SOCIAL, ECONOMIC AND DEMOGRAPHIC FACTORS INFLUENCING MEMEBRSHIP OF COMMUNITY HEALTH FUND (CHF), IN MAGU DISTRICT, MWANZA REGION, TANZANIA

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By

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled **SOCIAL, ECONOMIC AND DEMOGRAPHIC FACTORS INFLUENCING MEMEBRSHIP OF COMMUNITY HEALTH FINANCING (CHF), IN MAGU DISTRICT, MWANZA REGION TANZANIA** in partial fulfilment of the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences.

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Dr.Mughwira.A.Mwangu

(Supervisor)

Date_____

DECLARATION AND COPYRIGHT

I, Kaswahili Juma Peter, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

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ACKNOLEDGEMENT

I would like to thank the Almighty God for giving me strength throughout the time I worked on this dissertation. I owe many thanks to many people who made contributions in different ways to help me reach this final stage.

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Finally, I am responsible for errors or omissions made in this dissertation report.

DEDICATION

This dissertation is dedicated to my parents who supported me from my childhood to an adult. It was their effort which made me to have a good back ground that helped me work on this study confidently.

To my family, my beloved wife Tumaini Noah Masima, my sons Justice, Sosthenes and Noah for their unconditional love and care as they missed my presence at their tender age.

Abstract

Background:

The Community Health Fund (CHF) was introduced in Tanzania as part of the Ministry of Health's (MOHSW) endeavour to make health care affordable and available to the rural population and the informal sector. The scheme started in 1996 with Igunga acting as a pilot district, and was later expanded to other districts.

Despite of its apparent benefits, enrolment level in all districts has remained far below the projected target.

Objectives: The main objective of this study was to assess community knowledge and views on social, economic and demographic factors influencing CHF membership and participation in Magu district.

Methods and materials: The study adopted a cross-sectional study design involving 200 household heads. Data collection methods included administering of questionnaire and an in-depth interview to the key informants in the district. In order to answer all the objectives data was analysed to get frequencies, percentages and where the need raised cross tabulation was done to get interpretations using Statistical Package for Social Sciences (SPSS).

Results: The study findings revealed that 55% of community members interviewed reported inadequate information dissemination which caused poor understanding of the scheme. Major concerns were pointed out such as poor services delivery attributed by lack of medicine, community ability to pay, poor management of CHF funds, longer waiting time of health service especially in public health facilities, poor infrastructures just to mention a few.

Conclusion:

The decision to enrol in CHF membership is moulded by a combination of many factors including, education, gender, economic status, awareness strategies, improved health services and low margin of social inequality within the community.

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LIST OF ABBREVATIONS

AAR	American Air Rescue
CBHF	Community Based Health Financing
CHF	Community Health Fund
DMO	District Medical Officer
DED	District Executive Director
MKUKUTA	National Strategy for Growth and Reduction of Poverty
MOHSW	Ministry of Health and Social Welfare
MUHAS	Muhimbili University of Health and Allied Sciences
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
SHIB	Social Health Insurance Benefits
PMORALG	Prime Minister's Office of Regional Administration and Local Government
TIKA	Tiba Kwa Kadi
VEO	Village Executive Officer
VC	Village Council
WEO	Ward Executive Officer
WHC	Ward Health Committee

CHAPTER ONE

INTRODUCTION

1.1 Back ground information

Since independence the government of Tanzania has tried a number of strategies to increase access and equity to health care of its citizens. Following Independence in 1961, Tanzania with many other countries in Africa, adopted free health care provision by abolishing user charges in government health facilities [1; 2]. The Arusha Declaration in 1967 heralded the start of a series of health sector reforms with the intention of ensuring universal access to social services to the poor and those living in marginalized rural areas. The Government banned private-for-profit medical practice in 1971 and took on the task of providing health services free of charge, funded through public taxation and donors resources to all individuals attending public health facilities[3]

However, by the early 1990s, the pull of providing free health care for all became obvious in the face of rising health care costs and a struggling economy. In 1993, Central Government started the health sector reform process in an effort to better utilize health resources, improve primary care, increase user access, and cut rising costs. These reforms represented significant organizational, managerial, and financial changes to health care planning and services [3, 4]

Over the last decade, the main elements of the reforms have included: cost-sharing, the introduction of user fees, introduction of a National Health Insurance Fund (NHIF) for all civil servants in 1999 and the introduction of the Community Health Fund targeted at the poor and those living in rural areas) in 2001 [4; 5].

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 instalments. 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 [6; 7].

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 healthcare, empowering households and communities in health service management decisions and promoting partnership and local participation in health care financing [8; 9]

Initially CHF was supported by the World Bank and was implemented for the first time in 1996 in the Igunga District, in the central part of the country. The scheme has afterwards been expanded into other districts in the country [10; 11; 12]

According to the CHF Act Number 1 of 2001, CHF was designed to fulfil the following three objectives [13]

(a)To mobilize financial resources from the community for provision of the health care services to its members

(b) To provide quality and affordable health care services through a sustainable financial mechanism and,

(c) To improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health.

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. [14; 15]

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. [16]

Communication of the concept of CHF should be clear, consistent and understandable by the communities to win their confidence on CHF. 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 [17]. 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 [18].

1.2 Statement of the problem

Health care financing is very challenging in most of the developing countries, including Tanzania, because of limited resources available to support the health systems. The government of Tanzania, in collaboration with the World Bank and other donors, launched the Community Health Fund on a pilot basis in Igunga district in 1995[19; 20; 21].

From its inception in the country improvement in terms of equity and accessibility to rural community, improved quality of health services and improvement of resources mobilization has been felt in rural communities [22; 23; 24].

There has been reduced delay in seeking of health care and decreased self-medication of many rural community members [25; 26].

Although there is some evidence that certain schemes have shown relatively encouraging trends in enrolment, progress towards enrolment momentum in the country has never reached

the expected coverage. In its initial design CHF 65% of all household in each participating district were anticipated to be CHF active members [3;26].Currently enrolment per district ranges between 3-28% of total house hold, and in many district the enrolment rate is around 4% [18, 19,10].

To make the situation worse in some schemes, a decline has been found where enrolment was previously relatively high for example community membership to the scheme in Igunga and Singida rural districts was 6 and 4 percent respectively, which was low in comparison to expectations of 30 percent [1].In the assessment of the CHF in Hanang district found that membership in 2001 was around 3 percept of total households [10]; however, more recent data indicates that this fell further to 2.2 per cent in 2003 [27].

It is argued that the poor enrolment rates in many CHFs may be linked to, low income and income un-reliability[2], lack of information due to insufficient sensitization/education to the community; introduction of NHIF which took out public servants who were potential members of CHF, non-coverage of referral care; perceived poor quality of health care services at public facilities (drug availability and inadequate service provision); poor staff attitudes; and broad exemption policies which leave a limited number of people contributing to the CHF [19; 28].

Many studies have focused on managerial and health service provisions as contributing factors to low enrolment of CHF. This study aim to establish if social, economic and demographic factors play any role of influencing people to remain passive in participating in CHF in Magu district where the coverage stand at 13%.

1.3 Rationale of the study

Available finding on factors contributing to low enrolment of CHF members show that the status ranges between 3-28 % [3, 5]. Information obtained from this study which seeks to highlight the contribution of social, economic and demographic factors as influencing drivers of CHF membership will provide light to more comprehensive way of improving access and

equity among the most vulnerable rural population. High enrolment will reduce the transaction costs and increase efficiency, sustainability and coverage of expensive risks, such as hospital admissions or prolonged drug expenditure [29].A vibrant CHF will bridge government efforts through MKUKUTA [30], but also conform with other International commitment of improving health for all such as health related millennium development goals.

1.4 Research questions

(i) What is the current CHF membership and how is the community aware on issues pertaining to CHF in the district?

(ii) How knowledgeable is the community on CHF benefits?

(iii) What are the opinions from the community on payment of the premium for CHF membership?

1.5 Objectives of the study

1.5.1The general objective

To assess community knowledge and views on social, economic and demographic factors influencing CHF membership and participation in Magu district.

1.5.2 Specific objectives

1. To assess community awareness on CHF scheme
2. To determine CHF scheme membership among the community members
3. To assess perceived benefits of CHF scheme among members of the community
4. To assess community members' opinion on payment of the premium for CHF membership

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Health care financing context

After independence from colonial rule, the majority of African countries health systems ware funded by general tax revenue and external assistance from the donor communities, with no charges at the point of service [18; 31]. In the 1980s, substantial user fees were introduced in public-health facilities as part of a structural adjustment programme.

Tanzania has a similar history with free publicly funded health services after independence the government gave high priority to education and health with a prominent role as a provider. Through Arusha Declaration in 1967 the government committed itself to provision of essential health care services free at the point of use. This was financed through government (Tax financed) and external donor resources [1].Under this policy private practice in health sector was actively discouraged and in 1977 was prohibited by law. Following the prohibition the government remained the sole provider of health services for the purpose of removing inequalities to access, affordability and sustainable health care services to the Tanzanian community [17; 31].

Post-independence period was characterised by rapid population growth, in 1973 the price of oil raised and the world economy slowed henceforth the demand for raw products from developing countries declined, and developing countries had to borrow on the international markets in order to make the end meet. This crisis had dramatic effects on the government budget allocated to health [32].An increase in international aid was unavoidable if the ambitious goal formulated by at the 1978 Alma At conference on primary health care were to be achieved. By the mid-1980s, Tanzania like many African states faced economic constraints. In 1985-1986 the government embarked on policy of economic liberalization and by the end of 1980s, resources for the health sector had been substantially reduced [1].

The government could no longer afford to fund the growing public dominated health services, hence other complementary means of financing health had to be speculated. The primary goal was to complement declining government tax financed funding and to improve quality of care within the public health sector through an increased availability of essential inputs like drugs [1].

The introduction of user fees in the 1980s was one option, in the past decade, Tanzania has introduced mandatory health-insurance schemes for formal-sector employees, offering comprehensive health-care benefits to their members, the largest being the National Health Insurance Fund covering civil servants. The National Social Security Fund (for private formal-sector employees) has also introduced a Social Health Insurance Benefits. There is a voluntary insurance scheme, the Community Health Fund (CHF), for rural dwellers, with premiums of between Tsh.5000 and Tsh.30, 000 per household per year, offering public primary care to the informal sector. A similar scheme was introduced recently for urban dwellers, termed Tiba kwa Kadi (TIKA) [18]

Private insurance companies also provide health financing mainly to private sectors, Non-Government Organisation as well as private well to do families.

In view of the low level of coverage by insurance schemes, out-of-pocket payments remain a major share of health-care funding in Tanzania. Substantial attention is now being paid to expanding insurance coverage of the informal sector through the CHF and TIKA. Furthermore, management of the operation of CHF and TIKA has been assigned to the National Health Insurance Fund, which could open the way for greater integration across insurance schemes. [27]

2.2 Health Care Financing Systems in Tanzania

To archive an efficient, equitable and sustainable health systems aimed at the reduction of burden of disease, the government of Tanzania through health sector reforms has allowed the existence of a mix of health financing mechanism in the country. It is expected that to somehow the presence of this mix will direct the high levels of out of pocket spending into

either public or private pooling arrangements, so that individuals will have real financial protection.

Four main health insurance mechanisms are used to pool health risks, promote prepayment, raise revenues, and purchase services [28]

• Tax based health care financing (State-funded systems through ministries of health or national health services)
• Social health insurance
• Voluntary or private health insurance
• Community-based health insurance

2.2.1 Tax based health care financing system

Tax based health care financing also known as Ministry of health or national health service–style systems generally have three main features. First, their primary funding comes from general revenues. Second, they provide medical coverage to the country's entire population. Third, their services are delivered through a network of public providers [1]

In most low- and middle-income Countries, ministries of health function as national health services and generally exist alongside other risk pooling arrangements, so they are not the sole source of coverage for the entire population).The features of national health services give them the potential to be equitable and efficient. Their broad coverage means that risks are pooled broadly, without the dangers of risk selection inherent in more fragmented systems. And unlike other systems, they rely on a broad revenue base [15]

Tax based care financing systems have the potential for efficient operation. Most are integrated and under government control and they have less potential for the high transaction costs that arise from multiple players. But when power is decentralized or shared with local authorities, and when the decision-making authority is unclear, coordination problems can ensue. Provision under the pure National Health Service model is through public facilities and personnel, but in practice there is much variability many governments' contract services from

nongovernmental organizations, faith-based organizations, and other private providers. Whether public provision is more efficient, equitable, and sustainable than private provision is a question not of ownership but of the underlying delivery structures and incentives facing providers and consumers [15]

Although National Health Service systems have the theoretical benefit of providing health care to the entire population free of charge (except for any applicable user fees), the reality is less encouraging. Reliance on general government budgets is vulnerable to the vicissitudes of annual budget discussions and changes in political priorities. And in most low income developing countries, public health spending as a share of the budget is low [18]

Health services in many low- and middle-income countries are primarily used by middle- and high-income households in urban areas because of access problems for the rural poor. In addition, the poor tend to use less expensive local primary care facilities, whereas the rich disproportionately use more expensive hospital services. Public provision of health services may also face problems of corruption and inefficiencies caused by budgets that do not generate the appropriate incentives and accountability which has led many governments to split financing from provision [9].

To exploit the potential strengths of tax based health care financing system, it is important for developing countries like Tanzania to improve the capacity to raise revenue, the quality of governance and institutions, and the ability to maintain the universal coverage and reach of the system. It is also important to take specific measures to target spending to the poor, such as increasing the budget allocations for primary care. But the system must not neglect the needs of the middle- and high-income populations that way; they can maintain political support and deter the middle and high-income populations from opting for privately financed providers at the expense of supporting the public system [9]

2.2.2 Complementary Health care financing system

For convenience I will group them into the following categories:-

2.2.2.1 Formal Health Financing

This is usually tied to formal employment and the contribution to any mechanism is divided between the employer and employee and the benefit is accessible for the employee and their immediate family members.

2.2.2.1.1 National Health Insurance Fund (NHIF)

Planning for implementation of NHIF was expected to go concomitantly with cost sharing in 1993 but it was not until 2001 following the enactments by the act of parliament as NHIF Act number 2 of 1999 for all public sector employees [18].NHIF covers public sector employees and their immediate family members including spouse and up to four children or legal dependants. For employee it is obligatory to contribute to the NHIF. The contribution is 6% and is shared equally between the employer and employee at 3% each.

NHIF offers a benefit package that has all the primary health care services and other diagnostic services. NHIF accredits public, FBO and private for profit health facilities and pharmacies, in both rural and urban areas, to provide care to their members and their dependents. After retirements members receive benefits for up to three months [33].

About 2 million people are currently covered, which is substantial but still less than 5 percent of the 38 million Tanzanians. There is only one risk pool to cover all NHIF members. To increase membership, the NHIF has extended coverage to pensioners, police, prison staff, immigration officers, and fire and rescue service staff members, and it has allowed subscribers to pay extra for insuring family members beyond the numbers included in the basic package.

NHIF is also exploring mechanisms to enroll the private formal sector and the "organized" informal sector [18]

Providers are paid on a fee-for-service basis. Members must go to an accredited public or private health facility or provider to receive health services. The NHIF requires accreditation for health care providers who want contracts. All public providers are accredited regardless of quality; thus selective accreditation applies only to FBO and private facilities. Private pharmacies are also accredited. The accreditation process uses predetermined criteria and is based on MoHSW standard guidelines, which include the following: (a) availability of human resources, equipment, and facilities in accordance with MoH guidelines; (b) acceptance of a formal program of quality assurance prescribed by the NHIF; (c) acceptance of NHIF standard payment mechanisms and fees; (d) adherence with NHIF referral guidelines; (e) acceptance of reporting requirements; and (f) recognition of the rights of the patient. As of June 30, 2010, a total of 5,576 health facilities—68 percent of all health facilities in Tanzania—were accredited by the NHIF to provide services. Of the total, public facilities accounted for 91 percent of the dispensaries, 77 percent of the health centers, and 53 percent of the hospitals. The scheme is managed by a board of directors appointed by the government.

The NHIF offers a wide range of benefits, including basic diagnostic tests, drugs, outpatient services, inpatient services, and minor and major surgery. The NHIF currently reimburses 90–95 percent of the claims presented to it by providers, which is a significant increase over the 50 percent reimbursement rate paid when the NHIF was launched. At the same time, the expenditure of the NHIF is quite low. Despite continuing efforts, claim reimbursements still account for less than 23 percent of total NHIF income. Those claims account for about 2 percent of the total national health expenditure. [18]

2.2.2.1.2 Social Health Insurance Benefit (SHIB)

SHIB is the 7th benefit to be implemented in the NSSF Act section 41 of the NSSF Act No. 28 of 1997.It was established so as to provide crucial support to the Government's efforts of

increasing access to health care services to the poor majority in the country.Its principal aim is providing most of general healthcare services for beneficiaries [18]

However the scheme exclude diseases under special preventive programs and Public Health Care Services e.g. TB and Leprosy, Cancers, HIV/AIDS, Epidemics, Reproductive and Child Health (RCH), Mental Illness, Sexually transmitted Diseases (STDs), & Any other disease that will be categorized in this domain. Self-inflicted diseases or injuries e.g. drug abuse, tobacco, alcohol, attempted suicide, and criminal abortion Luxurious like Cosmetic treatments with no medical indications e.g. plastic surgery [24].

SHIB-Coverage and Eligibility

The Scheme covers a member and dependants (one spouse and up to four children); three months of healthcare services after stoppage of contributions due to termination, falling in arrears of contribution and retirement; qualifying members must have contributed for at least three months immediately before accessing the services; and pensioners willing to contribute 6% of their monthly pension shall continue enjoying healthcare benefits.

SHIB-Method of Payment

Payment of providers is by Capitation method, for the following reasons

- Easy to administer;
- Builds a self-monitoring system and accountability among the Stakeholders
- Links members to a specific provider who is responsible for providing healthcare and record-keeping;
- Provides a predictable cash flow.

Advantages

- Relief to the employers
- Relief to the members

- Contribution to the Government towards better healthcare services in the country, to become the 2nd largest healthcare provider after the Government.

2.2.3 Private Health Financing

Private Health Insurance schemes are relatively new modes of health care financing in Tanzania. These are such as AAR, MEDEX and Strategis. Are Voluntary and cover mostly salaried workers on an individual basis or as employees of a registered employer.
Benefit package is rated according to each member; weather has a specific benefit package depending on the premium he/she paid. Operates on an individual equivalency (no pooling of risks).There is adverse selection of risk Premiums are calculated according to the anticipated risk e.g. age, sex, risk exposure-medical family history, medical individual history etc. In Tanzania Private Health Insurance schemes mostly operate in urban areas and with private health providers.

2.2.4 User Fees (out of pocket payment)

Following the deterioration of both quality and quantity of health services due to declining health financing, the government introduced user fees in all government district, regional and referral hospitals in 1993 [3] .
User fees had the objective of complementing the government efforts of financing health care services with the purpose of improving of improving performance of health care services.
The informal sector especially people in rural areas have irregular income, which lead to periodic shortage of money to offset health care needs for their families, then user fees is not suitable for them to effectively access appropriate health care services at any time of the year. With the introduction of community based health financing scheme the community health fund user fees had to be extended to dispensaries and health centres levels where a family will decide to join in the community health fund or choosing to remain with the out of pocket payment mechanism. It is therefore argued that user fees have not met the intended

expectations, including fostering of equity, rationalization of the demand for and supply of health commodities and services, improvements of health workers' availability, performance and motivation and increase in revenues [28].

2.2.5 Community-Based Health Insurance

Community-based health insurance schemes have existed for centuries. They were the precursors to many of the current social health insurance systems, such as those in Germany, Japan, and the Republic of Korea, and they are currently prevalent in Sub-Saharan Africa. The schemes can be broadly defined as not-for profit prepayment plans for health care that are controlled by a community that has voluntary membership. Most community-based health insurance schemes operate according to core social values and cover beneficiaries excluded from other health coverage [34].

Community Based Health Financing (CBHF) has emerged in developing countries as a response to the existing challenges in the health financing system which include low economic growth, constraints on the public sector and low organizational capacity [34]. CBHF is a mechanism whereby community members (households) finance or co-finance costs associated with health services, offering them greater involvement in the management of community financing scheme and organization of health services [35].

In Tanzania, the concept of Community Health Fund (CHF) was first introduced in 1996 in Igunga district Tabora region as a pre-test district and later on rolled to all other districts following the policy enactment in 2001.

CHF was introduced as a response following the failure of user fees mechanism to significantly generate enough revenue, improve the quality of care and make health care universally accessible, especially by the poor [36, 37]

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

CHF is a risk pooling among families in the informal sector. In this respect each household pay a pre-determined premium once for the medication per year and is issued a membership card. Premium is often made during the time of harvesting or when the season of income is felt [38].User fee at the point of health care service delivery is paid by the no CHF members every time when they go to health facility for treatment.

To prevent new and parallel structure the CHF organisation structure has been left on already existing structure of the local Government operations. In overseeing CHF practical implementation and formulation of activities two ministries are involved , the Ministry of Health and Social Welfare and the Prime Minister's Office of Regional Administration and Local Governments. At the district level CHF is managed by District Council through district health board. At ward level it is managed by Ward Health Committee and at the village level it is managed by village council through village government advised by the village primary health committee [24]

There is evidence that CHF has reduced out-of-pocket spending, and one study found that they contributed to greater use of health resources. The fund has played role in resource mobilisation [39].Similarly quality of health care services has improved particularly on drugs, medical supplies and essential medical equipment needed by health facilities, health staff feel more motivated and obtain grater job satisfaction due to improvements in health services that has helped them to gain communities respect.
Through the scheme the community members feel more empowered to voice their opinions and demand health care since they are contributing for services [40].

Low enrolment to the schemes in many districts of Tanzania refutes its positive effect because only a small proportional will be protected. In additional sustainability of the scheme will be at stake due to incorrect mix of CHF members due to low enrolment and interfere with the vital goal of cross subsidization and risk pooling [24].

Poor Performance

CHF intention is indeed very good to help the Tanzanian community to access affordable and sustainable health care services, although it's up take has been low in many districts.

Some of the reasons cited to contribute to low enrolment include the following (Agyemang 1998) cited low income and income un-reliability as further reasons for low enrolment. They found that 60% of richer households in Igunga district joined the scheme compared to 33% of the poorest households [1].

Other reasons include: lack of information due to insufficient sensitization/education to the community; introduction of NHIF which took out public servants who were potential members of CHF, non-coverage of referral care; perceived poor quality of health care services at public facilities (drug availability and inadequate service provision); poor staff attitudes; and broad exemption policies which leave a limited number of people contributing to the CHF [24, 26].

Enrolment rates in many CHFs may be linked to a perception of poor quality of care. Thus, those who initially register into the scheme may drop out quickly if the quality of care does not reach expectations [30]

CHAPTER THREE

3.0 REASERCH METHODOLOGY

3.1 Introduction

This chapter presents the research approach and design, site of the study, population, sample and sampling techniques, research instruments and data analysis technique.

3.1.1 Description of the study area

The study was conducted in Magu district. Magu is among seven districts comprising Mwanza region, others include Nyamagana, Ilemela, Misungwi, Kwimba, Sengerema and Ukerewe.
The district is situated along Lake Victoria and receives two rain seasons per year making the district suitable for Agriculture and fishing activities. Cotton is the main cash clop in the district maize and paddy farming also compliment cotton both as food as well as cash crops. Due to its geographical position along the lake some community members participate in fishing activities.
Other economic activity in the district includes animal rearing where cows, goats, sheep and chicken are kept to serve different purposes.
The district is reached throughout the year as the highway from Mwanza to Mara region dissects it into almost two halves. Most of the roads in the rural areas are also passable all the time. Hence it was predictable the effect of the weather condition during the data collection excise which was carried out during December 2012.

3.1.2 Administrative structure

Magu is structured into 7 divisions, 24 wards 124 villages. The district has a population of 531,219 residents.

3.1.3 Health Facilities and services

The district has 2 hospitals, one being the district hospital and other one owned by Africa Inland church, 5 health centres and 47 dispensaries. All the health centres and dispensaries are owned by the government.

3.2 Study population

The study population comprised household heads in Magu district as well as three key district government officials. The household therefore formed both the unit of data collection and analysis. In this respect, a household was composed of a man, one wife or single parent/guardian and children who were less than 18 years of age during the data collection exercise. In the case of polygamous relationships, the different wives were regarded as belonging to different households. The definition fitted in to the one that is currently being applied by the CHF program in Magu district.

3.3 Study design

A cross-sectional study design was adopted to explore and describe issues related to CHF knowledge perception and practice amongst community members in Magu district.

3.4 Sample Size and Sampling Techniques

The formula for calculating sample size for one proportion was used. The following information was used to arrive at the required sample size for households.

$$n = \frac{z^2 p\,(100-p)}{\varepsilon^2}$$

z= level of confidence (1.96 estimated at 2 for 95% confidence interval)

p= expected proportion of CHF members in Magu district joining CHF estimated at 13%

ε = margin of error in this study was 5%

$$n = \frac{1.96^2 13\ (100-13)}{5^2}$$

n= 182 Households as minimum sample size, however during this study a maximum of 200 households was sampled.

- At the district level the DED, DMO, CHF coordinator were purposely selected because the principal investigator believed that by virtue of their posts, they were able to provide valuable information in the light of the study objectives.

- The best two divisions were purposively selected basing on performance in terms of CHF; this information was obtained from the DMO office.

- Within the two divisions, in order to get good mix four wards were purposively selected where two wards were selected on the basis of good performance in terms of CHF enrolment and these are Kisesa A and Nyanguge. The other two divisions were those ones which were performing poorly and these are Nyigogo and Kahangala.

Kisesa A and Nyanguge wards occupy the western part of the district while Nyigogo and Kahangala occupy the central part of the district. The Sukuma people predominantly occupy these parts. The economic activities in the areas include, subsistence farming, cultivation of cotton, maize and paddy as well as rearing of animals.

According to the previous district statistics, the four wards widely vary in terms of community health fund household membership (DMO 2011). They range from good performance Kisesa A and Nyanguge to poor performance in Nyigogo and Kahangala. The sampled areas covered the major socioeconomic divide in the district. The areas are also well spread geographically. It was therefore felt that the yield of the sampling process was fair representation of the entire district.

Sampling by proportion as shown in the table below was used as a basis for allocating the number of the study households among the selected villages. The weight was the number of households in each village. Information available at the district level is based on the 2002 national census. Kisesa A ward had the highest number of household while Nyigogo ward the lowest number of households.

Table 1 Sampling Proportional of house holds

District	Ward	Village	Population	Households	Sampled Households
Magu	Kisesa A	Ihayabuyaga	3,441	573	8
		Kitumba	4,793	798	12
		Isangijo	2,274	379	6
		Welamasonga	4,075	679	10
		Igekemaja	2,893	482	7
		Kisesa	15,621	2,603	38
			33,108	**5,514**	**81**
	Nyanguge	Matela	4,003	667	10
		Muda	2,585	430	6
		Nyanguge	3,961	660	10
		Mantare	4,039	673	10
		Majengo	3,401	566	8
		Bugohe	2,507	417	6
			20,500	**3,413**	**50**
	Kahangala	Nyamahanga	2,758	459	7
		Bundilya	3,281	546	8
		Bugabu	2,181	363	5
		Kahangara	4,932	822	12
		Shinembo	2,904	484	7
			18,667	**2,674**	39
	Nyigogo	Yichobela	2,220	370	5
		Nyashimba	3,257	542	8
		Ilungu	2,556	426	6
		Kipeja	1,137	189	3
		Segani	1,140	190	3
		Kinango	1,519	253	4
			11,844	**1,970**	**28**
				13,571	**200**

3.5 Data source

The study data source was mainly household heads that were obtained after an introduction to the household. Interview that were conducted using a structured questionnaire and an in-depth interview guide which was used to collect information from the three key informants from the district officials.

3.6 Method of data collection

The structured questionnaire was made up of five parts. Part one collected information on particulars of heads of the households. The particulars included age, gender, level of education and occupation of household.

Part two of the questionnaire contained questions covering community health funds. The areas covered included awareness of CHF scheme, sources of information on CHF, community knowledge on CHF and exploring community knowledge on how the community could be reached to sensitize CHF scheme.

Part three of the questionnaire examined issues on CHF proportions in the community as well as assessing if the community members were CHF members in the previous years.

Part four of the questionnaire had questions on perceived benefits of CHF and assessing if the community members actuary knew these benefits.

Part five had questions with intention to know if the CHF scheme is associated with any problems in the community and pointing out recommendations on how to make improvement to the scheme to attract many people to join the scheme.

3.7 Selection and training of interviewers

Two interviewers, who were local resident of Magu district, conversant in both Kiswahili and Kisukuma were recruited to assist with the interviews. Their selection process involved an interview and application of an aptitude test. They underwent one day of intensive training in interview techniques that also included questionnaire pre-testing.

3.8 Questionnaire Pilot testing

A structured household questionnaire in Kiswahili language was used in data collection, before being administered, the questionnaire underwent two stage pilots testing. The first stage took place in one of the CHF schemes located in Mkulanga Coast region of Tanzania, where a total of ten questionnaires were pre-tested and served the purpose of detecting major problem with the tool. Following the pretesting problems with logical flow of the questionnaire were detected and subsequently rectified. The pre-test also revealed language problems in the questionnaires. Based on inputs from the pre-test and further consultations, the language problems were also taken care off so as to conform to the standard. The second stage of the questionnaire pre-testing took place in Magu district during recruitment of the research assistants. The pretesting was done at MAPERESE office, where 14 people were randomly selected from a gathering of people at the office for interview. The pre-tests served the purpose of adapting the questionnaire to the local settings and familiarizing the interviewers with the questionnaire.

3.9. Data collection procedures

At the time of interview, household sampling was done as follows; starting point for the interview in all the villages was the office of the village executive officer. The survey team then worked going through three directions from one willing household to its nearest neighbour, until a pre-determined household number, based on the size of the village was reached.

4.0 Data Processing, entry and analysis

Data obtained through questionnaire were summarised in tables as shown in chapter four followed by description in relation to research objectives and questions. None quantifiable data were analysed through content analysis techniques. Content analysis was used because it was easy to access and work on one level of meaning, that is, content of data, units for coding were identified and the coding categories were defined .Then, by using statistics package for

social Sciences (SPSS) software, the data were entered and analysed to produce frequencies and percentages. Cross tabulation were used to generate meanings in places where relationships of variables were needed in order to get causal relationship. Interpretation was done according to the research objectives and questions.

4.1 Ethical Consideration

Ethical principles in the conduct of research include acquiring research clearance permit and informed consent of the participants as well as maintaining confidentiality [40].

For this study ethical approval was obtained from the research and publication committee of Muhimbili University of Health and Allied Sciences before the study commenced. The ethical clearance letter introduced the researcher to Magu district executive director, who then issued an introduction letter to the district medical officer. The DMO also issued an introduction letter to the ward and village leaders.

In administering the questionnaires, the household heads were informed the purpose of the study and its contribution to the country. The respondents were allowed to participate at their own will. The researchers assured the respondents that privacy and confidentiality would be guaranteed

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter presents, analyse and discusses the findings obtained from the study. The research findings are presented according to the research objectives and questions as shown in chapter one.

4.2 Household Characteristics

Included below is an explanation of the social, demographic and economic profile of 200 households spread among 20 villages in 4 selected wards in Magu district (Appendix 2, for details on wards and village sample)

4.2.1 Social demographic profile of the study population

The interview involved a total of 118 (59%) male and 82 (41) female heads of the households. The median age for the all heads of households was 43 years and the range was between 24 and 79 years.

Table 2 Age, gender of households

Social demographic variables	Frequency	Percentage
Age distribution of head of households in years		
20-29	**20**	**10**
30-39	**70**	**35**
40-49	**54**	**27**
50-59	**31**	**15.5**
60+	**25**	**12.5**
Total	**200**	**100**
Gender of heads of households		
Male	**118**	**59**
Female	**82**	**41**
Total	**200**	**100**

4.2.2 Social economic profile of the study population

A total of 200 households were asked about their education status and the majority 122 (61%) mentioned to have completed primary education, 42 (21%) household heads reported to have archived secondary education while 21(10.5%) household heads mentioned to have no formal education at all. And 15(7.5%) household heads mentioned to have higher education.

With regard to occupational, 139 (69.5%) were small scale farmers, 36 (17%) were formal employees, 3 (1.5%) of household heads were large scale farmers, 13 (6.5) of household heads were doing business and 9 household heads were doing petty trades. A summary of the profile on education and occupation of household heads is presented in table 2.

Table 3 Occupational and education level of house hold heads

Social demographic variables	Frequency	Percentage
Occupation of heads of household (N=200)		
Small scale farmers	139	69.5
Large scale farmers	3	1.5
Professionals	36	18
Business	13	6.5
Petty Trades	9	4.5
Total	**200**	**100**
Levels of education		
No formal education	21	10.5
Primary education	122	61
Secondary education	42	21
Higher education	14	7
Others	1	0.5
Total	**200**	**100**

4.2.3 Awareness about CHF

The household heads were asked to assess the level of their knowledge on CHF, the results show that 166 (83%) were aware of CHF while 34 (17%) were not aware.

Sources of information about CHF varied from one household head to another, Table 3 below provide a summary of different sources of CHF information as 59 (29.5%) from health facilities, 52 (26%) from sensitization meetings, 28 (14%) from village meetings, 23(11.5%)

from friends, 4(2%) from neighbour while 34 (17%) mentioned other sources like TV, radio and newspapers.

Table 4 Awareness of CHF of heads of Households and source of information

Source of information	Frequency	Percentage
Heads of household (N=200)		
Health facility	59	29.5
Sensitization meeting	52	26
Village meeting	28	14
Friends	23	11.5
Neighbour	4	2
Other sources	34	17
Total	200	100

Further to investigate on CHF knowledge in the community, household heads were asked to explain correctly what they knew about CHF. A total of 111(55.5) in their own words were able to explain correctly about CHF. A total of 89(44.5%) household heads could not explain correctly about CHF.

Probing further household heads were asked to give their own views about community knowledge on CHF and their judgement show that 81(40.5%) explained that the community knowledge is very good, while 119 (59.5%) said that the community knowledge is very poor.

Household heads were also asked to suggest how the community can best be reached with sensitization meeting and the findings are summarised in table 4 below.

Table 5 Sensitisation information about CHF

Source of information	Frequency	Percentage
Heads of household (N=200)		
Village meeting	115	57.5
Sensitization meeting	47	23.5
Health facility	24	12
Friends	10	5
Neighbour	4	2
Total	200	100

The findings suggest that the best way to reach the community through sensitization is through village meetings (57%) followed by sensitization meetings (23.5%) then through dissemination of information through health facilities.

4.2.4 Proportion of CHF scheme members in the community

Among 200 household heads, a total of 60(30%) were found to be CHF active members and 140 (70%) non-members due to different reasons.

Household heads were further asked if they were members of CHF scheme in the previous years and the results indicate that 37(18.5%) households were CHF members indicating a decrease of membership from the scheme. This could be attributed by different reasons.

Table 6 CHF membership currently and previously

Source of information	Frequency	Percentage
Current CHF membership (N=200)		
Yes	60	30
No	140	70
Total	200	100
Previous CHF membership (N=200)		
Yes	37	18.5
No	163	81.5
Total	200	100

4.2.5 Perceived benefits of CHF

Household heads were asked if they there is any benefit of being a CHF member, the finding indicate that 169(84.5%) agreed that CHF is beneficial, while 10(5%) of them refuted that there are any benefits from the scheme. Another 21(10.5%) could not state if CHF has any benefits to the community.

In additional respondents were asked to mention CHF benefits and the responses obtained 153(76%) perceived getting treatment with their family throughout the year without paying any money as a benefit, drug availability and reduced cost were cited as benefits by 30(15%) and 17(9%) respectively. The finding are summarised in table 6 below.

Table 7 CHF perceived benefits

Source of information	Frequency	Percentage
CHF benefits (N=200)		
Yes	164	84
No	10	5
Could not remember	21	11
Total	200	100

Responses	Yes	No	%
Perceived benefits to CHF (N=200)			
Treatment throughout the year without payment	153	47	76.5
Drugs availability	18	182	9
Reduced cost	106	94	53

4.2.6 Reasons for enrolment and non-enrolment with CHF

Respondent of households were asked to agree or not agree with the following reasons for enrolling with CHF, and the following were their views:- make drugs available throughout the year 125(62.5%), health workers to change their negative attitude 111(55.5), Reduced waiting time 36(18%), attended by unskilled health personnel 30(15%), Improved infrastructure 95 (47.5%), improved management and administration 91(45.5%)

On the other hand respondents were asked to agree or not agree with mentioned associated problems of being members of CHF scheme and the following were their responses, out of 200 respondents asked, a total of 142(71%) agreed with members are sometime required to

pay for extra, apart from the fee especially buying the drugs in public health facility as a problem, a total of 60(30%) respondents agreed with being attended by unskilled health personnel, and 120(60%) agreed with the reason that no-members of CHF scheme are treated better than members since they provide cash payment.

On top of that household heads were asked to give their own opinion that drives majority not to join at all in CHF scheme in the community and the following were their responses, a total of 24(12%) mentioned bad staff attitude, long waiting time in public health facilities were perceived by 55(27.5%) respondents, poor infrastructure were perceived by 12(6%) of respondents, lack of drugs were perceived by 72(36%), inadequate sensitization were perceived by 112(56%), poor management and administration was perceived by34(17%)

Table 8 summarises the findings on how to increase enrolment in the CHF scheme in the district

Table 8 Reasons for enrolment or no enrolment

Source of information	Yes	No	%
Reasons for enrolment (N=200)			
Make drugs available throughout	125	75	62.5
Health workers to change negative attitude	111	89	55.5
Reduced waiting time	36	164	18
Attended by unskilled health personnel	30	170	15
Improved infrastructure	95	105	47.5
Improved management and administration	91	109	45.5
Associated Problem of being CHF Members (N=200)			
Sometimes required to pay extra for drugs	142	58	71
Non-members treated better because they have cash	120	80	60
Drivers causing community not to join CHF (N=200)			
Poor attitude of health personnel	84	116	42
Lack of money	15	185	7.5
Unskilled health personnel	24	176	12
Long waiting time in public health facilities	55	145	27.5
Poor infrastructure	12	188	6
Lack of drugs	72	128	36
Inadequate sensitisation	112	88	36
Poor management and sensitization	34	166	17

4.2.7 Perceived attitude on CHF Insurance concept among community members

When asked what they understand on community member's perception on CHF. The house hold heads had the following responses, A total of 83(41.4%) had the feeling that CHF scheme is very beneficial but in order for it to do better the community need to be educated so that they understand it through meetings then people can join. Also 15(7.5%) household heads recommended sensitization meeting to be done intensively in the community for the scheme to be understood, it is only through clear objectives and goal the community can participate fully through giving their contributions in terms of money. A total of 30(15%) household heads had the following to say, the scheme is so good but people get discouraged to join when the supply of drugs is irregular, so it is when health services through public health facilities is improved then the community can join the scheme more willingly, but if no efforts are done to improve health services then the pace of joining the scheme will continue to be dwindling. Looking at their views to improve the scheme in order to eliminate all the obstacles which hinder CHF progress, to do more sensitization meetings and education so that the community become aware of all the benefits of the scheme, to improve on drugs availability in the public health facilities to attract more people to join the scheme and some said household heads admitted that the scheme is liked by many people.

Looking at the reasons given above it is obvious that the community perception is positive. No negative perception of CHF in relation to culture, norms, religious and ethnicity. However people need to be assured of quality of good health care before they join the scheme. The government need to ensure that the community is fully aware about the scheme and improving the health services in the public heath facilities.

4.2.8 Opinion on influential factors to pay the premium

When asked to mention the premium which is paid any time the family decide to join the scheme, the results indicate concurring with what the district official said. The amount is

Tsh.10, 000, Although the right answer was mentioned by 106 (53%) a reasonable number of house hold heads were not sure or did not know exactly what the premium was, this again indicate that the CHF concept is not well known to the community which call more sensitisation to make the community understand better about the scheme. The table below summarises the community knowledge on CHF premium in the district.

Table 9 Responses on current premium

Responses	Frequency	Percent	Valid %	Cumulative %
Tsh. 10,000	106	53	53	53
Depends on earning	2	1	1	1
Depends on kind of person	1	0.5	0.5	0.5
Do not know	91	45.5	45.5	45.5
	200	100	100	100

When asked to mention how the community was involved in setting up the premium a total of 68 household heads said that there were no community involvement at all and 100 household heads admitted that they knew northing as far as CHF introduction is concerned, the responses given indicate that although CHF mission and objective is good for the community, little was done in most district like Magu district were sensitization was not done effectively, this means a lot of efforts is needed to ensure that the community is full aware of CHF scheme in order for the scheme to work effectively in the community.

Household heads were asked to mention the period when CHF premium is paid, like in other aspects about the scheme, the majority 125(62%) did not know at what time of the year the household should pay their contribution. From the district officials the DMO, DHO and CHF coordinator the premium can be paid at any time of the year, but they encourage the community to pay their premium during the harvests seasons which is between May and July in the district. The district officials said they encourage household to pay the premium during

the harvest season because it is the only time when most of the households have the financial capacity after selling their farm produces, rather than during other time when most of the household run bankrupt and impossible for them to pay for the premiums.

However this seems not to be well understood at the grassroots level which again it calls for more community involvement through sensitisation meetings in order for the community to understand better.

Furthermore the household heads were asked if there are any barrier for them or the community to join the CHF scheme and 110(55%) agreed that people have several barriers which hinder them from joining the scheme and the most prominent one with this respect lack of money to pay for the premiums at 77(38.5%), other reasons were also being mentioned like distances to public's health facilities, and paying the premiums at once.

4.2.9 Qualitative data from the key informants

In this study a total of three key informants (KI) were interviewed through in depth interview that included the District Medical Officer, District Health Officer and District CHF coordinator all three of them were males.

4.2.9.1 Community knowledge on CHF

All the three officials had a clear understanding of CHF scheme; they were able to mention the benefits of CHF schemes and the concepts of health incurrences schemes. They were able to mention the number of people in the household who qualify for membership as well as the amount of contribution the household is supposed to pay which at the moment is Tsh. 10,000.

They all admitted that CHF is not doing well in the district as a result of many factors as demonstrated by the following quotations:

"*They do not have enough knowledge on CHF because people in our community do not like to attend sensitisation meeting, the turn up is usually poor when you call such meeting"(KI2)*

Another key informant had the following to say:-

"We do not have enough working tools and the budget for sensitisation is very little that is why we are not doing well. Had we having enough funds for sensitisation the majority of people could join the scheme" (KI3)

The other one said:-

"*Frankly speaking sensitization of community health fund was done only during the introduction, I think we need to put more efforts as a district to ensure that we send more information to the community as well as intensifying monitoring and supportive supervision to the boards and health facilities"(KI1)*

4.2.9.2 Perceived Benefits of CHF scheme

All the three district officials had high degree of understanding towards the whole issue of CHF benefits as seen from the following quotations:-

"*Truly speaking CHF has many benefits to us, apart from giving families with assurance to health services the whole year without additional payment CHF has assisted the procurement of medicines and other medical supplies than if we could depending on the government only"(KI1)*

"We have managed to construct public toilets, repairing of staff houses, paying guards as well as purchasing of medicines and other medical equipments and supplies"(KI3)

"*CHF has benefits, as human being is very difficult to predict when we fall sick, since the community members will have insurance, health services accessibility is assured at any time. Another benefit is the contribution from the government which is the same amount of what we have contributed"* (KI2)

4.2.9.3 Views on How to Increase Enrolment on CHF Scheme

All the three district officials suggested how best they could do to increase community health funds members in the district. One of the key informants had this to say: -

"I think we need to put more efforts to ensure we have enough drugs throughout the time this will encourage more people to join the scheme, luck of drugs and other supplies all the time hampers our efforts so we need more budget allocation"(KI1)

Probed further on how communities could be educated about the CHF, one informant had this to say:-

"The community has low knowledge on CHF matters, we need to device our sensitisation approaches by employing several ways of transmitting CHF sensitisation messages other than depending on sensitization meetings only which has not shown good results. Therefore I suggest other ways like using influential people, mass media, meeting, radios and television, brochures and leaflets just to mention a few"(KI3)

One of the key informants suggested some far reaching legal measures as can be observed from the quotation below:-

"From what I see, I think we need to review our bylaws in our district to make CHF compulsory to every household, but if we leave it on a voluntary basis, then the success of this scheme will take long time to achieve its intended benefits"(KI2)

4.2.9.4 Factors Contributing to Failure of Community Members to Pay the CHF Premium

Several reasons were mentioned as possible factors contributing to failure of community members to pay for the premium set for community health fund, the factors include poor quality of services provided at the public health facilities, the main being shortage of medicines at the public health facilities influenced by the government and the community. Low awareness of the community on all matters related to CHF also lack of efficiency in the government supply system. Furthermore they also mentioned that the CHF scope of services and coverage is another limitation due to the fact that the insurance package covers the basic health services at the primary level within the district council borders as demonstrated by the following quotations from one of the key informants:- .

"We have so many essential drugs that are missing, usually available only for a month and when they go out of supply it take a long time to get another supply, for this is an obstacle that hinders the majority of community members to join the scheme, on top of this the supply chain from Medical store department also worsen the problem since they sometime miss to supply the kind of drugs requested through the indent system (KI1)

Another key informant had this to say:-

"I have the views that what is being provided by CHF in terms of basic package as well as where to get treatment is a reason which make people to shy away from the scheme. On my own suggestion I think CHF could do better if the package was wider enough to allow people to be treated without limitations since the government could buffer other cost also allowing a person to get treated any where instead of restricting health services to be provided only at a single health facility" (KI2)

4.2.9.5 Community Involvement on CHF Matters

This section intended to probe key informant knowledge and experiences to understand if the community was involved during the planning, sensitization and implementation of the community health fund activities in Magu district. Views from the district officials suggest some solution on community involvement as confirmed by one of the key informant:-

"CHF is a top down scheme hence we need to ensure that every community member is aware of the good intention of this nice scheme, so the scheme has good benefits to the informal sector but efforts need to be done in order to ensure that the correct message is sent to the community, if we do not do this then people will continues thinking that it is a government property which normally has no sustainability"(KI1)

Another opinion was given by one of the key informant who explained what was done initially in the district to ensure that CHF is asuccee in the district, he had the following to say:-

"Community sensitization starts from district level whereby all head of departments have been involved. Also different stakeholders through primary health care meetings were also sensitized .Then we trained councillors and other political leaders and moved further to division leaders, WADC and up to the village government. Others do not know that why we have involved all levels and later we came down to community themselves through community sensitisation meetings (KI2)

CHAPTER FIVE

5.0 DISCUSSION

The discussion on study findings below is presented in six parts; household characteristics are discussed first, followed by awareness on CHF scheme among the community, a discussion on proportion of CHF scheme members in the community, a discussion on perceived benefits of CHF scheme among members of the community, a discussion on enrolment in the CHF scheme in the district, a discussion on perceived attitude on CHF insurance concept among community members is lastly followed by a brief discussion on some limitations which the study faced.

5.1 Social, economic and demographic characteristics of the respondents

Age and sex are important demographic variables that are the primary basis for demographic classification in vital statistics, censuses, and surveys. According to the study findings, 59% of the households were headed by male while the other 41% were headed by females. The age of respondents that gave information ranged from 24 to 79 years, looking at the age this is economically productive age and a substantial burden is placed on these people to support older and younger members of the population. This is good mix of ages of respondents that gave information from a wide range of people with different views, mission, vision and ability to understand the role of social economic characteristics influencing enrolment to community health fund.

Education is a key determinant of the lifestyle and status an individual enjoys in a society. Studies have consistently shown that educational attainment has a strong effect on health related issues such as contraceptive use, fertility, infant and child mortality, morbidity, and attitudes and awareness related to health issues [41]

The finding show the majority of households 122 (61%) have completed primary education, 42 (21%) household heads reported to have archived secondary education while 21(10.5%)

household heads mentioned to have no formal education at all. And 15(7.5%) household heads mentioned to have higher education.

The findings on the economic profile of the study population (Table 2) identify small-scale farming as the main preoccupation and hence main source of household income in Magu district. Similar observations have been documented by other sources [8, 24].Although most households are engaged in small-scale farming the monetary returns are little.

5.2 CHF awareness among the community

At the household level, the majority of the study population were aware of CHF (83%). Health facilities, sensitisation meetings and village meetings were identified as the main source of the awareness information. When asked to suggest the best way to send information on CHF to the community, the majority of them indicated the village meetings. It is with this view that the district authorities which is the custodian of this scheme need to ensure that efforts are done to disseminate enough information about the scheme through village meetings so that the community understands the scheme and therefore can become active members of the scheme.

Other sources of information particularly the mass media such as radio, newsletters and television although mentioned by few members of the study population had not been explored as a possible strategy for raising awareness about CHF in the community.

Overall, male heads of household had significantly higher levels of awareness on CHF than female heads of households. Whereas female relied on health facilities for such awareness, the male relied on health facilities, village meetings and sensitization meetings. It is known that in Magu district few female ventures into public meetings. It is also documented that most rural health facilities in Magu are understaffed [33]. Hence, heavy workload may not allow health workers to be consistent in spreading awareness about CHF at the health facilities. These two reasons could explain the disparity in awareness between male and female heads of household.

5.3 Proportion of CHF scheme among members in the community

Based on the original CHF membership recruitment target of 65% for the district by 1998 [38], enrolment of CHF membership according to district coordinator in Magu district is lower, standing at 13% although the findings in the study area indicate to be at 30% which is still lower as compared to the initial envisaged target by the government.

This finding confirm other similar findings in Singida and Igunga which was 6% and 4 respectively [10] and more recent data indicated that in some district were initially enrolment was recorded high a decline has been seen for example in 2001 at 3% and 2.2% in 2003

With this percent 5% the scheme will be susceptible to adverse selection due to the fact that families which think of having high health risk might be dominant among the scheme members. Opposing selection denies the quality of cross subsidization where by health and unhealthy people share health risks. To minimize the like hood of opposing selection, Magu CHF has to increase members' enrolment and retain members who can create a meaningful cross subsidization of risks between high risk and low risk individuals. High enrolment will also prevent collapsing of the scheme because for the small scheme like CHF which operates within the district the communities are endangered to the same environment and health risks.

The findings highlight the challenges district officials run into when calculating enrolment percent of CHF members who join the scheme. This arises because the community is free to register at any time of the year when they want to do so. I t could be easy if the agreement is reached between the district administration and the community on the exact time of the year of doing registration. This would also help the district council to meet its plans on time due to resource availability from both CHF members as well as matching grant from the government.

5.4 Perceived benefits of CHF scheme

The main reason for enrolment was easy accessibility of health care which means that once prepaid, the household members enjoyed unlimited access to medical care for one year without being bothered about treatment costs. Other specific reasons for enrolling as members included reduction in cost and drugs availability.

By paying Tsh. 10,000 and accessing treatment for the whole year is much cheaper than paying Tsh. 3,000 per every visit. When a particular family happens to have frequent visit to health centre or dispensary for the entire year, may end up paying large amount of money than the set fee of Tsh.10,000 per family not exceeding 8 people.

Drugs availability, provision of good services, good staff attitude, reduced costs, and renovation of health facilities such as building of public toilets for patients, painting and building a shade for health facility ambulance were only cited in few responses.

In short many individuals have shown high degree of understanding towards the whole issue of CHF benefits. Building of health facility infrastructures, allowances for health facility supporting staffs such as cashier and watchmen's ,procurement of medical equipments and supplies, health services assurance to household members and government contribution through government funds were the main benefits mentioned by majority participants who participated in the study area.

5.5 Community views on how to increase enrolment on CHF scheme

The findings indicate that, health services provided through CHF scheme was a major concern. Communities complained on lack of drugs, longer waiting time, and extra payment of CHF members especially on drugs, unskilled man power, and poor infrastructures.

In order to do better they proposed ways to do better, such as the importance of improving the CHF insurance in such a way that drugs are med available throughout, improve on insurance coverage and the services package offered by the scheme.

In addition to that health workers should change negative attitude towards CHF members through preferring cash payment, reduce waiting time during service delivery at public health facilities, improve sensitization by involving different stake holders from the district up to the lower level. Improved infrastructures as well as improved management and administration through increasing transparency on how CHF funds are managed.

Communities recommend on the importance of providing consistency information on how CHF scheme is operated. This will create trust to CHF members and therefore reduce complains on CHF implementation process.

The intention of CHF is to involve the community in management issues and financial planning and management skills to be available at community level. The comment reflects lack of community involvement in management of the scheme hence for more people to join information regarding CHF implementation should be provided on regular basis.

The finding show that 77 % of respondents mentioned financial constrain as a barrier in the community on how to join the scheme, and this could be solved by encouraging people to contribute their premium during harvesting time when they have money rather than waiting until the time the community do not have money to contribute. The studies have also suggested the same that the community contributions to CHF should be done during the time when the community have money, and this is usually when they have sold crops/during the harvesting season, if you wait until other time the community will have prioritised their money to other family placing needs [24]

5.6 Perceived attitude on CHF Insurance concept

The perceived attitude of the community towards CHF is very positive. This perception emanate from the benefit package that are anticipated by the community members by joining the scheme. Assurance of health care services as a result of a particular family registering for the health insurance was mentioned as a major factor people attach to the community health insurance.

Despite of good perception of the community on health insurance fund which according to this study is 83%, one would expect high number of citizens joining the scheme, however the result from the district officials have shown that only 5% are members and the findings from the community show only 30% of the community members are CHF members. The main complaint is constant shortage of drugs in the public health facilities. This could be among of the reasons contributing to low enrolment of the community to the Community Health Fund because most of the people take drugs availability as the main attracting factor for them to enrol.

In spite of the fact that 70% of the community members are not CHF members, health services utilization has increased comparing to previous period. People awareness on utilization of health care services has increased and the practice of self-medication as well as using traditional healers is somehow decreasing. In some instances the community is willing to go to private health facilities for treatment by knowing that even in public health facilities one would be required to pay for medicine as well.

While increasing utilization may indicate positive impact of the CHF policy as well as people awareness on using health facilities, however high utilisation of health services should be interpreted with caution as this might be induced demand from the community.

5.7 Community member's opinion on Influential factors to pay the premium

In Magu district, the current premium for a household to join CHF membership is Tsh. 10,000. Payment of insurance is done at any time of the year depending on what period a household wish to join.

This could also be the reason why the majority are not joining the scheme. In the initial CHF design manual it is mentioned that for rural people collection should coincide with harvest season when household have enough and in a better position of paying. Premium setting needs to be done through community participation. The majority of household heads denied of being involved in setting the fee.

However the community need to be involved in CHF issues to instil the sense of ownership, decision making, and ownership of the community health funds.

As far as the involvement of the community is concerned the government has emphasized CHF members to have a great say in the planning and management of CHF activities [30]. It states clearly that the CHF organisation structure builds on existing structures of government operations to avoid building up of new and parallel structure. At the district level the management of CHF is by district council and various committees are involved. This include village primary Health, Ward Development and District Health Board.

The study finding also show lack of community understanding on health insurance concept; the majority according to this finding76% are ready to pay by only looking on the anticipated benefits the insurance can offer. This means the communities don't understand the essence of risk sharing between the health and unhealthy people. This exposes the community to the risk of adverse selection. The majority are paying in exchange of health services like drugs availability. For example a person may be willing to pay because he expects the next day to visit the health facility and receive drugs, which means if he/she is sure that he might not fall sick he/she may decide not to join the scheme. This bring the impression that community sensitization should not focus on the benefits of the particular family to be a member but

insurance concept to the communities should be elaborated in a very clear way for the community to comprehend .

Another reason cited is lack of money resulting from low income generating activities mainly from substance agriculture, farming in Magu district depends on unpredictable weather changes. If it happens that the season is bad due to drought even the harvesting will fall affecting the community to raise money to pay the insurance fee. Basing on the same argument in place where there are other alternative for example in Kisesa A ward where enrolment is 45% the community have other activities to do there any time of the year and earn money. This is different from peasants who depend solely on agriculture and their income could fluctuate according to the season of the year.

The low income cannot be the sole contributing factor to enrolment the main problem could be emanating from lack of willingness and stinginess to ensure against health risks to ensure against health risk instead of actual financial ability of paying membership fee. Education on health insurance will motivate the people to generate the habit of saving for health insurance. In reality Tsh. 10,000 appears to be relatively too little to be raised by household because it is worth only one grown chicken. This implies that there is a need for more community education on the importance and benefits of insuring health.

The practice of some of the health staffs were not accepted by the communities because they normally prefer client who pay cash for health care services. A person with a health insurance card is seen as unworthy. The findings revealed communities complaining on lack of health care services accessibility because the health staffs want money in exchange of health services.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 Conclusion

The study has shown that the decision to enrol in CHF is shaped by the social economic and demographic characteristic of community members, and these include education and household's economic status, gender and age.

In relation to CHF awareness at the household level, the majority of the household in the study area in Magu district were aware of CHF. It is therefore concluded that level of awareness about CHF at the household level is very good.

CHF awareness was found to be contributed mainly by health facilities, sensitisation and village meeting. This means awareness is high in villages that were near health facilities and it decrease with increasing distance. Further to that although sensitisation meetings and village meetings were the commonest source of CHF awareness information, their respective contribution were found to be 47% as compared to other sources of information dissemination channels. It is therefore concluded that past use of sensitization and village meetings as the source of CHF awareness information in Magu district had not been satisfactorily effective.

As far as CHF house hold membership was concerned, low membership was both seen from the CHF coordinator and also from the study population, information is power but with this respect the community lack information, on this basis it is concluded that low awareness of CHF within the community could be the main reason contributing to low membership of CHF in Magu district.

Easy accessibility of health care services, reduced cost and drugs availability were cited as perceived benefits of CHF, this gives an impletion that the community is very aware of the perceived benefits of CHF.

6.2 Recommendations

Based on the above, the following recommendations are made:

In view of the short falls revealed in CHF awareness, a sustained CHF promotional campaign strategy is recommended to Magu district council. The strategy should embrace the following:

- The promotional campaigns should be clear on the benefits of CHF
- Count on the mass media e.g. radio in the sensitisation campaigns
- Women should be targeted
- The sensitisation meetings should target villages located far from public health facilities

For future research the following recommendation is made:

The effectiveness of village meetings, rural based health facilities and CHF village representative as a source of CHF awareness information.

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Appendix 1

QUESTIONNAIRE

CONTRIBUTING FACTORS TO CHF MEMBERSHIP IN MAGU DISTRICT

Introduction

I am a researcher, doing research on Community Health Fund, with the purpose of improving it, for the benefit of Magu community. I have few questions to ask you. Can I read this consent form for you to request your willingness to participate? Are you willing to participate?

1. Participant Yes (Proceed with the interview)
   No (Thank the respondent and wish him/her a nice day)

2. Questionnaire Number…….3.Village Name……

4. Interviewer Name……..

5. Interview Date: Day……..Month……..Year 2012

To be completed by research assistant: Fill the blank with correct answer or cycle the correct answer. If not applicable write N/A

Part 1. Demographic Particulars of the Head of the Households			
S/No	Question	Response	Skip Pattern
1	How old are you?	Years……..	
2	Sex of the participant	1. Male……. 2. Female……..	
3.	What is your level of Education?	1. No formal education…… 2. Primary Education…….. 3. Secondary Education…….	

		4. Higher Education…… 5. Other (specify)……	
4	What is your occupation?	1. Peasant…… 2. Commercial farmer……. 3. Business…….. 4. Petty trade…… 5. Employed by government….. 6. Employed by private sector… 7.Other(specify)	
Part II. Awareness on CHF scheme among the community			
5	Have you heard about CHF Scheme in this district?	1. Yes……. 2. No……	
6	From which source did you hear about it?	1. Village meeting/leader….. 2. Neighbour…….. 3. Sensitization meeting…… 4. Friends…… 5. From the health facility…. 6. Other……	
7	Could you explain what do you know about CHF? Here the Interviewer must listen carefully for the explanations and make	1. Correct…… 2. Not correct…….	

	correct judgement.	3. He/she cannot explain……	
8	Basing on your experience what is the community knowledge about CHF in your village?	1. Poor……. 2. Good……. 3. Excellent…….	
9	How can community members be best reached with sensitization information about CHF scheme?	1. Village meeting/leader….. 2. Neighbour…….. 3. Sensitization meeting…… 4. Friends…… 5. From the health facility…. 6. Other……	
Part III Proportion of the CHF scheme members in the community			
10	Is your household currently member of CHF scheme?	1. Yes……. 2. No……..	
11	Has been a member in previous years?	1. Yes…… 2. No…….	
Part IV Perceived benefits of CHF scheme among members of the community			
12	Do you think there is any benefit of being a CHF member?	1. Yes…… 2. No…… 3. I don't know……	
13	Can you mention those benefits?	1. After paying the fees you can get treatment with your family throughout the year without prompt	

		payment…… 2. Drugs are now more available than before…… 3. Less cost incurred for health care compared to out of pocket payment……. 4.Others(specify)	
Part V Community views on how to Increase enrolment in the CHF scheme in the district			
14	What are associated problems of being a member of CHF scheme?	1. Long waiting time in public health facilities…… 2. Members are some time required to pay for extra, apart from the fee eg buying drugs…… 3. Attended by unskilled health personnel…….. 4. Non-members treated better than members since they give prompt payment…… 5. Other (specify)……	
15	What should be done for you to get satisfied with it so that you can join the scheme?	1.Make drugs available 2. Health workers should change their attitude (specify)…. 3. Waiting time is reduced….. 4. Should have skilled health personnel…… 5. Infrastructure is improved…. 6. Management and administration	

		be improved….. 7.Other(specify)	
16	In your opinion what drives majority not to join at all in CHF scheme in your community?	1.Bad staff attitude(specify) 2. Lack of money……. 3. Unskilled health personnel… 4. Long waiting time in public facilities…… 5. Poor infrastructures…….. 6. Lack of drugs……. 7. Inadequate sensitization….. 8. Poor management and administration……. 9. I don't know…….. 10. Other…….	
Part VI Community members Perceived attitude on CHF insurance concept among community members			
17	What do you understand on community members' perception on health insurance?		
18	How is the community members understand CHF scheme?		
Part VII Community members on Influential Factors to pay the premium set for CHF membership			
19	Tell me what is the current membership fee?		

20	How is the current premium fee acceptable by the community members?		
21	At what time of the year are members supposed to pay the premium?		
22	Is there any barrier for you to join CHF scheme?	1. Yes…….. 2. No…….	
	Can you mention those barriers?	1. Lack of money to pay fee…… 2. Health facility is too far….. 3. I cannot pay fee at once…. 4. Other…….	
	Thank you for your cooperation		

Appendix 1

Dodoso Kwa wakuu wa Kaya

SABABU ZINAZOCHANGIA KUWA MWANACHAMA WA MFUKO WA AFYA YA JAMII WILAYA YA MAGU

Utangulizi

Mimi ni mtafiti, ninafanya utafiti kuhusu mfuko wa afya ya jamii kwa lengo la kuuboresha kwa manufaa ya jamii ya Magu. Tafadhali nina maswali machache ya kukuuliza .Naomba nikusomee fomu ya ridhaa ili kukutambulisha na kuomba ridhaa yako ya kushiriki kwenye utafiti huu-Je uko tayari kushiriki?

1. Mshiriki **Ndiyo** (Endelea na mahojiano) **Hapana** (Mshukuru aliyekujibu na mtakie siku njema)
2. Namba ya dodoso ……..
3. Jina la Kijiji……
4. Jina la Mdodosaji ……
5. Tarehe ya udodosaji: siku ……... Mwezi ……Mwaka 2012

Lijazwe na mtafiti msaidizi: jaza jibu sahihi sehemu zilizo achwa wazi au zungushia jibu lililosahihi. Kama haihusiki andika N/A

Part 1.Taarifa za Awali za Msingi za Mkuu wa kaya			
S/No	Swali	Majibu	Maelekezo ya ziada
1	Una umri gani ?	Miaka……..	
2	Jinsia ya mkuu wa kaya	1. Mwanaume……. 2. Mwanamke……..	
3.	Kiwango cha elimu?	1. Hana elimu…… 2. Shule ya msingi……..	

		3. Shule ya sekondari……. 4. Elimu ya juu…… 5. Nyingine (elezea)……	
4	Nini kazi yako?	1. Mkulima…… 2. Mkulima mkubwa……. 3. Mfanya biashara…….. 4. Biashara ndogondogo…… 5.Mwajiliwa serikalini….. 6. Mwajiliwa sekta binafisi… 7.Nyinginezo(taja)	
Part II. Uelewa na uhamasishaji jamii kuhusu mfuko wa afya ya jamii			
5	Umewahi kusikia kuhusu mfufko wa afya ya jamii(CHF)?	1. Ndiyo……. 2. Hapana……	
6	Ulisikia habari za CHF kutota chanzo kipi?	1. Mkutanao wa kijiji/kiongozi….. 2. Kwa jirani…….. 3. Mkutano wa uhamasishaji wa CHF 4. Marafiki…… 5. Kutoka kituo cha afya/zahanati…. 6. Njia nyinginezo(Taja)……	
7	Unaweza ukaeleza unajua nini kuhusu mfuko wa afya ya jamii(CHF)? **Mdodosaji anapaswa kusikiliza kwa makini ili kutoa alama mwafaka.**	1. Sahihi…… 2. Siyo sahihi……. 3. Hawezi kuelezea……	
8	Kwa kuzingatia ufahamu wako,elezea uelewa wa jamii kwa	1. Mzuri……. 2. Mbaya…….	

	ujumla kuhusiana na mfuko wa afya ya jamii(CHF)?	3. Mzuri sana…….	
9	Ni kwa jinsi gani wanajamii wanaweza kufikiwa kwa urahisi na huduama za uhamasishaji kuhusu mfuko wa afya ya jamii?	1. Mkutano wa wanavijij/Kiongozi….. 2. Majirani…….. 3. Mikutano ya uhamasishaji…… 4. Marafiki…… 5. Vituo vya afya/zahanati…. 6. Njia nyinginezo(Taja)……	
Sehemu ya Tatu:Kiwango cha uanachama wa CHF			
10	Je kwa kipindi hiki wewe na kaya yako ni wanachama wa mfuko wa afya ya jamii?	1. Ndiyo……. 2. Hapana……..	
11	Je kaya yako imekuwa mwanachama huko nyuma?	1.Ndiyo…… 2.Hapana…….	
Sehemu y a Nne: Mtazamo kuhusu faida za Mfuko wa afya wa jamii			
12	Je unafikiri kuna faida zozote za kuwa mwanachama wa mfuko wa afya ya jamii(CHF)?	1. Ndiyo…… 2. Hapana…… 3. Sijui……	
13	Taja faida za mfuko wa afya ya jamii?	1. Baada ya kulipa mara moja kwa mwaka,huduma za afya kwa kaya zinapatikana pasipo malipo yeyote…… 2. Upatikanaji wa dawa umekuwa mzuri…… 3. Gharama za matibabu zimepungua kulinganisha na ulipaji unapoumwa dirishani……. 4.Nyinginezo(Taja)	

Sehemu ya Tano: Mtazamo Kuhusu kuongeza idadi ya wanachama			
14	Ni chanamoto zipi zinazikumba kaya ambazo ni wanachama wa mfuko wa afya ya jamii?	1. Muda mrefu wa kusubiri huduma kwenye vituo vya afya ya jamii…… 2. Wanachama wanatakiwa kulipa hela za ziada hususani kununua dawa …… 3. Kuhudumiwa na wahudumu wasio kuwa na ujuzi wa kutosha…….. 4. Wasio kuwa wanachama wa mfuko kutibiwa bora zaidi kwa sababu wao wanapesa tasilimu…… 5. Nyinginezo (Taja)……	
15	Nini kifanyike ili kuwafanya watu walizike na hatimaye wajiunge na mfuko wa afya ya jamii(CHF)?	1.Kuboresha upatikanaji wa dawa 2. Watumishi wa afya kubadirika mtazamo …. 3. Kupunguza muda wa kusubilia huduma za afya….. 4. Kuwa na watoa huduma wenye ujuzi wa kutosha…… 5. Kuboresha vitendea kazi…. 6. Kuboresha utawala na usimamizi wa huduma za afya….. 7.Nyinginezo(Taja)	
16	Kwa maoni yako,unafikiri nini kinafanya watu wengi wasione umuhimu wa kujiunga na mfuko wa afya ya jamii?	1.Mtazamo mbaya wa watoa huduma za afya(taja) 2. Ukosefu wa fedha……. 3. Watoa huduma wasio na ujuzi wa kutosha… 4.Muda mrefu wa kusubulia huduma	

		za afya…… 5. Miundo mbinu mibovu…….. 6. Ukosefu wa dawa……. 7. Uhamasishaji haujatosheleza….. 8. Utawala na usimamizi mbovu……. 9. Sijui…….. 10.Nyinginezo…….	
Sehemu ya Sita:Mtazamo kuhusu Bima ya Afya			
17	Nini maoni yako kuhusu mtazamo wa jamii kuhusu bima ya afya katika kijiji chako?		
18	Je unafikiri jamii inaelewa faida zitokanazo kwa kuwa mwanachama wa mfuko wa bima ya afya ya jamii?		
Sehemu ya saba: Mtazamo kuhusu Uliapaji wa ada ya Uanachama			
19	Kwa sasa hivi ada ya uanachama wa CHF ni kiasi gani?		
20	Je ni jinsi gani wananchi walishirikishwa katika kupanga kiwango hiki?		
21	Kwa kawaida,jamii hulipa ada ya uanachama kipindi gani cha mwaka?		
22	Je,unafikiri kuna kikwazo chochote kinachozuia watu kujiunga na mfuko wa afya ya jamii?	1. Ndiyo…….. 2. Hapana…….	
23	Unaweza kunitajia baadhi ya hivi	1.Ukosefu wa fedha za kulipia	

	vikwazo??	uanachama 2.Kituo cha afya/zahanati iko mbali 3.Siwezi kulipia ada kwa mkupuo mmoja 4.Sababu nyinginezo	
	Ahasante kwa ushirikiano		

Appendix 2

CONTRIBUTING FACTORS FOR CHF MEMBERSHIP IN MAGU DISTRICT

A: Consent and demographic particulars of the respondent

Introduction

Name of interviewer……

Date……

Position of interviewer (Key information)……..

Health centre/Village……

C. Guiding questions

1. In your understanding what are the benefits or advantages of joining the CHF scheme?

(Probe benefits of the scheme, reasons for the majority of the people to join the scheme and procedure for joining

2.What are the problems or barriers that lead to majority of people in community to drop out from the CHF scheme?(Probe the problems or barriers of the scheme, reason for the people not joining the scheme, reason for the people not joining the scheme, reason for the members to drop out of the scheme)

-Probe for concrete example /case

3.What advice would you give to those organizing and running the CHF scheme in this district so as to improve performance and attract many people?

Appendix 2

MFUKO WA AFYA YA JAMII-WILAYA YA MAGU

Ridhaa na utambulisho wa mhojiwa

Taarifa Muhimu

Jina la Msailiwa ……

Tarehe……

Nafasi /Wadhifa wa Msailiwa (msemaji mkuu)…….

Wilaya……

C.Mwongozo wa maswali ya kuuliza

1. Kwa ufahamu wako, kuna faida gani za kujiunga na mfuko wa afya ya jamii? Ulizia zaidi faida za mfuko, sababu za watu wengi kujiunga na utaratibu wa kujiunga.

2.Ni matatizo au vikwazo gani vinavyopelekea watu wengi kwenye jamii hii kujiondoa toka kwenye mfuko wa afya ya jamii? (Ulizia zaidi matatizo au vikwazo vya mfuko, sababu za wanachama kujitoa kwenye mfuko)
-Ulizia mifano halisi ya matukio.

3.Unaweza kutoa ushauri gani kwa wale wanaopanga na kuendesha mfuko wa afya ya jamii hapa wilayani ili kuboresha uendeshaji wake na kuvutia watu wengi?

APPENDIX 3: INFORMED CONSENT AGREEMENT (English Version)

MUHIMBILI UNIVERSITY OF HEALTH SCIENCES, DIRECTORATE OF RESEARCH AND PUBLICATIONS.

INFORMED CONSENT

ID-NO ☐☐☐

Consent to participate in this study

Greetings! My name is ….. I am working on this research project with the objective to determine the Influence of Social, Economic and demographic factors on CHF Membership in Magu District Mwanza region.

Purpose of the study

This study has the purpose of collecting information on social, Economic and demographic factors influencing CHF membership in Magu district. You are being asked to participate in this study because you have particular knowledge and experiences that may be important to the study.

What Participation Involves

If you agree to participate in this study the following will occur:

1. You will sit with a trained interviewer and answer questions about what factors you think are associated with CHF Membership in Magu. The interviewer will be recording your responses in the questionnaire.

2. No identifying information will be collected from you during this interview, except your age, level of education, marital status.

3. You will be interviewed only once for approximately 25 minutes in a private setting.

Confidentiality

I assure you that all the information collected from you will be kept confidential. Only people working in this research study will have access to the information. We will be compiling a report, which will contain responses from several people without any reference to individuals. We will not put your name or other identifying information on the records of the information you provide.

Risks

You will be asked questions about CHF in Magu. Some questions could potentially make you feel uncomfortable. You may refuse to answer any particular question and may stop the interview at any time.

Rights to Withdraw and Alternatives

Taking part in this study is completely your choice. If you choose not to participate in the study or if you decide to stop participating in the study you will not get any harm. You can stop participating in this study at any time, even if you have already given your consent. Refusal to participate or withdrawal from the study will not involve penalty or loss of any benefits to which you are otherwise entitled.

Benefits

The information you provide will help to increase our understanding on factors associated with CHF membership in Magu district.

In Case of Injury

We do not anticipate that any harm will occur to you or your family as a result of participation in this study

Who to contact

If you ever have questions about this study, you should contact the study Coordinator or the **Principal Investigator, Juma Peter Kaswahili,** Muhimbili University of Health and Allied Sciences (MUHAS), P.O. Box 65001, Dar es Salaam (Tel. no. 0784669381 or 0654046852). If you have questions about your rights as a participant, you may call **Prof. M. Aboud, Chairman of Senate Research and Publications,** P. O. Box 65001, Dar es Salaam. Tel: 2150302-6 and **Dr. Mughwira Mwangu who is the supervisor** of this study.

Signature

Do you agree?

Participant Agrees [__] blessed

Participant disagree [__]

I _____ have read/understood the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of Participant _____

Signature of witness (if participant cannot read) _____

Signature of research assistant _____

Date of signed consent _____

Appendix 3: INFORMED CONSENT AGREEMENT (Swahili version)

MUHIMBILI UNIVERSITY COLLEGE OF HEALTH SCIENCES DIRECTORATE OF RESEARCH AND PUBLICATIONS.

FOMU YA RIDHAA

Namba ya Utambulisho ☐☐☐

Ridhaa ya Kushiriki katika utafiti huu

Habari! Jina langu naitwa …….. nafanya kazi katika mradi huu wa utafiti wenye lengo la kuangalia hali ya sababu mbalilmbali zichangiazo uwanachama wa mfuko afya wa jamii (CHF) wilaya ya Magu mkoa wa Mwanza.

Malengo ya Utafiti

Utafiti huu una lengo la kukusanya taarifa ya kuangalia sabaubu mbalimbali zipelekeazo kaya kuwa wanachama wa mfuko wa afya ya jamii(CHF) katika wilaya ya Magu Mkoa wa Mwanza.Unaombwa kushiriki katika utafiti huu kwa sababu una uelewa ambao unaweza kuwa muhimu katika tafiti hii.

Ushiriki.

Ukikubali kushiriki katika utafiti huu yafuatayo yatatokea:

1. Utakaa na msaili/mtafiti aliyepewa mafunzo ya jinsi ya kuhoji na kujibu maswali yahusuyo sababu mbalimbali zinazochangia wakuu wa kaya kuamua kujiunga/kutojiunga na mfuko wa afya ya jamii.Msaili atakua ananukuu majibu yako katika dodoso.

2. Hakuna taarifa zozote za utambulisho tutakazokusanya wakati wa usaili isipokua umri, kazi/shughuli za kazi, kiwango cha elimu na hali yako ya ndoa.

3. Utahojiwa mara moja tu kwa takribani dakika 25.

Usiri

Nakuhakikishia kwamba taarifa zote zitakazokusanywa kutoka kwako zitakua ni siri, ni watu wanaofanya kazi katika utafiti huu tu ndio wanaweza kuziona taarifa hizi. Hatutaweka jina lako au taarifa yoyote ya utambulisho kwenye kumbukumbu za taarifa utakazotupa.

Madhara

Utaulizwa maswali juu ya ufahamu wako kuhusu mwenendo wa mfuko wa afya ya jamii (CHF) Unaweza kukataa kujibu swali lolote na unaweza kusimamisha usaili wakati wowote.

Haki ya kujitoa na mbadala wowote

Kushiriki katika utafiti huu ni uchaguzi wako, kama utachagua kutokushiriki au utaamua kusimamisha kushiriki hutapata madhara yoyote. Unaweza kusimamisha kushiriki katika tafiti hii muda wowote hata kama ulisharidhia kushiriki. Kukataa kushiiriki au kujitoa katika utafiti hakutasababisha adhabu yoyote au upotevu wa faida yoyote unayotakiwa kupata.

Faida

Taarifa utakayotupatia itasaidia kujua kiwango halisi cha utendeji wa mfuko wa afya ya jamii na jinsi ya kuuboresha kiutendaji..

Endapo Utadhurika

Hatutegemei madhara yoyote kutokea kwa kushiriki kwako katika tafiti hii.

Watu wa kuwasiliana nao

Kama una maswaIi katika utafiti huu unaweza kuwasiliana na **mratibu mkuu wa mradi, Juma Peter Kaswahili** Chuo Kikuu cha Muhimbili, S.L. P 65001, Dar es Salaam (Simu. no. 0784669381 au 0654046852). Kama utakua na maswali yoyote kuhusu haki zako kama mshiriki unaweza kupiga simu kwa **Mwenyekiti wa kamati ya chuo ya utafiti na machapisho,** S.L.P 65001, Dar es Salaam. Simu namba: 2150302-6 na **Dr. Mugwhira Mwangu** ambaye ni **msimamizi wa utafiti huu**.

Sahihi

Unakubali?

Mshiriki amekubali [__]

Mshiriki amekataa [__]

Mimi _____ nimesoma/nimeielewa hii fomu, maswali yangu yamejibiwa. Nakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki _____

Sahihi ya shahidi (kama hawezi kusoma na kuandika) _____

Sahihi ya mtafiti muandamizi _____

Tarehe ya makubaliano _____