MANAGING THE COMMUNITY HEALTH FUND

Partnership between Communities and the Government

An Operations Manual

Part One

The Tanzanian Experience

Produced by the Tanzania Ministry of Health with support from ECSA Health Community

Table of Contents

List of Tables

List of Figures

List of Boxes

Citation: Commonwealth Regional Health Community for East, Central and Southern Africa, 2004*:*
Managing Community Health Funds:
An Operations Manual, The Tanzanian Experience. Health Systems Development Programme.

Printed in Nairobi, Kenya.

Foreword

Community Health Fund in Tanzania started as a pilot scheme in1996 in Igunga district. This scheme was a result of studies conducted in 1990-92 which revealed that the majority of people in rural and urban areas were willing to contribute provided drugs were available, medical services improved and contributions were reasonable and affordable by the majority. After evaluation, the implementation experience from Igunga was then used to roll out the scheme to nine more districts. In 2001, the policy decision was reached to cover all districts and is taken as one of the conditions to extend cost sharing in primary health care facilities.

CHF is risk pooling among families in the informal sector. In this respect, each household pays a pre-determined premium once for the medication per year and is issued a membership card. Payment is often made at the time of harvesting or when the season of income has arrived. There is a possibility for a household to pay in two installments. Non-members of the fund pay user fees in return for health care services. Since premiums are in the form of capitation, providers and contributors have the liberty to spend in preventive and promotive services. Moreover, CHF gives an opportunity to providers to increase efficiency due to the fact that contributors have a choice, which creates competition.

The implementation experience in Tanzania is characterized by successes but with different problems depending on the length of implementation in each district. The experience shows there is a significant improvement in the quality of health care services (i.e. availability of drugs, medical supplies and infrastructure). Furthermore, those unable to pay due to social or economic hardship have been identified by communities and protected through the exemption policy.

Studies done in Hanang district revealed that one of the major problems facing CHF in Tanzania is the insufficiency of proper management tools to capture CHF data appropriately which reduces the possibility of making losses. This manual has been prepared for use as a guide to ensure successful operations of the scheme to communities which are in the process of initiating CHF, programmes and improve performance in districts that have started implementing the scheme. The document provides important information to the stakeholders.

CHF is a tool of decentralizing decision-making and management of the health services beyond the district level. It strengthens community participation and ownership of heath services in monitoring quality of services offered to them through health committees.

I hope the users of this manual will find it appropriate as a reference document.

Hon. Anna M. Abdallah, MP
Minister of Health
The United Republic of Tanzania

Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ARI	Acute Respiratory Infection
BOD	Burden of Disease
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Services Board
CRHCS	Commonwealth Regional Health Community Secretariat, for East, Central and Southern Africa
DAC	District AIDS Coordinator
DED	District Executive Director
DHO	District Health Officer
DHS	District Health Secretary
DMO	District Medical Officer
DNO	District Nursing Officer
DPLO	District Planning Officer
ECSA	East Central and Southern Africa
EDP	Essential Drug Programme for Health Centres
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
I/C	In - charge
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illnesses
MCH	Maternal and Child Health
MOi/c	Medical Officer in charge
MOH	Ministry of Health
MSD	Medical Stores Department
MTUHA	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
OHC	Oral Health Care
OPD	Out Patient Department
PHC	Primary Health Care
PHR*plus*	Partners for Health Reform*plus* Project
RHC	Rural Health Centre
RHO	Regional Health Officer
RMA	Rural Medical Aid
RMO	Regional Medical Officer
STD	Sexually Transmitted Diseases
TBA	Traditional Birth Attendant
TB/LP	Tuberculosis and Leprosy
Tshs	Tanzania Shilling
URTI	Upper Respiratory Tract Infection
USAID	United States Agency for International Development
VC	Village Council
VHC	Village Health Committee

VHW	Village Health Worker
WDC	Ward Development Committee
WEO	Ward Executive Officer
WHC	Ward Health Committee

Acknowledgments

This manual was developed through the efforts of both the MOH-Tanzania and CHRCS. The collaborators acknowledge the technical support of PHR*plus* and the timely financial support of USAID/REDSO, Nairobi. In addition, the cooperation of Hanang District CHF Scheme Management and in particular the DMO and the CHMT who tirelessly supported the piloting of this model is highly appreciated. Finally, the consultants and Editors who persistently forged this tool are commended for their efforts and determination to complete this manual.

Ms. Mariam Mwaffisi
Permanent Secretary
Ministry of Health
The United Republic of Tanzania

Dr. Stephen Shongwe
Regional Secretary
Commonwealth Regional Health
Community Secretariat for East,
Central and Southern Africa (ECSA)

Preface

Why This Manual Was Produced

In 2001 the Commonwealth Regional Health Community Secretariat (CRHCS) in collaboration with the Partners for Health Reformplus Project (PHRplus), the Ministry of Health (MOH) Tanzania and the Hanang District authorities undertook a comprehensive assessment of the Community Health Fund and the District Health Systems. The assessment was multidimensional but mainly focused on looking into the overall performance of the Community Health Fund (CHF) scheme and the factors that were critical in determining its growth and eventually achieving its goal as a means of enhancing financing, availability and accessibility of health care services to the communities for improved health status.

The assessment concluded that CHF was a good framework for beneficiary active participation in financing and the management of health care service delivery in the district. However with all of this good intention the management function was not sufficiently effective. It limited the growth of the fund in terms of membership recruitment, effective and efficient utilization of resources, reporting and accountability on programme activities. In other words although CHF programme has great potential in Hanang District and the rest of Tanzania, the realization of this potential was constrained as a result of limited managerial practice.

The study also indicated that the managerial skill gaps could be addressed by imparting the right skills, knowledge and tools of best practices in relation to management and administration of CHF.

A manual was developed to address these issues. The key players were trained and the system was commissioned on a pilot basis in Hanang district in August 2002. A year later a review showed that a substantial amount of improvements in the management of CHF was evident and that its effectiveness in terms of the problems earlier mentioned was significant. With these encouraging results stakeholders of the Community Health Fund felt it was important to develop and improve the tools into an Operational and Training Manual that could be used in scaling up the good management practices in other districts implementing the CHF programme in Tanzania.

How This Manual Was Produced

This manual was developed in a participatory manner involving all key stakeholders. A set of tools was developed and pre-tested for clarity and relevance. Both the CHMT and PHRplus technical staff undertook supportive supervision in the implementation on the management practices. This intervention resulted in improved financial management of the CHF, especially in record keeping and internal control over revenues collected.. Because of this success it was decided that the system and tools should be improved and developed in the form of an Operations Manual, for wider dissemination and application. This success prompted the CRHCS to hold consultations with MOH officials, which recommended the incorporation of other tools developed earlier by the Ministry. This current volume of CHF Operations Manual has therefore absorbed and incorporated the main messages and tools developed earlier.

Who This Manual is for

This manual is written and developed to address the management skill gaps in starting and operating the CHF. The target group for this manual includes both promoters and more specifically the managers of CHF at all levels. Trainers for CHF will also find this manual extremely useful.

Basis for This Manual

Although this manual is tailor made, i.e. developed to suit the Tanzanian design of CHF it can be adopted by other countries in ECSA wishing to start a community-based health financing (CBHF) scheme similar to the CHF that involves partnership between the community and government. It is important to note that there are other community health financing schemes in Tanzania which are provider or community-initiated. Specifically, a number of church related hospitals have started their own CBHF schemes.

Dr. Mark Bura, Coordinator,
Health Systems Development
ECSA Health Community

1. Concept and Design of Community Health Fund

1.1 Overview of Community Health Funds in Tanzania

Tanzania like many other developing countries in sub-Saharan Africa has been experiencing a serious crisis in financing her health care. All stakeholders in the health sector of Tanzania, including households, health providers, non-governmental organizations and donors aim at reducing the burden of disease through more efficient, equitable and sustainable systems of care. This is indeed a focus of the revised Health Sector Policy for Tanzania.

The trend of health financing in Tanzania shows that despite the increasing population and magnitude of burden of disease, the expenditure on health has remained constant and has declined in real terms during the past decade. Poverty and low economic growth in the past decade has contributed to this situation.

The budgetary resource allocations to the health sector are far from being sufficient to pay for the essential inputs for the production and delivery of health care services. These financial constraints have negative effects on the delivery of service, availability, accessibility and quality of both preventive and curative health services. In addition, the health care delivery system in Tanzania suffers from gross inefficiencies, inequalities and lack of financial sustainability.

- Inefficiency *shows itself in two forms.* First, *physical infrastructure, facilities and staff time are underutilized because most of the time they are idle due to inadequate drugs, medical supplies or necessary equipment.* Second, *people have a tendency of jumping the referral system and going directly to district, regional and tertiary hospitals for ailments which otherwise could have been treated at primary level units just because services are free at those levels. The cost of providing treatment for these conditions is higher at district, regional and tertiary units than at primary level units.*

- Inequalities *occur because in many instances, drugs and other medical supplies are available only for a period of one or two weeks in a month soon after the regular delivery of drug kits. The rest of the time, the number of patients treated or utilizing health services falls drastically. Only those who can afford it may go to a private health facility.*

- Lack of Financial Sustainability *is another problem facing the health sector. In the absence of drugs and medical supplies, services are not offered and equipment and infrastructure are run down without provisions for replacement or repair.*

However, even with large amounts of funds to improve the supply-side and improve efficiency, equity and financial sustainability, these reforms cannot on their own effectively improve the delivery of health services to the grassroots, without the community becoming active participants and owners of the reforms.

The community health fund in Tanzania therefore focuses on achieving the demand-side response in terms of creating an environment and in particular an opportunity for the community, the consumers of health services to participate in and own the health service delivery process. The funds generated through user fees and prepayments into the CHF are used locally to improve (renovate) infrastructure, procurement of supplementary drugs and medical supplies. *The CHF and user fee programme is not intended to replace the government funding for health services but rather complement it, hence it is not an alternative financing but a complementary financing*.

The Health Sector Reforms in Tanzania have focused on reforming the financing of the health sector as one of the eight strategies of the reforms.

1.2 Objectives of the CHF

According to the CHF Act, the objectives of CHF are:

- *"to mobilize financial resources from the community for provision of health care services to its members;*
- *to provide quality and affordable health care services through a sustainable financing mechanism; and*
- *to improve health care services management in the communities through decentralization by empowering the communities in making decisions affecting their health"*.

1.3 Design of the Community Health Fund

The Community Health Fund in Tanzania is a pre-payment scheme, which offers a client (household or individual) the opportunity to acquire a "health card" after paying a premium. The card enables members and eligible household to access a basic package of curative and preventive health services.

The premiums may be paid in two equal installments. Those members of the community not willing to join the prepayment scheme participate in the CHF, by paying a user fee when they visit a health facility for any chargeable service.

The design of the CHF aims at meeting the community health service needs in a rural situation where there is an extensive network of public facilities and few private facilities in the rural areas.

This scheme is considered to have the potential of ensuring greater security of access to health care, empowering households and communities in health service management decisions and promoting partnership and local participation in health care financing.

CHF and the District Health System:

The CHF is linked to the public or government health facility network in the respective district with cardholders having access to any public service delivery point in the district. However private voluntary health facilities and in very special cases private for profit facilities may be accredited to provide services to CHF members. The fund contributes to the district health service budget. The district supports the fund through supervision and guidance.

The District Hospital is primarily meant for referral although the outpatient department is open to communities residing in the vicinity of the hospital. The public health facilities have to ensure that they have appropriate equipment, standard drugs and are adequately staffed.

1.4 Implementation Status of CHF

Since CHF was conceived in 1994/95, consultations held with communities and individuals, revealed that CHF was received positively. This is particularly so because for most rural people, incomes are seasonal while sickness is unpredictable. CHF provides an opportunity for communities to pay premiums when they have money and access health services whenever they fall sick. CHF prepayment and user fees are available and people have the choice of how to pay for health services.

The CHF concept was originally pre-tested in Igunga District, Tabora region. The initial success of the scheme was rolled over to nine other districts. By April 2004, twenty-three districts were operating CHF in Tanzania.

Evaluations done on CHF have confirmed its usefulness in enhancing availability, accessibility and quality of health care services. In response to these findings, the Community Health Fund Act was enacted by parliament of the United Republic of Tanzania in 2001. This act paved the way for other districts to adopt the scheme and their number is increasing all the time.

1.5 Implementation Concerns and Challenges

The community Health Fund as a financing mechanism is designed to improve access to health services through the pooling of financial risks. However, the last eight years of experience have shown that despite being acceptable to the communities, there are concerns and challenges that need to be addressed.

1. Low Enrollment

The original design of the scheme recommended that at least 65% of households should enroll in the scheme in any particular district or locality for the scheme to be successful. This has not yet been achieved and in fact the maximum that has been reached for the best district is 30%. Membership has actually leveled off at about 10% on average. There has been a high turn-over of membership because of dropouts but new members are joining the scheme at the same time. Several reasons contribute to the drop out and low recruitment rates. These include:

- *Misconception of the whole idea of solidarity. When a member has contributed in a particular year and does not fall sick, the contribution is considered to be a loss.*
- *The flat rate premiums for households are considered to be unfair for single persons or families without children, making user fees more attractive.*
- *Competition with the NHIF which is taking some members who would otherwise have enrolled in the CHF.*
- *Poor marketing and community mobilization have also been obstacles to membership.*

2. Setting the Right Premium

The membership premiums or contribution rates are in most cases set arbitrarily without active participation by the members. They may be too high in relation to the economic status of the potential members. In some districts, members prefer payments of premiums by installments. Others prefer payment in kind. However, due to the increased challenges these methods of payment would pose, payment in cash is generally adopted and members are allowed to pay in one or two installments.

3. Over-Utilization of Health Services

There has been abuse of health facility utilization by some scheme members. In some cases members consistently visited health facilities for minor complaints. Regular visits to facilities may be harmful to the scheme or may be a good indicator that people are accessing health care services. In some cases, cards may be borrowed by non-members due to the lack of a comprehensive identification system. This situation, usually referred to as "moral hazard" is a risk that needs to be controlled to guard the scheme from financial loss.

4. Management Gaps

While CHF is expanding or being rolled over to other districts very fast*, the management skills have not been growing at the same pace*. A review in Hanang District has identified a number of management gaps, which could undermine the achievement of the goals of the Fund. This management manual and the accompanying tools aim at addressing the management skills gap.

5. Sustainability

Sustainability of CHF depends very much on continued membership growth, strict financial management and fund administration. The financial sustainability will also depend on the benefit package and its support through government subsidies and donor input.

1.6 CHF Success Factors

Despite the risks and concerns outlined in the previous section, experience gained in the implementation of community based health financing schemes in Tanzania and elsewhere has shown that various factors or prerequisites, if in place, will result in enhanced success of such a scheme. These factors can be divided into demand and supply side factors. The demand side factors refer to community socio-economic and health-seeking behavior. On the other hand, the supply side factors refer to the provision of health services, provider, staff and finance. The following are some of these factors.

1. Demand Side Factors

The pre-requisites or success factors from the demand side includes among others:

- *A conducive economic and social environment which facilitates potential participants to have the capacity to put money aside and accept relinquishing ownership of the amounts of their contribution in order to protect themselves against certain risk. A person who is pre-occupied with day-to-day survival may not consider entering a prepayment scheme such as CHF. Potential CHF members will be those able to go beyond short-term survival economics.*

- *Cohesive societies, which have practiced some sort of solidarity schemes such as credit, burial and wedding associations, are fertile grounds for CHF.*

- *Other success factors include appropriate premium level, absence of fraud, adverse selection and moral hazard.*

2. Supply Side Factors

The following are some of the supply factors that are likely to lead to successful CHF schemes.

- Availability of quality health services. *People are not prepared to pay in advance for poor quality healthcare or for care they are not sure to receive. Membership will be low if the target population does not have confidence in the health facility.*

- Integration of the scheme into the district health system*. Staff of the formal health system must be motivated to support CHF. Potential members will not subscribe to a system where the staff is not supportive or responsive.*

- *Adequate support from the district authorities and other key stakeholders.*

- Cost containment *in health service provision that will reduce chances of exhausting the CHF.*

- *Low administrative costs.*

It is important to note that success will be achieved in schemes if demand, supply and management factors go hand in hand.

2. Setting-up, Structure and Operation of CHF

2.1 Setting-up Community Health Fund

2.1.1 Introduction

This chapter describes the pre-requisites for setting-up CHF in a district, the structure and its organization. It ends by introducing the procedures for the operations of CHF, the details of which will be described in Chapter 3.

2.1.2 Pre-requisites and Enabling Conditions

The success of CHF depends on the stewardship role of the government coupled with active participation of communities and individuals. For CHF to succeed, the following conditions are important.

Genuine Community need and Expressed Priority: The community members have to be made to understand that CHF will provide a solution to the members' financial barriers to health care services. It should be seen as a priority need for the improvement of their welfare. As such the social marketing, advocacy and awareness raising requirements at the community level is quite intensive during the initial phase.

Emphasis on Solidarity and Trust: The question of solidarity is not new in traditional Tanzanian societies especially for people living in the same village sharing the same socio-economic conditions. People express solidarity during cultivation of farms, funerals and weddings.

Peoples Confidence in CHF: Communication of the concept of CHF should be clear, consistent and understandable by the communities to win their confidence on CHF.

Quality Health Care Services: Communities have witnessed drug shortages, unfriendly staff and run-down buildings in the recent past. With the health facilities in such a state, people might not find it worth to joining CHF. Communities must be made to understand that CHF will enhance improvement of health care quality and the District Council must demonstrate their commitment by ensuring sufficient drug supply before asking people to contribute. The other aspect in relation to quality and the link to government health facilities is that all facility staff must be sensitized and made to understand the concept of CHF so that they can become effective disciples.

2.1.3 Feasibility of CHF

The feasibility study is an important aspect of setting-up of CHF in a particular district. It is the first step. The study may be brief or based on similar generic studies done before.

General Feasibility

The general feasibility will primarily focus on the pre-requisites of establishing CHF in a particular district. The feasibility has to provide answers to the following questions.

- *Are there access problems to health services and specifically seasonal due to variability of income?*
- *What is the quality of the available health services?*
- *Is there an unmet demand for health services because there are not enough facilities or appropriate service?*
- *What are the main community priorities?*
- *What are the priority health problems of the target population?*
- *What health services should be covered by CHF?*
- *What are the socio-economic conditions and characteristics of the target population?*
- *What is the seasonal pattern of income accrual?*
- *What is the level of solidarity among the community members?*
- *Existence of other complimentary financing options.*

Answers to these questions should lead to the general conclusion of whether CHF is feasible in the particular district in question. It should specifically enable one to arrive at the decision of whether the community and individuals will accept or agree to contribute and support CHF.

Financial Feasibility

The financial feasibility is an integral part of the general feasibility study. Financial feasibility is for assessing under what financial conditions the Community Health Fund can be viable. It also assesses the financial needs, sources of possible funds and the costs to provide the health care services as defined by the benefits package, the revenues that are needed and can be expected.

The financial feasibility should provide answers to the following:

- *The socio-economic status of the target population*
- *Their sources of income*
- *Whether the income is regular or seasonal*
- *Household expenditure priorities*
- *Willingness and ability to pay*
- *Cost of providing health services*

- *Financial gap to determine subsidies*

Premiums and benefit package will then be determined by applying answers to the issues addressed above.

2.1.4 Determining Benefits Package[1]

The *first step* in costing the benefits package is to define the contents (or what it includes). For example, a typical package would include.

- *Consultation with the doctor or clinical officer including registration and diagnostic services*
- *Drugs or pharmaceuticals and other supplies*
- *Hospitalization*

The *second step* is to calculate the cost per unit of providing these services. Because getting the best approximate figure requires a lot of statistical calculations, the average value is quite appropriate. Using the three categories of benefits packages outlined above, one would need to know precisely.

- *The average cost of consultations (including diagnostic services) per CHF member (OPD)*
- *The average cost per prescription, per CHF member*
- *The average costs of hospitalization, which may be per day (this may also include surgical costs).*

The *third step* is to estimate the consumption or utilization rate of these services. That is worked out by finding the proportion of members likely to use these services. For example, it could be estimated that each member will make three outpatient visits and 6 - 8% of members will be hospitalized in a year.

The *fourth step* is to work out the total costs of benefits for all members in the scheme, which may be the district, ward or village.

This is done by using the figure of estimated level of utilization for each category of services and multiplying them with the estimated cost per unit. The total benefits costs of the scheme can be obtained by summing up the results of these calculations.

[1] The assumptions used in this section are hypothetical. In ideal situation actuarial assumptions based on utilization rates are used. In Tanzanian CHF the term *contribution* rather than the *premium* applies to Community Health Funds but is used to mean the clients contribution to National Social Health Insurance Fund (NSHIF). Premiums are determined by the management of NSHIF while CHF contributions are determined by communities within the districts. Generally CHF contributions vary between 5,000 and 10,000 Tanzanian Shillings (TShs) per annum.

Table 1: Illustration on How to Find the Cost of the Benefits Package

Benefit A	Average unit cost B	Average annual utilization C	No. Of members D	Utilization level E	Total costs (B x E)
Consultations (OPD)	**3,500**	**3**	**3,000**	**9,000**	**31,500,000**
Hospitalization (Admissions)	**5,000***	**4%**	**3,000**	**120**	**600,000**
Total cost of benefits package					**32,100,000**

*NB: Assumes average length of Stay of 7 days.

Using the example in Table 1 above,
The average benefits package cost per member is TShs. 32,100,000/3,000 = 10,700

2.1.5 Overall CHF Costs and Determining Premiums Levels

In principle, premiums are determined by considering the cost of benefits package just as worked out in the example above. So, in this case, the premium per CHF member should be TShs. 10,700.

However, two other elements must be considered. In order for the scheme to operate sustainably, it must also cover its own administrative costs as well as maintain a reserve to cushion it against future losses. Some schemes set aside a regular amount to cover this contingency reserve. The calculation of costs should therefore ideally include these two items as shown below:

Total costs

Assuming that the operating or administrative costs add up to TShs. 1,500,000; and the reserve fund is pegged at TShs. 3,000,000. The overall or total costs can be worked out as shown in the table below.

Table 2: Calculating Total Costs

Cost item	Estimated Cost	No. of Members	Cost per Member
A	**B**	**C**	**D = B/C**
Benefits	32,100,000	3,000	10,700
Operating or Administrative Costs	1,500,000	3,000	500
Reserves	3,000,000	3,000	1,000
Estimated Total Scheme Costs	36,600,000	3,000	12,200

The total costs of the scheme, including reserves, per CHF member and a full cost recovery premium is TShs. 12,200 per year.

Members of Community Health Fund are entitled to coverage of a minimum package of health care services at primary level. The cost of health services and benefits package will shape the premium structure. To encourage membership some non-monetary benefits or incentives such as preferential treatment or fast track while visiting health facilities or special rooms when admitted are sometimes provided by similar funds in some districts of Tanzania. A standard basic benefits package of health services in Tanzania is summarized in Table 3.

Table 3: Tanzania CHF Standard Basic Benefits Package of Health Services

Service Type	Dispensary/Health Centre Level	First Referral/Hospital Level
Reproductive and Child Health Care	▲ *Antenatal care* ▲ *Delivery* ▲ *Postnatal care* ▲ *Immunization* ▲ *Micronutrient* ▲ *IMCI* ▲ *Family Planning Services* ▲ *Well baby and child care*	▲ *Obstetric and Gynecological care including Caesarian Section* ▲ *Complicated Pediatrics*
Communicable Diseases	▲ *Diagnosis and treatment of common diseases such as malaria, STDs, Cholera, TB etc.*	▲ *Outpatient and impatient care for severe disease condition*
Non-Communicable Diseases and Trauma	▲ *Diagnosis, treatment and referral*	▲ *Outpatient and inpatient care for severe cases* ▲ *General surgery*
Clinical Support Services	▲ *Essential Drug Supply* ▲ *Basic Diagnostic services*	▲ *Advanced Diagnostic services such as X-ray and Ultra Sound.*

Source: Tanzania CHF operations guidelines.

Costing of Benefits Package

The cost of providing the minimum benefits package should be determined and there are various methods for doing this. Alternatively, there are costing studies, which have been done to determine the costs of providing the minimum essential health care package at the district level. This essential health care intervention package (EHIP) should ideally guard the determination of the benefits package for CHF members. The per capita costs of providing the essential health care package adjusted for inflation could be a good pointer or indicator of the level of premium, which CHF members could contribute.

2.2 Structure and Organization of the Community Health Fund

The Tanzania CHF scheme is based on a partnership arrangement between the community and government. The management and operation of CHF has been left to the communities and their structures. The government provides technical and financial support and allows the use of its network of health facilities in the district.

The partnership has the following characteristics.

- *The Central government has a Secretariat that supports CHF technically and financially.*
- *CHF uses existing government infrastructure such as offices, equipment and staff at no extra cost.*

- *The government structure is used to support the community structure at the respective level. For example, at the district level, the district authorities support the Council Health Services Board, which is a community structure with the responsibility of managing CHF in the district among other health management responsibilities. At the ward and village level, the respective CHF structures are supported by peer government structures at this level.*

- *The CHF is not part of the exchequer; funds generated are deposited in a local bank account, which is managed by the community members themselves using government financial regulations and control.*

- *The government has a stewardship role and has set up a legal framework to support CHF policy.*

It has been mentioned earlier that the Community Health Fund in Tanzania is a joint venture or partnership between the public sector network of health facilities and the communities in the respective districts. The organization structure therefore follows a framework which is similar to the organization structure of the district public service.

2.2.1 Organization Structure

The CHF organization Structure builds on existing structures of government operations to avoid building new and parallel structures.

The legal entity or unit of operation of CHF is the district; in many other schemes in Tanzania the legal entity of operation is the provider. The lower level facility or ward level units subscribe to the larger district unit. The following are the key structures of CHF in a district:

The Council Health Services Board

It is part of the council subcommittee on education, health and water i.e. the Social Service Sub-committee. The Council Health Management Team advises the Board.

At the sub-district level the following are the CHF structures:

The Ward Health Committee

This committee deliberates on all health activities at the ward level. It is a structure, which ensures community participation. It is assisted by the Council Health Services Board.

The Facility Health Committee

This committee is charged with the responsibility of managing the health services delivery process.

2.2.2 Responsibilities of Various Structures and Stakeholders

The President's Office, Regional Administration and Local Government

- *Supports the implementation of health policies and strategies*

- *Allocates government funds for purchasing drugs for the health centers and dispensaries.*
- *Oversees the District Council in the supervision of CHF*
- *Endorses by laws.*

Ministry of Health (MOH)

- *Develops and disseminates health policies, operational guidelines, regulations and standards*
- *Trains Health personnel*
- *Mobilizes resources for health*
- *Promotes the implementation of CHF*
- *Provides technical support*

Regional Secretariat

- *Provides technical assistance to district committees*
- *Links and advises on the health development activities for the districts in the region*
- *Receives, analyzes reports and provides feedback to the district*
- *Supports the districts in developing comprehensive District Health Plans*
- *Monitors adherence of districts to Ministry of Health' s guidelines*
- *Monitors and evaluates progress being made on CHF activities in the districts*

Local Authorities and Councils

- *Provide operational guidelines for health activities to Council Health Services Board*
- *Provide guidelines that facilitate ownership and management of the fund*
- *Receive CHF management report*
- *Guide the Council Health Services Board to submit various reports as required*
- *Ensure that Council Health Services Board is autonomous in management of CHF*
- *Ensure that Council Services Board works harmoniously with other implementing agencies such as Ward Committee, Health care providers, Councilors and CHF members*
- *Social marketing of CHF to communities.*
- *Ensure funds are available for health development activities in the district*

- *Ensure that essential drugs, vaccines and medical supplies are timely available.*

Council Health Services Board (CHSB)

- *Responsible for overall routine monitoring of CHF operations.*
- *Works in consonant with CHMT to ensure quality care and professionalism.*
- *Administers, mobilizes funds and open bank account.*
- *Sets exemption policy and targets for CHF.*
- *Reviews reports from Ward Committees and other sources.*
- *Monitors and makes verification on collection, expenditure and control of funds.*

Council Health Management Team (CHMT)

- *Monitors activities of both private and public health facilities*
- *Sets a mechanism of monitoring and evaluation of CHF*
- *Assures quality of services provided*
- *Supervises all health activities in the District*
    - Assesses performance of the referral system
    - Provides technical advice on CHF activities and progress to CHF District Board
    - Arbitrates grievances with clients, community and health providers
    - Receives and acts on report from village health committees, WEO and DMO on client satisfaction
    - Carries out supervision visits on a monthly basis to check prescription procedures, what has been collected, use of registers, use and storage of drugs and any other issues pertaining to the operation of the scheme as the need may arise.
- *Prepares quarterly reports*
- *Develops comprehensive council health plans.*

Ward Health Committee (WHC)

- *Mobilizes communities to join CHF.*
- *Prepares membership lists and supervise the collection of fees.*
- *Reviews specific cases and situations of their communities.*
- *Monitors the level of contributions and user-fee revenues.*
- *Reviews CHF operations, makes recommendations and takes remedial actions.*

- *Initiates and coordinate community health planning.*
- *Implements and monitor the community health plans.*
- *Organizes bi-annual general meetings of members.*

2.3 Procedures for Community Health Fund Operation

Procedures for operating the CHF should be clearly laid down. The following section introduces the operations and management procedures. Experience has shown that good management protocols enhance the performance of schemes. This is further described in Chapter 3.

2.3.1 Membership

Definition

A CHF member is someone who belongs to CHF and abides by the rules that govern CHF operations, and has paid their dues. A member may include a certain number of persons directly dependent on him/her for utilizing CHF health care benefits package. These people are called dependents and their number is decided by the Council Health Services Board in collaboration with the communities in the district. Membership is here defined on the basis of a household.

Dependants

It is important at the outset to accurately identify the standards that define dependant status. This is particularly critical because the numbers of eligible dependants may have a substantial financial impact on the Community Health Fund. Defining dependants is a sensitive decision that may depend on local customs.

CHF in Tanzania generally accepts the following as dependants.

- *Spouse*
- *Children up to the age of 18 years*
- *Orphans and other people residing in the household*

However, for cases of polygamy, it is considered that the number of households equals the number of wives.

Registration Procedures

Once an individual (or household head) has decided to join the Community Health Fund he/she will approach the nearest health facility and pay the required combined membership fees and annual premium. This fee covers the registration costs and the membership card, which is issued immediately to the member. Members bring with them passport size photos that are affixed to the smaller card. The member keeps the smaller card and the main card is left behind. A receipt is issued to acknowledge receipt of funds. The member also provides names of all dependants who are then listed on the main card.

Contribution rates may vary and can take any form such as:

- *The member and dependants pay the same dues*
- *The dependants pay lower dues than the member*
- *Two dues rates are used: one for persons with dependants and the other without dependants*
- *Dues per household are exactly the same regardless of the number of dependants. This is the option which is currently used in Tanzania.*

Exemption Policy for the CHF Card

Membership is open to all, however certain people may not be able to pay the required contribution. These are orphans, destitute or elderly people with no one to care for them. These persons will however *NOT* be denied medical care. An exemption policy and procedures have been defined and should be followed. The process to exempt a person or persons follows steps outlined below.

- *The village council or its committees should identify people who are very destitute (i.e. the poorest of the poor)*
- *The list is forwarded to the Ward Health Committee for further scrutiny*
- *Once endorsed, the list is forwarded to the Council Health Services Board which will issue CHF membership card for those people to access health care services.*

In exceptional cases such as accident victims, non-CHF members who are critically ill (life threatening status) and have no money to pay user fees are considered for exemption.

2.3.2 Procedures for Accessing Health Services

Members upon arrival at an accredited health facility will produce their membership card at the registration desk (for larger units e.g. hospitals and health centers) or to the clinical officer or Nurse who is attending to them. Upon being satisfied that the card shows the membership is valid, the clinical officer will attend to them and provide the required services. The person attending to them will record the transactions in the patient register as usual indicating the membership number. A member and their dependants will access health services as long as their membership is valid.

2.3.3 Financial Management Procedures

All districts implementing the Community Health Fund programme must establish and maintain a separate bank account for CHF fund. All CHF premiums, user fees and other contributions such as matching grants from the government should be deposited in this account. The DMO has the responsibility for CHF banking transactions and record-keeping. The DMO should maintain a ledger for each ward or health facility.

Expenditure of CHF Money

The Ward and communities themselves will use CHF money according to approved budgets that originate from a comprehensive health plan developed in a participatory manner. The ward or facility health committees will periodically request purchases of items or any other expenditures according to the approved budget.

Expenditure is authorized by CHSB following the laid down financial regulations.

3. CHF Management Systems

3.1 Introduction

Management in any organization involves mobilizing, planning, organizing, leading, and overseeing the use of all available resources efficiently in carrying out the activities in order to achieve its goals. Managers of Community Health Funds (CHF) need to employ effective management practices by establishing operational systems and tools that will ensure efficient utilization of resources. Managers should also ensure that operating procedures are clearly defined and documented in a user-friendly form, which are periodically revised and updated.

CHF operating procedures are the steps and activities that take place in the process of enrolling members, collecting their contributions, subsequent custody and disbursements, accessibility of member to health care services and tracking utilization of services.

This chapter sets out procedures for effective management of the CHF at the district and health facility level. It describes activities that support general management of the CHF, as well as financial accounting and basic self-auditing procedures.

3.2 General CHF Management Responsibilities

3.2.1 CHMT Role and Responsibilities

The CHMT supports, supervises and monitors management of the CHF in the district. Specific CHMT management responsibilities are as stated in the box below.

Specific Records maintained at CHMT/ DMO's office include the following:

- *Membership cards*
- *Membership Register*
- *Receipt Books*
- *Cash Book*
- *Financial ledger*
- *Monthly Status Report Summary*
- *Stores Ledger*

Box 1: CHMT Management Responsibility in CHF

- *Distributing CHF membership cards, registers and receipt books to health facilities;*
- *Collecting, recording and depositing premiums and user fees from health facilities into the bank account.*
- *Recording and tracking all CHF account deposits, withdrawals, and payments*
- *Compiling and analyzing CHF data;*
- *Supervision of financial management records*
- *Conducting monthly supportive supervision visits to all health facilities; both public and private in the district.*
- *Documenting and reporting to the DMO any problems found during supervisory visits or grievances raised by facility staff or community members;*
- *Facilitating wards to prepare ward health plan*
- *Notifying the health facilities of any expenses (e.g. allowances or fees) deducted from the CHF account*
- *Preparation and submission of quarterly comprehensive council health reports.*
- *Preparation of Annual Comprehensive Council Health Plans.*

3.2.2 Health Facility Responsibilities

The health facility staff is responsible for the sale of membership cards and registration of members. In addition, they record CHF membership data, collect premium and user fees as further specified below.

Specific health facility management responsibilities include:

- *Sale of CHF membership cards*
- *Documentation of accurate premiums and user fees transactions and maintain up-to-date records using the following tools.*

Box 2: CHF Management Tools

- *Patient Register*
- *CHF Membership Register*
- *CHF member card filing system*
- *CHF and user fee receipt books*
- *CHF Financial Ledger*
- *CHF Daily Status Report*
- *CHF Monthly Status Report*
- *User fee and CHF membership fee receipt books*
- *Indent system records*

- *Tracking the collection, use, and balance of CHF funds in the CHF Financial Ledger.*

- *Filing deposit receipts issued by the District Accountant.*
- *Educating the community about CHF and use of CHF funds.*
- *Convening meetings of the Ward Health Committee and acting as Secretary to the committee.*
- *Facilitate the development of participatory health plans.*

This operations manual will describe how each of these records is to be maintained by the health facility:

3.3 Purchasing and Recording CHF Membership

Any patient visiting a CHF-participating health facility (HF) may choose to pay for services by paying user fees, purchasing a CHF member card, using an existing CHF membership or using their NHIF membership card if the facility accepts NHIF patients. The CHF member card entitles the member's household to a basic package of services at any CHF-participating HF in Hanang District for one year or six months if only half the membership fee is paid.

3.3.1 Procedures for Purchasing and Issuing a CHF Member Card

Steps

1. The HF staff retrieves a blank CHF member card, the CHF receipt book, and the CHF Membership Register.
2. The purchaser pays to the HF staff 100% of the annual CHF membership fee, or 50% of the fee upon agreement that the remaining 50% will be paid within 6 months.
3. The HF staff fills in and signs a receipt from the CHF receipt book and gives a copy to the new CHF member.
4. The HF staff enters the required household information on a blank CHF member card and asks the new CHF member to provide two pictures of the household. When provided, the pictures are to be placed in the designated space on the CHF member card kept at the facility and on the card issued to the CHF member.
5. The purchase date, amount paid, the remaining membership fee balance, and the receipt number are entered on the bottom portion of the CHF member card kept at the facility. The HF staff then signs this portion of the card.
6. The HF staff must clearly note the EXPIRATION DATE (day/month/year) of the membership purchased on the member's portion of the CHF card. If 100% of the membership fee was paid, then the expiration date should be one year from the date of purchase. If only 50% of the membership fee was paid, then the expiration date should be 6 months from the purchase date.

7. On the reverse side of the member's card, the HF staff should record the list of household members covered by CHF and the expiry date.

Before issuing the new member his/her CHF card, the HF staff must enter the required information on the new CHF member in the CHF Membership Register (see below).

3.3.2 Recording a CHF Member in the CHF Membership Register

Steps

1. The HF staff enters the CHF card number, date of purchase, household information and expiry date.

2. In the column headed, "Membership Type", the HF staff indicates whether the CHF member is a new member purchasing membership for the first time (N) or is renewing a membership (R).

3. The HF staff then enters the amount paid and CHF membership balance remaining after this transaction. If the full annual membership fee was paid, then a balance of zero should be indicated in the appropriate column. If only 50% of the balance was paid, then the remaining 50% should be indicated.

4. If the full balance was paid, then today's date (the date of purchase) should be indicated under "Date Paid in Full". If only 50% of the balance was paid, then this column should be left blank until the remaining 50% is paid.

3.3.3 Special Procedures for Payment of a CHF Membership in Two Installments

Steps

1. The HF staff must inform the purchaser that the CHF membership will expire in 6 months if the remaining payment is not received within 6 months.

2. The **expiration date** (6 months from purchase date) MUST be marked on the CHF member card issued to the purchaser.

3. When the second installment is received, the HF staff issues a receipt to the CHF member indicating that he/she has paid the remaining balance.

4. The HF staff looks on the member's card to find the CHF card number and finds (i) the member's entry in the **CHF Membership Register** and (ii) the **CHF member card** on file at the health facility. See example of Membership register below.

5. In the **CHF Membership Register**, the date, receipt number and amount of the second installment payment is indicated in the same box as the initial amount paid.

6. The remaining balance is changed to zero and the date of the second installment payment is noted under "Date Paid in Full".

7. After the new information is entered in the CHF Membership Register, the HF staff indicates on the portion of the **CHF member card** kept at the facility the date and amount of the second installment payment and the receipt number. The HF staff then signs the card in the appropriate box.

8. Lastly, the HF staff writes the new expiration date on the **CHF member card** held by the CHF member. The new expiration date is six (6) months from the date of the second installment payment (or one year from the date of the first payment).

Figure 1: CHF Membership Register

CHF 1

HANANG DISTRICT HEALTH FACILITY

CHF Membership Register

CHF Card No.	Date paid	Receipt Number	Name	Ward	No. of HH members	Membership Type N=New, R=Renewal	Expiry Date	Amount Paid	Balance	Date paid in full
3085	1/7/2002	16001	Gakunju	Dawar	8	N	30/6/03	10,000	0	1/7/2002
3086	1/7/2002	16002	Abubakar	Dawar	10	R	31/12/02	5,000	5,000	
3087	2/7/2002	16003	Abed	Dawar	7	N	1/6/2003	10,000	0	2/7/2002
3088	2/7/2002	16004	Suleiman	Dawar	8	R	1/6/2003	10,000	0	2/7/2002
3089	3/7/2002	16005	Shirima	Dawar	10	N	2/1/2003	5,000	5,000	

3.4 Maintaining Membership Cards

Steps

1. All CHF member cards should be filed in numerical order by CHF card number.

2. At the end of each month, the In-charge must discard all CHF member cards that have expired. To figure out which cards have expired the facility In-charge can look at each CHF card individually or look at the **CHF Membership Register**:
   - △ All memberships that were paid in full one year ago should be discarded.
   - △ All members who paid 50% of the membership fee six months ago and have not paid the remaining 50% should be discarded.

3.5 Recording Payment Information for Patients

All CHF and user fee transactions must be recorded at the time of the transaction.

3.5.1 Recording Patient Transactions in the Patient Register

The last column of the patient register is used to record information about the method of payment used for services rendered and the daily total of all fees collected at the facility. This new column should be added to both the Outpatient and Inpatient Registers.

Steps

1. The HF staff records the type of payment used by each patient in the "Method of Payment" column. There are five "methods" of payment:
   - △ Payment of the user fee (Papo kwa Papo) – enter **'P'** along with the receipt number
   - △ Use of a CHF member card – enter **'CHF'**, along with the CHF card number
   - △ Exempted from user fees – enter **'E'**
   - △ Patient is unable to pay because of poverty or promises to pay later or is a revisit that is non-chargeable – enter **'No Payment'**
   - △ Patient is a member of the NHIF – enter **'NHIF'** along with the NHIF member number.
2. See Figure 2 below for an extract from a patient register. Please note: the format of this Patient Register will change when the new indent system is introduced. The new system will contain more information on diagnosis and drugs prescribed.

Figure 2: Patient Register

CHF 5

HANANG DISTRICT HEALTH FACILITY
Patient Register

Visit No.	Date	Name	Village/Street	Age	Sex	Diagnosis	Prescription	Method of Payment (Papo kwa papo = P E = Exempt; CHF; No payment; NHIF
1	1/7/2002	Thuo	Dawar	22	F	Malaria		NHIF # 0063201
2	1/7/2002	Mwangi	Dawar	45	F	Skin rash		CHF - #03059
3	1/7/2002	Gakunju	Dawar	34	F	Machete wound		CHF - #03085
4	1/7/2002	Mapunda	Dawar	40	M	Cough		P - #15633
5	1/7/2002	Musa	Dawar	20	M	Malaria		No payment - pay later
6	1/7/2002	S. Ngoi	Dawar	1	M	Eye infection		CHF - #03100

3.5.2 Preparing a Receipt for All User Fees Paid

A receipt from the user fees receipt book must be given whenever receiving any cash from patients for user fees.

3.5.3 Daily Recording and Reconciliation of Fees Collected

All CHF and user fee transactions must be reconciled at the end of the day. The reconciliation ensures that any problems are identified right away and can be corrected or resolved immediately. For the reconciliation to happen smoothly, it is important that the cash for the day is kept separate from cash collected on previous days.

3.5.4 Daily Reconciliation of Fees Collected

At the end of each day the In-charge will complete the CHF Daily Status Report. The purpose of this record is to make sure that cash received is reconciled to the number of patients seen at the facility that day and to make sure that a receipt was issued for all cash received. By doing this every day, the In-charge will be able to identify right away any problems and can resolve them while the memory is still fresh about the transactions of the day.

Figure 3: CHF Daily Status Report

HANANG DISTRICT HEALTH FACILITY *CHF 2*

CHF Daily Status Report

Facility: _____ **Month/Year:** _____

Date	NUMBER OF PATIENTS												REVENUE			
	User Fees		CHF		NHIF		Exempt		No Payment		Total Patients		User Fees Collected Today	CHF Fees Collected Today	Other Fees Collected Today (Including late user fees)	TOTAL FEES
	Today	Month to-Date	Today	Month to-Date	Today	Month to-Date	Today	Month to-Date	Today	Month to Date	Today	Month to-Date				
1	2	2	5	5	0	0	0	0	1	1	8	8	2,000	15,000	0	17,000
2	2	4	3	8	0	0	0	0	1	2	6	14	2,000	20,000	0	22,000
3	3	7	1	9	0	0	0	0	0	2	4	18	3,000	5,000	0	8,000
4																
5																
6																

Steps

1. At the end of the day, the facility In-charge counts the total number of patients in the Patient Register, noting the totals separately for those paying user fees, CHF members, NHIF members, exempt patients, and those who make no payment (e.g. some re-visits; poor; those treated on credit to pay later). The In-charge then records them in the CHF Daily Status Report.

2. The In-charge makes sure that for each patient paying a user fee, a receipt number is noted in the Patient Register.

3. The In-charge makes sure the total amount collected in user fees matches the total of the user fee receipts.

***QUICK CHECK**: Multiply the number of patients paying user fees by the fee per patient. That should give you the same amount as you got from adding up the receipts. If it is different, please find out why and make correction or explain. For example, are there patients who did not pay the full amount?*

4. The In-charge retrieves the **CHF Membership Register** and counts the number of new CHF memberships sold during the day. The In-charge then records the number of CHF membership fees that should have been collected on that day.

5. The In-charge makes sure that the amount that should have been collected in CHF membership fees matches the total of the CHF receipts issued that day.

***QUICK CHECK**: Multiply the number of memberships paid for by the membership fee. If there were partial payments, calculate these separately and add the two totals together. The grand total should give you the same amount as you got from adding up the receipts. If it is different, please find out why.*

6. The In-charge then records amount of user fees, CHF membership fees and any other fees collected from patients during the day. The amounts are recorded in the **CHF Daily Status Report** in the columns headed "**User Fees** ", "**CHF Fees**" and "**Other Fees**"

7. The In-charge transfers information from the Daily Status Report (CHF 2) and the Membership Register (CHF 1) to the financial ledger according to the Financial Ledger procedures in Section 3.7.

3.5.5 Rules for Daily Reconciliation

- *Problems that cannot be resolved during daily reconciliation should be noted and reported to the DHMT as soon as possible. Examples of such problems include:*
  - Cash in hand does not match the total amount collected according to Patient Register and CHF Membership Register plus the balance brought forward at the beginning of the day.
  - Total funds collected do not match receipt books.

3.6 Depositing Funds at the DHMT

Funds collected at the HF should be deposited at the DHMT on a regular basis. A facility In-charge can deposit funds at the DHMT headquarters or with a DHMT member during a monthly supervisory visit. The HF In-charge should ensure that funds are properly recorded at the facility and with the DHMT.

Steps

8. The In-charge depositing funds should present to the DHMT member the following:
   - User fee receipt book, indicating the range of receipts for which cash is being deposited.

- △ CHF receipt book
- △ All funds being deposited

9. The DHMT member counts the total funds to be deposited and checks it against the total of all CHF and user fee receipts since the last deposit.

10. If the funds do not match, the DHMT member must review the **Patient Register** and **CHF Membership Register** to verify the amount in user and CHF membership fees that should have been collected since the last deposit was made. The review would entail the following:
    - △ In the patient register, the DHMT member checks to see if for every patient paying a user fee there is a corresponding receipt number.
    - △ The DHMT member then calculates the total amount of user fees that should have been collected based on the number of user visits.
    - △ In the CHF Membership Register, the DHMT member calculates the amount of CHF membership fees that should have been collected, based on the number of new members since the last deposit was made.
    - △ The DHMT member checks to see if the amount of CHF membership fees that should have been collected matches the total of all CHF receipts.
    - △ The DHMT member should notify the DHMT immediately of any problems that could not be resolved during this review process.
    - △ The DHMT should document and keep a record of all such problems.

11. The DHMT member marks the last user fee receipt and CHF receipt being deposited and indicates the date of deposit on the receipt.

12. The DHMT member issues a receipt (or, in the absence of a receipt, any other officially recognized evidence of cash received) to the In-charge indicating that the funds were received. The receipt should indicate the date and total amount of funds deposited.

13. The In-charge records the date and amount of the deposit in the **CHF Financial Ledger**.

3.7 Maintaining the CHF Financial Ledger

As stated earlier, the Financial Ledger tracks the collection, use and balance of CHF funds. All user and CHF membership fees collected should be recorded in the CHF Financial Ledger on a daily basis. In addition, deposits, expenditures, and matching grants received should be recorded in the CHF Financial Ledger.

The Financial Ledger is shown below in Figure 4.

Figure 4: Financial Ledger

Hanang District
Financial Ledger

Facility: XXXXX

	CASH ON HAND			BALANCE OF CHF FUNDS		
Date	**Details**	**Daily Fees Collected**	**Cash on hand**	**Deposits**	**Expenditures**	**CHF Account Balance**
5/08/02	Opening Balance					2,048,464
6/08/02	Fees collected	15,000	15,000			
7/08/02	Fees collected	10,000	25,000			
8/08/02	Deposit fees		0	25,000		2,073,464
8/08/02	Petty cash				20,000	2,053,464
8/08/02	Fees collected	20,000	20,000			
9/08/02	Building materials				253,000	1,800,464

NOTE: The total amount of monthly petty cash should be recorded as an expenditure on the ledger and subtracted from the balance. An itemized list of how the petty cash was spent should be recorded on a separate ledger. **All petty cash should be kept separate from cash from fees collected**.

Steps

1. User fees and CHF membership fees collected must be recorded in the CHF Financial Ledger **at the end of every day**.

2. Total cash on hand must be recorded at the end of each day. Total cash on hand includes the amount stored away in the lockbox (safe) and the amount collected during the day.

3. The date and amount of user fee and CHF membership fee deposits with the DHMT must be recorded after the deposit is made.

4. All expenditures must be recorded in the CHF Financial ledger as they occur.

5. The DHMT must give the health facility written documentation of all withdrawals made from the CHF account, including withdrawals made for CHF Board allowances, bank fees, etc. All these expenditures must be recorded in the CHF Financial Ledger.

6. The DHMT must inform the health facility of the date and amount of all matching grants received from the government and deposited into the CHF account.

7. As soon as deposits and expenditures are recorded in the CHF Financial Ledger, a new balance should be calculated.

3.8 Month-End Record Keeping and Reconciliation

The CHF Monthly Status Report records utilization, CHF membership, and fee collection information on a monthly basis. The information entered into the CHF Monthly Status Report is based on the Patient Register, CHF Daily Status Report, CHF Membership Register, and the CHF Financial Ledger. The Worksheet is to be filled in on last day of each month. Figure 5 is an extract from the CHF Monthly Status Report:

Figure 5: CHF Monthly Status Report

CHF 3

CHF Monthly Status Report

Health Facility: XXXXX **Year: 2002**

Month	Number of Patients						CHF Membership				Fees Collected			Total Collected
	User fees	CHF members	NHIF Members	Exempt	No Payment	Total No. of patients	New	Renewal	Expired	Total Active	User fees collected	CHF fees collected	Other collections (including late user fees)	
							Continuing members from last month →			30				
Jan.	150	200	0	20	2	372	2	4	1	35	20,000	50,000	0	70,000
Feb.														
March														
Dec.														
TOTAL														

Steps

1. At the end of the month, the In-charge records the following based on information in the **CHF Daily Status Report**:
   - △ Total number of user fee patients
   - △ Total number of CHF patients
   - △ Total number of NHIF patients
   - △ Total number of exempt patients
   - △ Total number of patients who were unable to pay at the time of service
   - △ Total number of patients
2. The In-charge enters this information into the first six columns of the CHF Monthly Status Report.
3. The In-charge retrieves the **CHF Membership Register** and counts the number of CHF members who purchased a new or renewed membership. This information is entered in the "CHF Membership" columns of the CHF Monthly Status Report.

*Remember to **DISCARD EXPIRED MEMBERSHIP CARDS**, as described in Section 2.4. To figure out which cards have expired the facility In-charge can look at each CHF card individually or look at the **CHF Membership Register**:*

- *All memberships paid in full one year ago should be discarded.*
- *All members who paid 50% of the membership fee six months ago and have not paid the remaining 50% should be discarded.*

4. The In-charge then enters the total number of current CHF members. The CHF Active Members" at the end of the month is the Total Active (i.e. "Continuing") at the end of the previous month **plus** the **N**ew and **R**enewals, **Less** Expired. This calculation can also be confirmed by using the steps in Box 2 below. The number of CHF cards should equal the Total Active members at all times.

5. The In-charge picks the total amount of user and CHF membership fees collected during the month **from the CHF Daily Status Report**. This amount of user fees and CHF membership fees collected during the month, and the total of all fees collected, are entered into the appropriate boxes.

6. The In-Charge sends an extract of the Monthly Status Report to the District Accountant by the 5th of the following month (for example report for January should be submitted by 5th February).

Box 3: How to Calculate the Total Number of CHF Members on a Monthly Basis

Total Members Last Month
+ Expired Members
+ New Members
+ Renewing Members
= Current Members

Steps:

1. In the **CHF Membership Register**, count the number of memberships that have expired. To do so, count all members who:
   - *paid 100% of the CHF membership fee one year ago; and*
   - *all members who paid 50% of the membership fee 6 months ago and have not paid the balance.*
2. Subtract the number of expired memberships from the Total CHF members last month. The total number of CHF memberships last month is recorded on the **CHF Monthly Status Report** in the column "Total to-date"
3. Add to this sub-total, the number of members who joined this month as new or renewing members. This is the total number of current members

3.9 Procedures for DHMT Supervision Visits

The DHMT is responsible for supervision and monitoring of the CHF, as well as responding to problems regarding the CHF at the facility and ward levels. During the monthly supervisory visits to CHF-participating health facilities, the DHMT member is required to review the following for completeness and accuracy:

- *Patient Register*
- *CHF Daily Status Report*
- *CHF Membership Register*
- *CHF Financial Ledger*
- *CHF Monthly Status Report*

The DHMT member should document all problems encountered and report them to the DMO as soon as possible.

This section contains detailed steps, as well as a supervision checklist that should be completed by the DHMT during every visit to a CHF-participating facility.

Steps

1. Patient Register.
    - The DHMT member reviews the Patient Register to see if for every user fee patient there is a corresponding receipt number.
    - The DHMT member also reviews the register to see if for every CHF patient, there is a corresponding CHF card number.
2. CHF Daily Status Report
    - The DHMT member looks through the CHF Daily Status Reports to make sure that they are filled in daily.
    - The DHMT member randomly selects 3 days to check if the daily total of fees collected matches the number of user fee patients and CHF memberships paid for on that day.
3. CHF Membership Register and Member Cards
    - The DHMT member calculates the amount that should have been collected in CHF membership fees for the current or previous month and checks if it matches the total amount of CHF receipts for that period.
    - The DHMT member checks wether the CHF cards are filed by card number and if expired cards have been discarded.

4. CHF Financial Ledger.

- △ The DHMT member reviews the CHF Financial Ledger to see if the In-charge is recording all information in a complete and timely manner. This includes fees collected, expenditures, deposits, and the balance of the CHF account. Specific question to be answered are:
- △ Are there daily entries for user and CHF fees collected?
- △ Are all deposits made to the DHMT noted?
- △ Is the balance up to date?
- △ For the 3 days chosen for the review of the Patient Register above, the DHMT member checks to see if the daily total of user fees collected and recorded in the Daily Status Report (CHF 2) matches the CHF Financial Ledger.

5. CHF Monthly Status Report

- △ The DHMT member checks the entries in the Monthly Status Report (CHF 3):
- △ Have all amounts been correctly transferred from the Daily Status Report?
- △ Is the Total number of CHF members being calculated correctly? See Box 2 for how to check the calculation of number of CHF members.

Figure 6: CHF Supervision Checklist

Hanang District
CHF Supervision Checklist

Date of Supervision: _____

Facility Visited: _____

Person(s) doing supervision: _____

7. Are the CHF membership cards kept in order by card number? Y___ N___
8. Is the total number of CHF members calculated correctly (See Box 1)? Y ___ N ___
9. For the last month, does the number of new CHF members on the CHF Monthly Status Report = the number of new members from the receipt book = the number of new CHF Cards? Y__ N ___
10. Are deposits to the DHMT noted in the Financial Ledger? Y___ N___

Select Three Days for Detailed Review:

Enter selected dates on column heading			
Number of User Fee Patients			
x User Fee (e.g. 1,000 or 1,500, etc) =			
Does this match the daily total on Patient Register? (Y/N)	YES / NO	YES / NO	YES / NO
Was an entry made in the financial ledger? (Y/N)	YES / NO	YES / NO	YES / NO
Number of new CHF members that day			
x CHF Fee (10,000) =			
Was an entry made in the financial ledger? (Y/N)	YES / NO	YES / NO	YES / NO

4. Management of General Stores: Equipment, Drugs and Medical Supplies

4.1 Introduction

Management of resources for the Community Health Fund is critical and should be done diligently. CHF resources include drugs, equipment and other supplies. Effective management of these resources requires clearly laid down procedures and standards. The disposal of capital items should also follow similar procedures. Regular maintenance and servicing are in addition a critical component of resources or stores management.

4.2 Procurement

Procurement and acquisition is a critical activity of resource management. Thorough research of price, quality and appropriateness of all goods should be done before procurement.

Procurement should follow the Tanzania Procurement Act of 2001 and other such procurement regulations at the council level.

The district tender committee should be used for large value purchases. All purchases should be according to the approved comprehensive health plans and upon request from the communities through their committees. The Council Health Services Board normally approves such plans.

4.2.1 Requisition

The officer, unit, department or facility requiring an item or items has to complete a Purchase Requisition Form, a sample of which is illustrated in Figure 7.

The Purchase Requisition Form should be approved by the appropriate authority and will be presented to the stores department. This department will determine if the commodity is in stock and will subsequently issue it if it is in stock. Otherwise the requisition is presented to the Purchasing Unit for further action.

Figure 7: Sample Purchase Request or Delivery Form

Purchase Request Form **Box 4.1**

Department Requested ……

Requested By ……

Date ……

S/N	Equipment/Supply	Quantity	Price per Unit	Amount	Remarks
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
Total					

Total Amount in words Shillings ……

Requested By ……

Approved by (Print Name) ……

Signature ……

Date ……

4.2.2 Purchasing

Purchasing begins by making selection, requisition, followed by securing a Purchase Order for ultimate purchase of required items.

The process of purchasing should follow the procedures as defined in the Tanzania Procurement Act of 2001, usually through competitive bidding. A supplier is authorized to supply goods either by a Local Purchase Order (LPO) (See Figure 8) or a supply contract agreement.

Figure 8: Sample Purchase Order (PO)

Purchase Order (PO)

Name of Supplier ……..……..……
Reference (Tender Purchase Request No.) ……
Date ……..…….

S/N	Equipment/Supply	Quantity	Price per Unit	Amount	Remarks
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
Total					

Total Amount in words Shillings ……..……
Approved by (Position/Title) ……..……..……..…
Signature ……..……..….
Date ……..……..
Approved by (Position/Title) ……..……..……..….
Signature …….
Date ……..……

4.2.3 Delivery

Once a local purchase order or agreement has been issued, the supplier has the obligation to deliver all specified commodities.

Upon delivery all purchased goods must be entered in the stores or equipment ledger. "The Goods Received" note should be completed when receiving commodities a sample of which is shown in Figure 9. The Goods Discrepancy Form, Figure 10 should be completed in case there is any discrepancy, damage etc. to goods delivered.

Figure 9: Sample Goods Received Note

Ministry of Health

Goods received note No. …...

Name of supplier: ……..…….
Supplier invoice No. ……..……
Transporter: ……..……..
Boxes in shipment: ……..……
Received by: ……..……..

Supplier delivery note ……..
Supplier receipt No. ……..……..
Driver: ……..……
Boxes received: ……

Condition of items received

Items ordered but not received

Order form	Description	Ordered	Received

Items with close expiry date (3 months)

Description	Quantity

Received by (Name and Title) ……..
Signature
Witness 2: Name

Signature

Witness 1: Name: ……..…….
Signature
Witness 3: Name: ……

Signature Date: ……./ ……./ …….

Figure 10: Discrepancy

Discrepancy

Breakages						
	Invoice	Code	Item Description	Unit	Quantity	Received
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Invoiced but missing						
	Invoice	Code	Item Description	Unit	Quantity	Received
1						
2						
3						
4						
5						

Over-issued						
	Invoice	Code	Item Description	Unit	Quantity	Received
1						
2						
3						
4						
5						
6						
7						

Other						
	Invoice	Code	Item Description	Unit	Quantity	Received
1						
2						
3						
4						
5						

Received by (Name and Title) …….. Witness 1: Name: ……..……

Signature Signature

Witness 2: Name Witness 3: Name: ……

Signature Signature Date: ……../ ..……/ ……

4.2.4 Assets Inventory Ledger

Purchasing assets and or equipment requires maintaining and managing records. One such record is the assets inventory ledger. This inventory should be supported by periodic physical counts or verification and valuation. A typical inventory ledger page is as shown in Figure 11.

Figure 11: Sample Inventory Ledger

Inventory Ledger

Folio …….

Type of Equipment ……

Date	To/From	Incoming	Outgoing	Balance	Remarks

4.2.5 Bin Cards

Bin cards are used for purposes of tracking down received goods and issue of items from the stores. The card has columns which show the date when the item is received together with brought forward balances to show the current stock. The current stock is deducted when items are issued. A sample bin card is shown in Figure 12.

Figure 12: Sample of Bin Card

Ministry of Health Code number: ……..
Year: ……

Name of item: ……..……

Unit of issue: ……

Maximum stock level: …… Minimum stock level: ……

Average monthly consumption: ……. Re-order level: ……

Ledger folio: ……..

Date	Receipt/ Issue Voucher	Received from/ Issued to	Expiry Date	Quantity			Signature
				Received	Issued	Balance	

4.3 Issue of Supplies

All supplies and equipment must be issued against a requisition order. The storekeeper in turn provides an issue voucher. A sample stores issue voucher is as shown in Figure 13.

Figure 13: Sample Issue Voucher

Issue Voucher

Date ……...

Delivered to ……..…….

Department/Unit ……..……

Reference/Approval No. ……..……

S/N	Item	Quantity Requested	Qty Issued	Remarks

I certify that I have received the above items in good order.

Received by (print name) ……...……..

Signature ……...…..

Date ……..……...……..……

Once goods have been issued they should be indicated in the Bin Card and stores ledger.

4.4 Management of Drugs and Medical Supplies (Indent System)

Management of these important resources encompasses processes, which include selection, quantification, purchasing, storage, distribution and their use. Previously most of these functions were undertaken by the center through MSD (using the drug kits). The facilities especially dispensaries and health centers were only involved in their utilization. However with the introduction of the indent system in Tanzania, facilities (health centers and dispensaries) will be fully involved in executing these functions of selecting, quantifying, and requisitioning through their respective councils.

4.4.1 Management Tools

The following are the tools for the management of Drugs and Medical Supplies. It should be noted right from the beginning that tools specifically relating to drugs and medical supplies should be used in conjunction with the complete set of tools for the management of facility health care system.

These tools include, patient registers, CHF membership cards, cash receipts, daily status reports and monthly status reports.

4.4.2 Description and Use of Management Tools

Order Form

The order form, which has the drug list, is used to order drugs and medical supplies from MSD.

- *The order form which is filled in four copies(A,B,C,D) is used to monitor the movement of orders from the facility to the District (DMO), MSD/ZMS and back to the facility via the (DMO).*
- *The list also provides free space for ordering and giving reasons for ordering of "additional drugs" which are specifically needed for the HC/Dispensaries catchment area.*

Order Process

Before ordering drugs, the following information should be at hand:

- *MSD price list or catalogue*
- *Data on actual utilization of drugs for the last three months (you can get this information from the dispensing register and patient injection register)*
- *Data on drugs available in the store (look into the ledger and the "actual stock position"*
- *Data on the pattern of diseases in your service area and seasonal variations*
- *Credit Note of previous cycle if any.*

Note: All responsible staff should jointly undertake the order preparation exercise.

Steps to follow and tasks to be done

A: At the Health Facility

Use the data above to calculate the requirements for the health facility for the next order cycle (three months). Then record these quantities in the order form.

- **Quantification of order**

The following formula can be used to calculate how much to order.

- **Data required**
  - Monthly consumption = MC
  - Stock in hand = SI

Figure 14: Sample Order Form

MSD Order form

Name of Health Facility: ……

District: ……

Region:…….……..…….

Client code MSD……

MSD code	Description of item	Unit	Qty to order	Qty issued	Price	Value of Order
	Drugs					
	Acetylsalicylic Acid, 300mg,tabs					
	Allopurinol, 100mg, tabs					
	Aminophyline, 100mg, tabs					
	Aminophyline, 25mg/ml, inj					
	Amitriptyline, 25mg, tabs					
	Amoxycillin, 250mg, tabs					
	Amoxycillin, 500mg, tabls					
	Amoxycillin, syrup					
	Ampicillin, 1gr/ml, inj					
	Ampicillin, 500 mg/ml, inj					
	Atropine, 1mg/ml, inj					
	Bendrofluazide, 5mg, tabs					
	Benzathine Penicillin, 2.4mul, inj					
	Benzoic Acid Compound ointment					
	Catheters and tubes					
	X-ray products					
	Miscellaneous					
	Management tools					
	Local stores requisition and issuing form					
	Goods received note/discrepancy form					
	Ledger book					
	Bin cards					
	Prescription form					
	Exchequer receipt					
	Exemption voucher					
	Hospital use voucher					
	Daily dispensing register					
	Daily collection register					
	Money-transfer-slip					
	Stock taking sheet					
	Drug revolving fund report					
	Inventory Record					

Example

If stocks show that there are 350 units and the monthly consumption is 80 units while it takes 3 months to get next supply the quantity to order is calculated using the following formula.

Quantity to Order:

(1)	Q	=	6months x MC -	SI
(2)	Q	=	6months x 80 -	350
(3)	Q	=	130 units	

- *The MSD price list should be used to write down the price of each drug .*
- *Multiply the quantities in column (Quantity required by the MSD price for each item and then write the answer in column written, "Budget needed for this item"*
- *Add the total cost of all items on page one in the column written, "Budget needed for this item".*
- *The answer is written (sub-total) in the box in front of the words" total budget amount for ordered Items on this page"*
- *Transfer this value into the corresponding column after the words "total from previous page"*
- *Calculating the values of various items required as done previously.*
- *If additional drugs are needed specifically for the catchments area, which are different from the listed ones, these should be written in the space provided called "INFREQUENTLY USED DRUGS", showing pack size, quantities required, MSD price and the budget for each item ordered.*
- *The reasons for ordering additional drugs are written in the corresponding space*
- *The total value of drugs and medical supplies required for the coming cycle is the sum of all the items ordered on this page together with the total value from previous page at the top. The answer is written after the word "Total Order Value"*
- *The total value of the next cycle is then written on the "Order Monitoring- Form" in the space provided after the words "Order value of coming cycle"*
- *The value of credit note from MSD (if any) should be entered in the space provided after the words "Value of Credit Note previous cycle" coming cycle" to get the actual amount required to be paid to MSD. The answer should then be written in the space after the words: "Procurement Budget needed"*
- *The health facility in-charge should write the date, sign and submit the Order Form to the office of the District Medical Officer in three copies (A, B and C)*
- *The person in the office of the DMO who receives the Order Form writes the receiving date and signs it. Copy C should be given back to the health facility for reference.*

Note: Copy C of the Order Form should be used to compare the actual quantities supplied by MSD with what was ordered.

The completed Order Forms should be submitted to the DMO at the earliest time possible, two months before the next Supply Cycle.

B: At the DMO's Office

After receiving the Order Form from the facility the DMO should do the following:

- *Write the receipt date, sign and send back copy C to the facility.*
- *Make sure that all Order Forms from all the facilities in one respective group have been received and, if not, follow-up immediately.*
- *Examine the correctness of each order especially the quantities required, MSD price and value of total budget needed.*
- *Check and confirm, where possible, the justification for ordering the*
- *"INFREQUENTLY USED DRUGS" which are the additional drugs or medical supplies for the specific catchments area taking into account the "value of credit note previous cycle" from "Order value" of the following:*
  - The drugs are allowed for the PHC facility level
  - Reasons given by the health center/dispensary

The DMO can question the ordering of any items on the basis of his knowledge of prescribing skills of staff in the health center/dispensary as perceived during previous supervision/support visits.

- *Compare the quantities ordered with the information in the Monthly Drug Value Summary Sheet of the facility and with the Order of the previous cycle*
- *Considered whether a serious mathematical error has been made. Otherwise the DMO should avoid making changes to the contents of the orders e.g. quantities ordered if he/she is not sure that the order is incorrect e.g. when a facility has not ordered an item it may well be that their stock is sufficient.*
- *Any relevant comments with respect to the Order Form should be discussed with staff in the health facility at the next visit to the facility. The DMO should not hold the Order waiting for discussion!*
- *Make sure that all Orders for each group are sent together to MSD/ZMS as soon as possible. Use the "Order Compilation Form" to list health facilities that have submitted Order Forms and their budget*
- *Request supplementary funds from CHF (if necessary) to bridge the financing gap. It is advisable to deposit some funds at MSD quarterly from CHF to cover the costs of supplementary drugs. Such arrangement will reduce unnecessary delays in order processing at MSD, thus improving availability of drugs and medical supplies at the health facility.*
- *Copy B of the Order Form remains with the DMO in the file of the health facility. Copy A of*

the Order Form is sent to MSD.

Note: In order to ensure that supplies reach health facilities (dispensaries and health centers) as scheduled, the DMO should make sure that the Order Forms reach MSD two months before the new Supply Cycle.

C: At MSD

Upon receiving the orders, MSD should undertake the following:

- *Write the receiving date and sign each order;*
- *Supply the goods in compliance with the orders;*
- *Ensure the return of copy A of the order to the facility together with the goods in a separate envelope attached to each facility box.*

MSD should pack the goods in firm and secure boxes, which are clearly labeled with labels indicating the destination.

D: At District Level – DMO's Office

Immediately after receiving the supplies at the DMO's Drug Store, the receiving officer should undertake the following:

- *Write the receiving date and his/her signature on "Order Monitoring Form"*
- *On the day of dispatching the supplies to the facilities, write the dispatching date and sign on the "Order Monitoring Form" and send copy A of the order form from MSD together with the goods.*
- *The DMO should facilitate timely delivery of drugs to the facilities.*

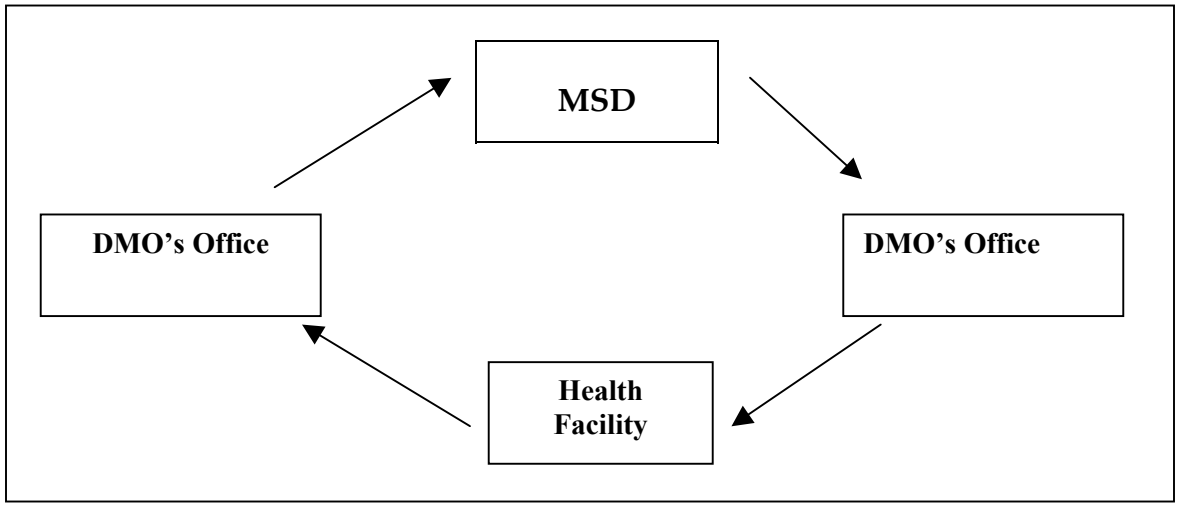
E: At the Health Facility

Upon receiving the supplies, the following shall be undertaken:

- *Write the date and sign the Order Monitoring Form*
- *The signing of the Order Monitoring Form confirms the date of receiving the goods but not necessarily the contents since the boxes may not be opened in the presence of the driver*
- *Store the supplies in a secure place while waiting for opening. Give notice to the Health Facility Governing Committee (HFGC)*
- *Open the box/boxes in presence of a representative of the HFGC and health facility staff.*
- *Check the goods against MSD packing list for the following:*
  - Ordered quantity against quantity received
  - Price and budget during ordering against MSD/ZMS Invoice.

- Short supply/over supply by MSD/ZMS.
- Damaged drugs in transit, expired and poor quality supplies etc.
- Complete the Packing List as indicated by MSD after checking all the supplied/received goods.
- Record discrepancies in the MSD packing list in the space provided under "Remarks and/or comments on goods received".
- The facility in-charge and the witnesses should sign in the respective parts shown at the bottom of MSD pack list.
- The officer in-charge of stores should immediately enter all the drugs and medical supplies in the stores ledger.
- Send the two signed copies of the Pack list (one for MSD and one for DMO) to the DMO promptly.

Figure 15: Order Process cycle



Note: The process of ordering starts with the Health facility and the supplies come from the MSD and are finally delivered to the HF.

4.4.3 The Use of the Order Form

The order form enables the HC/Dispensary:

- *to order the drugs and medical supplies necessary to replenish their stocks;*
- *with the list of drugs it acts as a checklist to remind the facility staff which drugs/items can be ordered;*
- *contributes to creating cost awareness regarding drugs at the facilities;*
- *facilitates planning and budgeting at the facilities;*

- *promotes better mathematical calculation as it is a quarterly repeated activity;*
- *promotes good working relationship among facility staff through teamwork in determining needs.*

The Order Monitoring Sheets create awareness at all levels involved to abide/adhere to the planned time schedule of activities in the Supply Cycle.

4.4.4 The Purpose of MSD Pack List and Credit Note

- *MSD pack list acts as a Goods Received Note (GRN)*
- *It shows the actual goods supplied and the total value*
- *It enables the facility to check the goods received against the order*
- *Assists in initiating complains to MSD in case of any discrepancies*
- *The credit note informs the facility and DMO on the value of credit in favor of the facility due to undelivered goods.*

4.4.5 Filling in the Prescribed Drugs in the Patient Register

To fill the patient register, the following instruction should be followed:

- *All quantities of drugs prescribed should be recorded in whole numbers (i.e. avoid recording 10.5% tablets instead write 11).*
- *All syrups, suspensions/ointments etc. should be recorded in terms of bottles/tube etc. e.g. 1 bottle, 2 bottles etc, but not ½ a bottle 10mls or 30cc etc.*
- *All injectables should be recorded in terms of the total number of injections prescribed once. e.g. if you prescribe 5 injections of PPF just write 5 under Procaine Pen. Fortified.*
- *All "ADDITIONAL DRUGS" should be written in the heading of the approximately nine blank columns. This shall be in the same alphabetical sequence from one page to another for overview of use and consumption.*
- *Wound Stitching and Dressing should be recorded in terms of the number of times the patient is supposed to be dressed; e.g. if stitching is prescribed, followed by refreshing the dressing say two times on following days, the first time is with dressing included. Then it will be written '1' under "Wound stitching / dressing" and '2' under "Wound dressing".*

Note: No words should be written inside the drug boxes, for example do not write 5 Inj, 1 bottle, or 2 tube etc., but write 5; 1; or 2. Skip two lines when starting a new day.

Recording drug consumption

In order to record regular consumption and develop a view of quarterly needs the following should be done:

- *Add up the quantities of each drug prescribed for every completed page*
- *Write the total of each drug per page in the row of boxes at the bottom of each page.*

Importance of the Patient Register (PR)

The PR provides the following information:

- *Gives average daily attendance's and seasonal/economic influences*
- *Insight in calculation skills of staff*
- *Assesses prescribing habits/technical skills (rational or irrational prescribing)*
- *Rational drug use indicators at the facility*
- *Frequency of use of certain drugs (may differ per area!); providing data for next order (and for possible modification of the NEDLIT)*
- *The actual use of drugs that were specially ordered for the facility's catchment area.*
- *The consumption pattern of the drugs at the facility both as a basis for new order and as parameter for rationality of order*
- *Estimates the facility's drug requirements*
- *The morbidity pattern of the catchment area*
- *The number of cases that have been referred to higher levels*
- *(R) Age group and/or sex is often affected differently by a certain disease. This can be tracked by the PR together with special relation with village or hamlet from which patients come.*
- *Overview of the number of CHF members who actually use the facility.*

4.4.6 Prescription Forms

The prescriber uses the form to prescribe drugs.

The prescription has three major parts:

- *General information and personal data of the patient.*
- *Space for prescribing the drugs*
- *Name and signature of prescriber and dispenser*

The prescription forms will be obtained from MSD.

Figure 16: A Sample of Prescription Form

Ministry of Health

Serial number: ……

Patient: ……

Address: ……..

Age: …… Sex: ……

Ward: ……..

Medical use	Pharmacy use	
Item prescribed	Amount	Tshs
1		
2		
3		
4		
Total cost		

Name Doctor Signature Date

Dispensed by Signature Date

4.4.7 The Dispensing Register (DR)

The DR is similar to a ledger book. Each page may record between 30 to 35 prescriptions.

The book has to be used from left to right across the two pages. The names of all drugs have been pre-printed. There are free spaces for recording the "ADDITIONAL DRUGS".

Figure 17 : Sample Dispensing Register

Hospital ……

Daily dispensing register

Date: …… / ……. / ……

Starting time: ……..…..…. End time: ……..…….

Description of item	Units dispensed	Total daily units

Name: ……..……. Signature: ……

Use of the Dispensing Register

The process of filling data in this book begins with:

- *The date*
- *The patient's Prescription Number*

Recording Drugs Dispensed

Drugs prescribed are recorded in this register in terms of quantities dispensed and should not be merely copied from the prescription. These quantities shall be written in the respective column of the drug, in accordance with same instructions as in the patient register .Skip two lines to start a new day.

Recording drug consumption

In order to record regular consumption and develop quarterly needs the following should be done:

- *Add up the quantities of each drug dispensed for every completed page*
- *Record the total of each drug per page in the row of boxes at the bottom of each page.*

Importance of the Dispensing Register

The DR provides the following information:

- *Figures on average daily attendance and seasonal/economic influences*
- *Insight in calculation skills of staff*
- *Frequency of use of certain drugs (may differ per area!) providing data for next order (and for possible modification of the National Essential Drug List)*
- *View of actual use of drugs that were specially ordered for the facility's catchment area.*
- *Provide the consumption pattern of the drugs at the facility as basis for new order*
- *Provide a rough estimate of the facility's drug requirements*
- *Total of drugs dispensed will be approximately equal to the quantities taken from the store minus the stock at hand.*

4.4.8 Injection Register

The Patient Injection Register (PIR) records the general movements of stocks of all injectables.

Each type of injectable is recorded on its own page. The PIR is used to record:

- *The quantities received from stores, in terms of vials or ampoules*

- *The dosages and balances in hand at any point in time, in terms of strengths of the injectables (i.e. mega units - MU or MG)*

Attending Patients

Extract the following information from the prescription and enter it in the appropriate line/box of the PIR as follows:

- *The date*
- *The prescription number (with Patient's name)*
- *Age of the patient*
- *Dosage (mg/MU)*
- *Route of administration (tick the appropriate one)*
- *Signature*

Additional stock during day

If you receive any new supplies from the store during the day, use one blank line to record this:

- *Write the quantity in vials/ampoules in column A.*
- *Write the quantity in MU/mg in column B.*

Replenishment of Stocks from Stores

When the stocks in the Injection room get depleted or are nearing depletion, you must go to the stores to arrange for replenishment as follows:

The PIR must be taken to the stores for counter checking.

The stores in-charge should: -

- *Compare the quantity of injectable(s) lastly issued to the injection room with the total quantity of injectables which have been administered to patients and recorded in the PIR*
- *Where the quantities do not tally, thorough accountability must be sought before new stocks can be issued from stores.*
- *If the quantities tally, more supplies of injectables can be issued to the injection room.*

After that, the injectables will be recorded in the PIR as instructed above by the staff responsible for injections.

Closing the day

When all patients have been attended to; (at the end of the day/shift) you should close the day as follows:

- *Add up the total dosage used.*
- *Subtract the total dosage used from the opening balance in column B*
- *Write the difference in column B in the same line with the total dosage used.*

General remarks on the Patient Injection Register

- *Any injection given should be recorded in the register.*
- *The data in this PIR can be used in estimating the facility's requirements for injectables during order preparation.*
- *Before ordering injectables the stock position should be compared with quantity consumed.*

Figure 18: A Sample of Injection Register

Injection Register

Name of Injectable……

S/N	Prescription No	Patients Name	Age	Dosage	Route	Sign	Quantity	
							Received	Balance

4.4.9 Monthly Drug Value Summary Sheet (MDVS)

In this system total values of drugs prescribed and dispensed are recorded on a sheet.

The drug value summary sheet has the following features: -

- *Name of facility, its code number and the council (District).*
- *MSD Unit price (obtained by dividing the MSD price by the total dispensing units in a container or pack from MSD)*
- *Value (obtained by multiplying MSD unit price by the quantity dispensed in a month)*
- *Total value of drugs dispensed (obtained by adding up all values of each dispensed drug that month).*

Filling the MDVS

The MDVS should be filled by the in-charge of the facility assisted by the dispenser as follows:

- *Add up the total of each drug dispensed on each page (from the 1st day to the last day of that month)*
- *Record this quantity in the column "quantity dispensed" against that drug*
- *Repeat this procedure for drugs dispensed that month.*
- *When all the quantities for each drug are recorded, multiply each quantity by the MSD unit price*
- *Write the answer from above in the column "value"*
- *Repeat the process for all drugs dispensed in that month*
- *At the end add up the value of each drug to get the total value of drugs dispensed that month.*
- *Compare stock utilization and stock position in the store by referring to the ledger*
- *Write any remark if any, in the remark column.*

The quantities of the total value of drugs dispensed each month should be submitted to DMO every quarter.

The Importance of the Monthly Drug Value Summary

Can be used to:

- *Provide the basis of the order value for the coming cycle to replenish the items consumed*
- *Quickly determine the appropriateness of drug utilization in the facility by comparing with other related data (e.g. patient attendance etc.)*
- *Determine the drug budget requirements for the council public facilities.*

4.4.10 The Stores Ledger

The "Stores Ledger" (MTUHA Book No.4) is a register for recording the movements of stocks in the store.

- *It is used to record receipts and issues of supplies.*
- *It MUST be kept up to date by recording transactions immediately (every receipt or issue of supplies).*
- *Every item MUST be recorded on a separate page.*

- *At any point in time, every item kept in stores must be recorded only once in the ledger.*
- *The items should be recorded in its smallest form (e.g. a tin of 1,000 tablets or a vial of 250mg).*
- *Write page numbers of the ledger. When the page in use is full, indicate to which page the information has been carried forward. Similarly, the new page should indicate the page from which the information has been brought forward.*

Filling in the stores ledger

1. Write in the name of the drug or medical supplies on the space indicated at the top of the page
2. Write the unit of issue (e.g. in tablets, vials, etc)
3. Write the date of:
   - Receiving new stocks
   - Issuing stocks to the dispenser
   - Carrying out stocktaking.
4. In the Receipts column write:
   - Quantities of drugs received (say from MSD or from the DMO) using the unit of issue shown at the top of the page. For instance, if the unit of issue is in tablet form then stocks should be received in tablets form.

All receipts should be written in red ink. Write in the issues Column the quantities of drugs or medical supplies issued from the store e.g. to the dispensing unit.

All items should be issued by using their respective "Unit of Issue" in the same way they were recorded on the receiving date. Write in the balance column the following:

a) Receipt of new stocks
b) Issue of stocks

Sample Store Ledger

KUMBUKUMBU YA DAWA NA KIFAA				Namba ya ukurasa…….…….....		
Namba ya Dawa/ Kifaa	Jina la Dawa/ Kifaa			Hali maalum ya utunzaji inayohitajika		
Kiasi kinachokubalika kuagiza			Maelezo maalum ua uagizaji			
Kipimo kinachotumika	Kiwango cha juu kabisa		Kiwango cha chini kabisa		Mahali pa kutunzia	
Tarehe	Kumbukumbu za Kuingiza/ Kutoa	Kiasi Kilichopokelewa	Kiasi Kilichotolewa	Marekebisho (Upotevu/ Kurudishwa	Kiasi Kilichopo	Maelezo

4.4.11 Stock Taking

Carry out stock taking at the end of every month by physically counting each item in the store. All staff of the health facility should be involved in this process. Compare the physical count with the quantities recorded in the ledger. If there are any discrepancies find out the reasons and record them in the remarks column. Stocktaking should be recorded in red ink.

4.4.12 Supervision

The Council Health Management Team has the responsibility of supervising and advising facility clinical officers in charge on the management of drugs and medical supplies. They should also facilitate the training of other facility technical staff so as to ensure that there is no management gap in the absence of the clinical officer.

Annex: CHF Management Tools

Patient Register

Visit No.	Date	Name	Village/Street	Age	Sex	Diagnosis	Prescription	Method of Payment (P=Papo kwa papo E=Exempt CHF/No Payment/NHIF

CHF Membership Register

CHF Card No.	*Date paid*	Receipt Number	Name	Ward	No. of HH members	Membership Type (N=new R=renewal)	Expiry Date	Amount Paid	Balance	Date paid in full

CHF Monthly Status Report

Health Facility: _____ **Year:_____**

Month	Number of Patients						CHF Membership				Fees Collected			Total Collected
	User fees	CHF members	NHIF Members	Exempt	Unable to pay	Total Number of Visits	New	Renewal	Expired	Total Active	User fees collected	CHF fees collected	Other collections (Including Late User Fees)	
							Continuing members from last month →							
Jan.														
Feb.														
March														
April														
May														
June														
July														
Aug.														
Sept.														
Oct.														
Nov.														
Dec.														
TOTAL														

CHF Daily Status Report

Facility: _____ **Month/Year:** _____

Date	NUMBER OF PATIENTS												REVENUE			
	User Fees		CHF		NHIF		Exempt		No Payment		Total Patients		User Fees Collected Today	CHF Fees Collected Today	Other Fees Collected Today (Including late user fees)	TOTAL FEES
	Today	Month to-Date	Today	Month to-Date	Today	Month to-Date	Today	Month to- Date	Today	Month to-Date	Today	Month to-Date				
1																
2																
3																
4																
30																
31																
Total																

CHF Financial Ledger

Health Facility: _____ Year: _____

	CASH ON HAND			BALANCE OF CHF FUNDS		
Date	**Details**	**Daily Fees Collected**	**Cash on hand**	**Deposits**	**Expenditure**	**CHF Account Balance**