
   Irregular income
5. **What is the number of Members and/or Beneficiaries [FY 2003 - 2005]? Use the table below.**

	Year 2003	Year 2004	Year 2005
Male	37	37	38
Female	51	51	51
Total	88	88	89

6. **What does the benefit package include?**
   a. Health education/Prevention care
   b. Out patient care (including hospitali zation at a health center)
   c. Inpatient care
   d. HIV/AIDS care
   e. Other services

7. **Are there specific exclusions?**
   Yes, Treatment guideline
8. **What is the premium amount?**
   Tsh 25/= perday per head

9. **Is the premium paid daily?**
   No response
10. **How are premiums collected?**
    By collector
11. **Are there co-payments? How much and how are they administered?**
    No
12. **Reasons for co-payments**
    No
13. **What is the scheme income trend for the last three years? Refer to the table below.**

Income Source	Year 2003	Year 2004	Year 2005
Premiums	105615	94130	NIL
Co-payment Donors	NIL NIL	NIL NIL	NIL NIL
Others	NIL	NIL	20000
Totals	105615	94130	20000

14. **What is the scheme expenditure trend for the last three years? See table below**

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical Claims	156500	159580	NIL
Administration	37820	NIL	NIL
Personnel	NIL	NIL	NIL
Others (Specify)	NIL	NIL	NIL
Totals	196320	159580	NIL

15. **What is the legal and regulatory framework of the CBHF? Is the scheme registered? What are the governing documents (specify)?**
    Yes, Registration certified and constitution
16. **Please describe the management structure of the scheme.**
    Chairman
    Secretary
    Treasurer
    6 committee members
17. **Is the community involved in scheme management? How?**
    Yes, In case of demand quality of services
18. **How many people work on scheme management?**
    9 people - part time
19. **Is there a feedback mechanism for scheme members?**
    Receipt of health services are reported to the office
20. **Is there a waiting period?**
    Yes, 3 months
21. **Are there controls over moral hazard?**
    Yes
22. **Are there controls over adverse selection?**
    Targeted groups are provided by identity, there are treatment guidelines
23. **Are there controls over Fraud?**
    Yes, by monitoring sch eme weekly/monthly
24. **Are there controls over cost escalation?**
    Yes, due to high cost by health care providers, there is termination of contract plan
25. **How are providers reimbursed for services?**
    Payments are made monthly after health care provider delivers invoice
26. **Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?**
    Yes, prepared monthly

27. Are there income -generating activities that contribute to the scheme?
No

28. Are there external donor funds or support that contributes to the scheme?
No

29. Are they mechanisms for enrolling indigents?
No

30. What are the scheme's major successes to date?
Delivering health services to members

31. What are the major obstacles to sustainability?
Risk -pooling mechanisms are not clearly understood by members. Premium rate is too low to cover cost of services.

32. What strategies or plans are in place to address the issues above?
Educate and mobilize people to join scheme