PROMOTING FAMILY PLANNING THROUGH HEALTH INSURANCE: A CASE OF NHIF INSURANCE PROGRAM FOR WOMEN IN MBARALI DISTRICT, TANZANIA

Jitihada Baraka

Master of Public Health Dissertation
Muhimbili University of Health and Allied Sciences
October, 2016

PROMOTING FAMILY PLANNING THROUGH HEALTH INSURANCE: A CASE OF NHIF INSURANCE PROGRAM FOR WOMEN IN MBARALI DISTRICT, TANZANIA

By

Jitihada Baraka

A dissertation Submitted in (Partial) fulfillment of the Requirements for the Degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences

Muhimbili University of Health and Allied Sciences
October, 2016

CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the Muhimbili University of Health and Allied Sciences a dissertation entitled; ***Promoting family planning through health insurance: A case of NHIF insurance program for women in Mbarali district, Tanzania,*** in (partial) fulfillment of the requirements for the Degree in Master of Public Health of the Muhimbili University of Health and Allied Sciences.

_____

Dr. Amani Anaeli

(Supervisor)

_____

Date

DECLARATION AND COPY RIGHT

I, **Jitihada Baraka,** declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other University for the similar or any other degree award.

Signature……..……. **Date ……**

ACKNOWLEDGEMENT

I would like to thank the almighty Allah for his mercy, guidance and protection throughout the year of my study. My sincere gratitude goes to my supervisor Dr Amani Anaeli for his tireless efforts in giving me valuable and excellent advice from the initial stage of development of the research proposal to the final completion of this dissertation.

I am also very much indebted to a colleague at Ifakara Health Institute, Donat Shamba, who tirelessly went through the document and gave me invaluable support and guidance to its current state.

I would like to extend my sincere gratitude and appreciation to the District Medical Officer (DMO) of Mbarali District, the CHF/NHIF Coordinator and Health staff in the RCH unit for their cooperation which made my fieldwork successful.

Deep gratitude is extended to all my respondents in Mbarali District, for taking initiatives and participates in my study voluntarily.

My earnest thanks and appreciation goes to my research assistants Beatrice Bilikwija and Adela Paul for their assistance during the whole period of data collection and data analysis.

Last but not least, many thanks are extended to my family for their unlimited moral support, encouragement and care.

DEDICATION

This work is dedicated to my son Noah Nitikesyosa Ghambi.

ABSTRACT

Background: In rural Tanzania vulnerable groups, notably pregnant women and children often pay to some of medical equipments when they want to give birth, pay for medicines and modern contraceptive despite the existing exemption policies. The Tanzanian National Health Insurance Fund (NHIF) with financial support from donors initiated a five year program to distribute free health insurance cards to poor pregnant women and their partners. The insurance cards empower them to overcome financial barriers in accessing family planning, maternal and child health services. This study aims to explore the role of health insurance scheme in promoting family planning services in Mbarali district, Tanzania.

Objective: To explore the role of health insurance scheme in promoting family planning services in Mbarali district.

Methodology: A total of 15 individuals participated in IDIs and 5 FGDs involve 40 participants, were conducted comprising of 6 participants in the smallest group to 10 participants in the largest group. Respondents were purposively selected basing on their participation in the scheme.

Results: The results of this study have testified that health insurance to some extent has promoted the use of family planning services in Mbarali district.That is having insurance card allowed community members to choose any family planning service provider of choice. The health insurance has increased availability of family planning commodities and medical instruments in all range of health care facilities. Furthermore for male partners who accompanied their wives to family planning clinics, their wives were reported to be as attentive to instructions and show up for their next visits as advised, this was compared with women who come by themselves at the first visit.

Conclusion: For the family planning services to be promoted there is a need that the benefit package and criteria for targeting beneficiaries are well understood by community. Income earned through the health insurance scheme can be used to improve availability of contraceptives and quality of care to satisfy clients' needs and ultimately improving health seeking behaviours of the target population.

TABLE OF CONTENT

LIST OF TABLE

LIST OF FIGURES

LIST OF ABBREVIATIONS

CHF	Community Health Fund
CHMT	Council Health Management Team
CPR	Contraceptive Prevalent Rate
DMO	District Medical Doctor
DMPA	Depot Medroxy Progesterone Acetate
FGD	Focus Group Discussions
FP	Family Planning
IDI	In-depth Interview
Kf W	Kreditanstalt für Wiederaufbau
MCH	Maternal and Child Health
MoHSW	Ministry of Health and Social Welfare
NHA	National Health Accounts
NHIF	National Health Insurance Funds
PI	Principal Investigator
RA	Research Assistant
RCH	Reproductive and Child Health
TDHS	Tanzania Demographic and Health Survey
THE	Total Health Expenditure
TNVS	Tanzania National Voucher Scheme

DEFINITION OF TERMS

Beneficiaries: Women and partners who are entitled to free health services from National Health Insurance for a period of 24 months

DMPA: Depo-Provera is the main type of injectable contraceptives available in Tanzania. It is like progesterone hormone in the body and stops the ovaries from releasing an egg (ovulation).

Family planning service provider: Any location where family planning services are provided.

Health insurance scheme: In this study, it is the health insurance established by NHIF funded by Development Bank of German with a goal to provide financia coverage to pregnant women and partners to acess free health services.

Implementer: In this study, means those NHIF has hired to oversee the Implementation of health insurance to poor pregnant women and partners to access free health services.

KfW: Formerly KfW Bankengruppe, is a German government-owned development bank, based in Frankfurt. Its name originally comes from Kreditanstalt für Wiederaufbau.

Partners: Refer to a person who is the husband or wife of someone, or to refer to a person who someone is living with and having a sexual relationship with, without being married to them.

Pregnant woman: Is the state in which woman is in the period from conception to birth.

RCH personnel: These are health care providers dealing with reproductive and child health and family planning service

Voucher: Vouchers are a demand-side financing mechanism for subsidizing the price of services/products to target population groups, with the goal of improving access to and utilization of those services and products**.**

CHAPTER ONE
BACKGROUND

1.0 Introduction

This chapter is about an overview of the country situation on family planning and family planning services, country health financing situation, overview of the prepaid health insurance scheme. Further, this section also provides the statement of the problem, rational of the study, research questions and the objectives.

1.1.1 An overview of family planning

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy (WHO, 2014).

Understanding the reproductive preferences of women, particularly motivation to utilize contraceptive methods, should drive the design and implementation of family planning programs in less and middle income countries. It has been found that contraceptive use levels have increased from 10 percent in the 1960s to more than 50 percent in the 1990s in developing countries, including some sub-Saharan countries (Robey et al., 1994). Despite the recent increase in contraceptive use in sub-Saharan Africa, the region is still characterized by high levels of fertility and considerable unmet need for contraception (Babalola, 2004). In sub-Saharan Africa women have been using family planning methods to prevent unwanted and unplanned pregnancies (Moultrie et al., 2012). Furthermore, in such countries many women desire to either space pregnancies or end childbearing altogether and yet they do not use any form of contraception thus maintaining an unmet need for family planning (Ali and Okud, 2013).

Evidence suggests that family planning reduces the demand for health services and also helps reduce the number of unintended and high-risk pregnancies that result in high levels of maternal and child illness and death (Moultrie et al., 2012). Unplanned pregnancies that result from lack of contraceptives can impede a woman's ability to support her family. Findings have shown that reducing unintended pregnancies by fulfilling the need for

family planning programs is a cost-effective strategy for increasing access to education for all children. Birth spacing through family planning reduces child mortality (Dibaba, 2010).

In Tanzania the focus on family planning was not to spread family planning methods for the purpose of population control but to enable families to have healthy children and healthy mothers (Richey, 1999). The Government of Tanzania has aimed to increase contraceptive prevalent rate (CPR) to 60% by 2015 (doubling Family planning users from 2.1 million recorded in 2010 to about 4.2 million by 2015) and reducing Maternal Mortality Ratio to 193/100,000 (Mutashobya, 2014).

The change from antenatal and post-natal clinic, mother to child health intervention (MCH) to Reproductive and Child Health (RCH) was intended to involve men in maternal health. Evidence from Tanzania shows that one in four married women of reproductive age want to space or limit births but are not currently using any family planning method (TDHS, 2010). Comparing an access and use of family planning between urban and rural areas, rural women are less likely to be using contraceptives than urban women. The poorest couples have the highest fertility, the lowest contraceptive use and the highest unmet need for contraception. It is also in the low resource settings where maternal and child mortality is the highest (Prata, 2009).

Failing to provide adequate reproductive health and family planning services to young mothers also passes risks to their children. However, the vast majority of married women in rural Tanzania reported significant problems in accessing contraceptive methods of their choice (TDHS, 2010). Although reasons for low usage are complex, shortage of resources, distance to the services, high costs and low capacity to provide services remain significant barriers to access family planning services (Campbell et al., 2006). Reducing maternal mortality is hindered by lack of access to family planning and reproductive health services. Hundreds of thousands of women die each year from pregnancy-related causes, and almost all of these deaths took place in the developing world. But what has been successful in reducing maternal mortality is a package of interventions covering maternal, new-born, child and reproductive health (Borghi et al., 2005, Olsen et al., 2000).

1.1.2 Health care financing mechanism for family planning services

In rural areas, vulnerable groups' notably pregnant women and children often pay for health services despite the existing exemption policies on reproductive health services. In order to address low usage of reproductive health services including family planning countries have adopted demand side financing (social health insurance, conditional cash transfers and vouchers) interventions to influence access, use and provision of reproductive health (Borghi et al., 2005). Conversely, prepaid health care schemes or community health insurance and maternal and child health insurance has been implemented in East Africa (Kenya, Tanzania and Uganda) and South Asia (Bangladesh and Cambodia). The voucher financing mechanism emerged potentially as a significant strategy to finance health sector (Emanuel, 2005, Lindsay, 2012). The initiative strategy targeted the disadvantaged population and contract health facilities providers to give care to the beneficiaries by offering them a subsidy to help purchase health services and preferably being able to choose a provider from a number of alternatives (WB, 2005). However literature shows that the health insurance programmes have been associated with increased skilled birth attendants, uptake of long acting family planning methods, reduced out of pocket expenditure and to improve quality of care and improve access to health services (Schellenberg et al., 2003). The health insurance scheme provide incentives to clients and health facilities workers to subsidize specific health care services based on pre-determined prices when client needs services at one of the accredited facilities. However the provider is then reimbursed services costs upon submission of claim and support evidence (Bellows et al., 2013).

1.1.3 Health care financing in Tanzania

In Tanzania, total health expenditure for health is about 9.2 percent of Gross Domestic Product (GDP) for 2016/2017. Of this budget to health sector, with family planning currently receive 0.2 percent of the total health expenditure according to Tanzania health budget (FB, ATTONEYS, 2016).

Tanzania health care system is financed from various sources, including public payments 26%, external donor funding 40%, Households payments 32% and private firms and employers 2% and prepayment schemes (figure 1).

Like many other countries in the low-income group, Tanzania's health financing system is dominated by public resources contribution and donor funded health delivery system, with insignificant proportion of the population enrolled in Community Health Insurance, or private health insurance.

Figure 1: SOURCES OF HEALTH FINANCING IN TANZANIA 2009/201

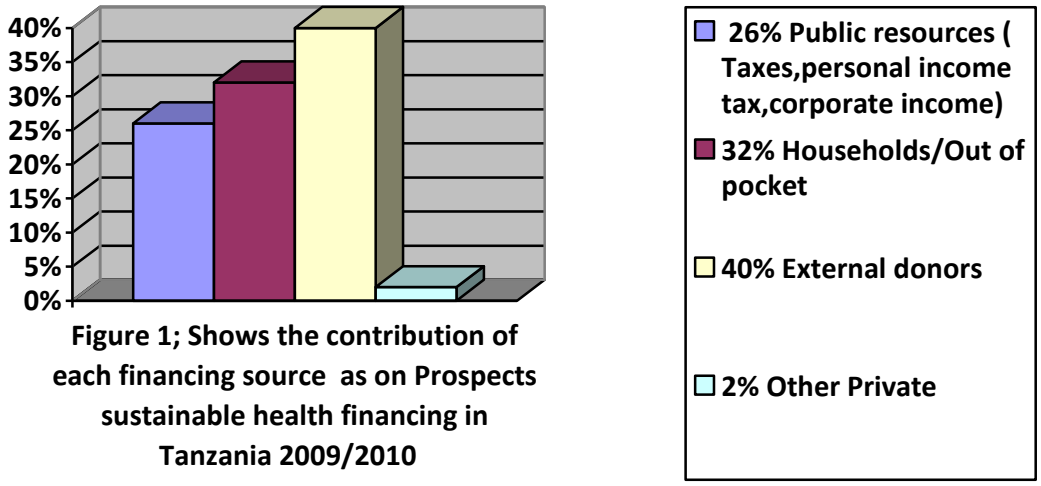

Figure 1; Shows the contribution of each financing source as on Prospects sustainable health financing in Tanzania 2009/2010

Tanzania like in other Sub Saharan Africa, household payment is a serious equity concern as they limit access to care for the poorest groups. To cover the gap Tanzania aimed at expanding health insurance in the country to reach 45 percent of the population by 2015 (HSSP III, 2009 – 2015).

It is estimated that 80 percent of family planning services are provided by decentralized public-sector health facilities through 133 local government authorities (LGAs). These include regional and district hospitals, health centers, dispensaries and community health services. In addition, all of these health facilities obtain their family planning commodities through the national level Medical Stores Department (DSW, 2014).

With evidence from other countries**,** this shows that the health insurance mechanism can increase health services coverage (Emanuel, 2005). Tanzania through National Health Insurance Funds (NHIF) has introduced the pilot study on removing demand side

mechanism financial barriers to increase utilization of quality reproductive health services to poor families in Mbeya and Tanga Regions.

The NHIF is a health insurance scheme which was set up as a mandatory system for the public formal sector in 2001, with members contributing 3% of their annual income, matched by employers. The NHIF has recently started attracting clients from the private formal sector as well. The scheme offers free inpatient, outpatient care and surgeries with limited exclusions to its members. Drug costs are reimbursed from accredited pharmacies. Furthermore, the NHIF introduced Community Health Funds (CHF) for the informal rural sector and TIKA (Tiba Kwa Kadi) to urban sector.

1.1.4 Health insurance to pregnant women for family planning services

Utilization of family planning services in rural Tanzania was and is still low due to financial challenges (Borghi et al., 2005). This has led to unplanned pregnancies of which many end up in planned abortions or children born in numbers that families cannot raise efficiently. To improve utilization of family planning services in rural areas, NHIF set up a pilot scheme in 2010/2011 in selected districts in Tanzania. The scheme provided NHIF heath insurance cards to poor pregnant women in Mbeya and Tanga Regions.

The purpose of the pilot scheme was to test whether a combination of removing demand side financial barriers, provider reimbursements, and quality reviews, could increase utilization of quality maternal services by women. The health Insurance card entitles women and partners to seek health care from accredited providers and the potential to increase access to quality services and to reduce inequities in access and use.

Furthermore, using these NHIF insurance cards, women could use them to obtain health services without having to pay from their pockets.This covered also family planning services. At the time of designing the current study, no published reports that evaluated this scheme on family planning issues could be retrieved. The current study was designed to evaluate the impact of NHIF insurance scheme in promoting family planning services in Mbarali District. However, an in-depth qualitative analysis of the health insurance and family planning in Tanzania was missing. Therefore, this study sought to employ qualitative methodology to understand the role of health insurance in promoting family planning service provision.

1.2 Problem Statement

Several interventions have been implemented to improve maternal and child health in Tanzania. Literature shows that there is a decrease in maternal death and child mortality. Data from the World Health Organisation (WHO, 2014) indicate that during the period 1990 to 2015, death during pregnancy and childbirth decreased from 28.9% in 1990 to 18.4% by 2015. The Government of Tanzania has been implementing multiple strategies in addressing Millenium Development Goals (MDGs) 4 and 5 (Reduce under-five mortality rate by two-thirds, between 1990 and 2015. And reduce the maternal mortality ratio by three quarters between 1990 and 2015).

Unintended pregnancy imposes potentially serious burdens on individuals and families, as well as considerable economic costs on society. The most effective contraceptives methods are most cost-effective. Unfortunately, the cost to individuals can be a substantial barrier to the use of highly effective methods (Cleland, et al., 2016). Previous study presented the Rwanda experience, provides a useful example of effective implementation of policies that reduce the financial barrier to health services. Rwanda has improved financial access for the poor, increased utilization of health services and reduced out-of-pocket payments for health care services include family planning services, (Sekabaraga, et al., 2011).This been fulfilled because of Innovative health care financing policies.

The NHIF health insurance membership services pilot project, however seeks to support poor families in paying for health charges out of their pockets.The pilot scheme aims to remove financial barriers by reimbursing health providers and hence stimulate women and their families to utilize reproductive health services including family planning service at the desired health care outlet.

Previous studies in this area focused on reproductive health voucher system as a mechanism to address disparities in reproductive health on demand subsidies to the most in need within transparent health care delivery system. Recent findings show that the use of the health insurance card has increased the frequency of using family planning services (Bellows, et al., 2011). Overall, few studies have attempted to look at the use of prepaid insurance schemes in supporting family planning services in health system. Therefore, this study seeks to employ qualitative methodology to understand the role of health insurance scheme in promoting family planning services provision in Mbarali District.

1.3 Rationale of the study

The study has highlighted the importance of prepaid health insurance scheme (demand side financing) in increasing the use of family planning services into the growing body of evidence. Findings of this study help the implementers of the program to better understand the barriers facing women with the NHIF insurance card, in order to improve provision of family planning services in the District. The findings of this study provide the basis for further studies to those who are interested in the same or related areas.

1.4 Research Questions

1. What is the role of health insurance card in the choice of family planning service provider?
2. What is the role of health insurance scheme to the choice of family planning contraceptives methods?
3. What is the role of health insurance scheme to male participation in decision making and use of insurance card for family planning services
4. What are the barriers in using health insurance card among beneficiries to access family planning services

1.5 Study Objectives

1.5.1 Broad Objective

To explore the role of health insurance scheme in promoting family planning services in Mbarali district.

1.5.2 Specific Objectives

Specifically the study intended to:

1. To examine the role of health insurance card in choice of heath facility
2. To assess the role of health insurance card in choice family planning contraceptives
3. To explore the role of health insurance card male involvement in decision making for family planning services.
4. To explore the role of health insurance card on resolving barriers to using family planning services.

1.6 Conceptual Framework

The conceptual framework reveals the interaction of factors for the role of health insurance schemes in promoting family planning services in Mbarali District. The presence of different barriers including social cultural and health system factors has facilitated unmet needs and limited choice of contraception and/or failure to access family planning services in communities. See figure 2.

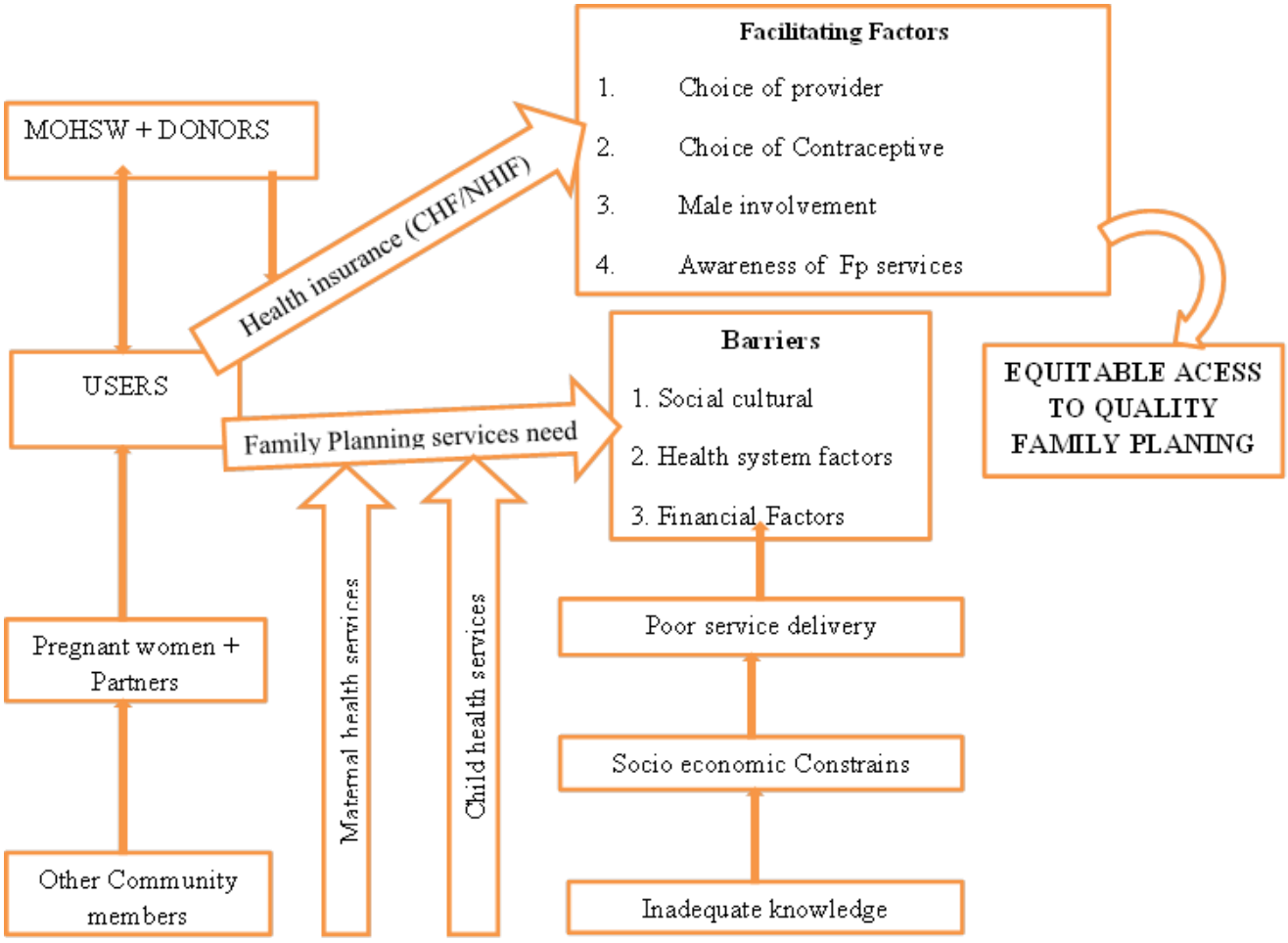

Figure 2: Shows Conceptual framework on Role of health insurance scheme in promoting family planning services in Mbarali District.

Source: Researcher May 2016.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews literature on understanding the use of health insurance scheme in promoting family planning services in Tanzania. With a special interest on exploring the role of health insurance scheme in promoting use of family planning services according to the laid down objectives of this study.

In 2010, the German Development Bank (KfW) provided funds to the government of Tanzania through NHIF to deliver subsidies for the safe motherhood and family planning. The pilot study targeted the large population specifically the marginalized group (pregnant women and partners).However the membership of the insurance is voluntary. The health insurance is regulated under the CHF Act 2001 and is managed at the district level. It is pre –paid council's based scheme. In 2009 the NHIF took over the management of the CHF from the Ministry of Health and Social Welfare (MoHSW), a first step towards merging of these schemes. The merger of insurance schemes, particularly schemes targeting the informal and formal sectors, is a precursor to the development of social health insurance (Borghi et al., 2013).

Family planning is critical for preventing unintended pregnancies, eventually family planning contributes in reducing maternal and child mortality. Family planning helps to decrease poverty and empower women and men to choose the number of children they want. A number of studies depicted that universal access to family planning would reduce unintended pregnancies by two thirds, which will lead to 21 million fewer induced abortions (Singh et al., 2012). As family planning is a vital structure for economic gain in sub-Saharan countries, thus has given priorities. The government and their development partners are looking for new ways to increase the uptake and quality of family planning services.

2.1 Use of family planning services (contraceptives) in Tanzania

The total fertility rate in Tanzania has been consistently high and stands at 5.7 children per woman (ORC Macro International, 2011). Notably increase in use of contraceptive methods has been registered in Tanzania. According to TDHS 2010, 29 percent of all women with age 15-49 used contraceptive methods, and about 24 percent majority of them use modern method. Furthermore TDHS shows that only 22 percent of women with no education were using modern method as compared to 52 percent of women with least some secondary education. Contraceptive use also increased rapidly as the number of living children increases. The use of contraceptive methods among women continues to face challenges in meeting clients' expectations and needs. Despite high knowledge on contraceptives of 90 percent only 34 percent of the married women use any method of contraception. Currently usage of modern contraception is higher among sexually active unmarried women than among married women (TDHS, 2010). Other challenge include low acceptance of modern family planning methods is the unreliable supplies of contraceptives with limited choices and provider biases to make informed choices.

2.2 Insurance mechanism and family planning services

Previous studies in this area focused on maternal health voucher system as a mechanism to address disparities in reproductive health including family planning services on demand subsidies to the most in need within transparent health care delivery system (Bellow et al., 2011). In Tanzania, prominent voucher system Tanzania National Vouches Scheme (TNVS) (Hati Punguzo) has been implemented in maternal health care with focus on provision of long lasting insecticide mosquito nets to pregnant women. Literature, reported that there were steady increases in nets coverage indicators over the three year study period. Between 2005 and 2007, household ownership of at least one net (untreated or insecticide treated) increased from 44% (2686/6115) to 65% (4006/6198; $P<0.001$), (Hanson et al., 2003).

The use of contraceptives doubled among sexually active, non-pregnant voucher redeemers and voucher receivers had significantly higher utilization rates of reproductive health care and condoms compared to non-voucher receivers, (Liesbeth, 2006).

A study on voucher system conducted in Kenya on maternal and child health and family planning by National Health Insurance Funds (NHIF), the study indicated that a good number of surveyed respondents heard about family planning insurance (family planning voucher). The voucher system also improved the quality of care, empower women to make family planning decisions (Rebecca et al., 2013).

2.2 Factors influence use of family planning services and choice of health care facility

The Donor Agency in Kenya assigns funds to a voucher agency which contracts and train services providers from health facilities and organises distribution of vouchers/insurance card to a targeted population. The recipients' use the voucher to provider of their choice and exchange them for goods and services and the providers return the voucher to the agency and then are reimbursed according to terms of contract agreed (Sandiford et al., 2005). A review of the effect of insurance on maternal health found that insurance positively influences uptake of facility – based delivery across all type of insurance scheme in a number of developing countries, (Naik et al., 2014).

A different study in Lesotho found that the type of facility to which women has access example hospital, health centre, dispensary or community based voluntary health workers, were significant predictor of current use of contraception (Tuoane et al., 2004). Accessibility, reliability and responsiveness to women needs of contraceptives were also a predictor in the use of contraceptive methods by Iranian women (Mackenzie, 2010).

In Kenya from the voucher system program, has reviewed that the utilization of the family planning methods depended on local availability and training level of the health staff at the facility level.The family planning services showed an average increase of 69% over the baseline for those facilities that were recorded both before and after the program starts (Bellows et al., 2011).

2.3 Health insurance mechanism and choice of family planning methods

Studies have indicated that supply and demand factors have profound influence in utilization of family planning services which includes use of contraceptive method (United Nations Report, 2009). The overarching strategy of successful supply side family planning programs is to ensure that contraceptives methods are as readily accessible to clients as possible. This includes ensuring that a wide range of affordable contraceptive methods are

offered. This therefore make the services widely accessible through multiple services-delivery channels, ensuring that potential clients know about the services, following evidence based technical guidelines that promote access and quality and providing client centred services. These types of supply side interventions ensure that women and husbands are able to use contraceptive methods and family planning services effectively (Burgard, 2004; Mwaikambo et al., 2011).

In Bangladesh, women delivery in voucher areas reported lower out of pocket costs than women who do not use voucher (Hatt et al., 2010). Voucher acceptors had initial higher fertility rates, higher rate of use of abortion services and higher rates of not wanting additional children compared to non-voucher acceptors (Hatt et al., 2010). Literature shows that individual who receive a voucher had statistically significantly higher level of knowledge about modern contraceptives and STIs than those who did not received voucher (Liesbeth, 2006).

Literature shown that Insurance program offers a way to improve the quality and equitable provision of family planning services. Also provide the evidence that the synergies between family planning inclusions benefit package and well-designed insurance program can improve family planning services (Mellissa et al., 2008). Analysis by Brookings institution in United States of America found that expanding access to publicly provided family planning services through Medicaid, government run programs that provides health coverage for low income clients significantly increased the use of contraceptives (Mellissa et al., 2008). For family planning services specifically, the evidence is more limited though nonetheless promising. In United States, which has long term experience with various financing schemes, insurance and health care coverage plans have been shown to increase family planning uptake (Mellissa et al., 2008).

2.6 Male involvement in family planning service

Male involvement in family planning is the inclusion of men in family planning services to support their partners. When men accompany their partners to meet with a family planning counsellor of health worker, they can learn about available contraceptives methods and choose one. Some studies demonstrated that male involvement in family planning services to have best results couples should be targeted. This was clearly justified by the review on couple done by (Becker, 1996). Uptake of contraceptives methods is limited by spousal

communication, inadequate male involvement and misconception on the modern contraceptive methods (TDHS, 2010).

In literature indicated that it is difficult to access some of the family planning services from some of the accredited health facilities due to different factors including the male involvement in reproductive health issues as well as poor understanding of the benefits associated with the possessing of the voucher as a barrier to access reproductive health services (Rebecca et al., 2013).

Knowledge on family planning services means the ability of the individual to name the methods or other practices and sources of the services or supplies. In Tanzania, majority of men heard about family planning use. However knowledge of proper use, risks and benefits of methods was lacking especially in rural areas. Lack of information and belief in rumours discourage family planning methods use (Baraka et al., 2015). Similar results of limited knowledge about family planning depicted by the study done in Uganda (Kaida et al., 2005). In additional to lack of information, misunderstanding and rumours about some of the methods like vasectomy process contribute to people reluctance to opt for a method (Bunce et al.,2007). Other studies have shown that opposition from husband, ineffective communication has influence in the use of contraceptives methods (Abebe and Nigatu, 2011).

The qualitative study done in Mpingi district Uganda on male participation in family planning noted some barriers to utilize the family planning services among men. The barriers are lack of information or misconception; side effects associated with the use of family planning methods, unavailability of family planning services and supplies, lack of trust in family planning personnel, couple communication cultural and belief factors (Kaida et al., 2005). Uganda emphasizes on couple oriented approaches to family planning services. The approach suggested were recruiting male providers, offering more family planning methods and counselling couples (Kaida et al., 2005).

Use of family planning services is not a problem of developing countries only even in developed countries experience a similar problem. A study done in United States of America noted that the most commonly barriers for men to utilize public funded family planning services was unawareness of the availability of the family planning services.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This section of methodology presents systematic process of data collection and analysis as well as ethical consideration observed during the study, while putting into context of the study area. Decisions that were taken in sampling and analysis based on practical context of the study area are also presented.This section is presented starting on study area whose context influenced sampling, this is followed by study design, study population and sample size, data collection methods and participant recruitment criteria, data analysis and the study ethical considerations.

3.1 Study area

The study was conducted in Mbarali District, one of the 10 districts in Mbeya Region located in southwest of Tanzania (National Bureau of statistics, 2002). The district has a population of 300, 517 (Census 2012). In Mbarali District agriculture contributes about 69 percent of the Region's Gross Domestic Product (GDP). The main activity in the district is paddy farming with females doing most of these activities. The district is divided into 6 administrative wards and has two hospitals, one public and the other is a private-not-for profit (PNFP)—owned by faith based organisation. It has 5 health centres and 36 dispensaries (NHIF, 2013).

The District is wide, covering 16,000 square kilometres with a population density of 38 per square kilometers (National Bureau of statistics, 2002). This indicates a wide but sparsely populated area, perhaps to allow more land for type of farming activities.

3.2 Study design

The study is cross-sectional survey, exploring the role of health insurance scheme in promoting family planning services in Mbarali district. The study draws entirely on qualitative techniques of data collection and analysis. These techniques were chosen with the aim of exploring insights, feelings and perceptions of implementers and beneficiaries of health insurance scheme (Creswell, 2007).

3.3 Study population and sample size

The population of interest for the study was implementers and beneficiaries of the insurance scheme.This study largely sought experiences of beneficiaries from implementation of the health insurance scheme. Implementers who directly provided services were chosen to participate. This is because direct implementers have experiences of their clients. National level implementers were not involved as they would have less experience on the clients. Both sexes, male and female in the reproductive age-group were targeted for the study.

The sample size for each group participants is shown in table 1, along with rationale.

Table 1: Shows planned number of participants to participate in the study

Participant type	Approach	No: Planned	Reasons for selection
NHIF Managers	IDI	2	Implementer managers, dealing directly with management of the insurance scheme, and were responsible for allocation of resources and reimbursement programme to the district.
Family planning service providers	IDI	3	These are the frontline implementers of family planning services in the district; they were drawn from three levels down the cascade of district service delivery system: Hospital, Health Centre and Dispensary.
Drug shop attendants	IDI	4	These were drawn from private sector suppliers of family planning supplies to the community. These included the only one shop accredited by NHIF and two non-accredited for participation in the reimbursement scheme. The purpose was to find out if other mechanisms of paying for family planning services existed in addition to the reimbursement scheme.
Women in the scheme	IDI	10	Women who received and used health insurance card for the past 12 months as at April 2014. One year period was chosen for the reason that by this time, a woman who had delivered should have started to use family planning services.
TOTAL NUMBER OF IDIs		**19**	

CHMT Members	FGD	6	These are leaders of the District Health Management Team, responsible for planning and managing implementation of family planning services. These include DMO, DRCHco, CHFco, District Health Secretary, District Doctor In-charge and District Pharmacist.
Men in the scheme	FGD	34	These included men whose wives were using family planning services under the scheme for the past 12 months as at April 2014. The sampling of disproportionately more men than women was purposed at widely exploring men's views regarding use of family planning. It is widely documented that low male involvement affected use of family planning methods (Kabagenyi, et al. 2014); so this higher number created the opportunities to assess various views of men andhow they involved in the program and decisions making towards use of family planning services by women.
TOTAL NUMBER OF FGDs		**5** (40 Participants)	

3.4 Inclusion criteria

Providers were sampled based on their role in family planning services provision. The CHMT were sampled as this group comprised of District management team that was responsible for planning, oversight and managing implementation of family planning services in the District. Officers from the Hospital, Health Centres, Dispensaries and Drug shops were sampled because as direct providers, they had first-hand experience of the clients they serviced regarding use of family planning services. The NHIF officers included here were responsible for management of the scheme and quality assurance of services of the providers.

Women and men sampled were those who had experience with the use of family planning under the scheme, and they all had used for at least 12 months as at April 2014.

In which period, a woman who had had a delivery should have started to use artificial contraceptive method.

Also important was the willingness of the sampled individuals to participate in the study. All participants expressed willingness to participate and consents were provided.

3.5 Sampling procedure

The sampling technique used to obtain the geographical area and participants for this study—purposive sampling. Mbarali District was purposively sampled as study area because it was one the first three Districts of to implement the scheme at the start of its rollout in the region. Therefore, the population here had longer time experience with the program.

Three levels of health facilities were purposively chosen for this study. Only one District hospital available in the District was chosen. One Health Centre was sampled because records showed that it had a high volume of clients next to the Hospital (Impact evaluation report 2015), while the Dispensary was chosen because it has a lot of health deliveries and far from District Hospital.

Upon arriving at the Reproductive and Child Health (RCH) unit in each level of health facility, the researcher team asked for the health insurance enrolment register to identify women who has been enrolled as at April 2014. Four women were selected in each level of

health facility. Women in the register were stratified into two groups including those living within 5 kilometres and living more than 5 kilometres from each level of health facility.
Thereafter the research team visited health facilities catchment areas with assistance of local leader, asked to assist selecting eligible men, who have a child from 12 months and less to participate. Also to considered their reproductive age, from 15 years old to 49 years.
The RCH in charge asked to assist to select private sector suppliers of family planning supplies to the community (Drug shops). These included the only one shop accredited by NHIF and two non-accredited for participation.
At each health facility level the family planning service providers were purposively selected as they are the frontline implementers of family planning services in the district.
The research team chooses the following CHMT members DMO, DRCHco, CHFco, District Health Secretary, District Doctor In-charge and District Pharmacist. These are responsible for planning and managing implementation of family planning services.
The research team also, purposively selected the NHIF Zonal Managers dealing directly with management of the health insurance scheme. Choose the Zonal manager and Quality assurance manager as were responsible for allocation of resources and reimbursement programme to the district.

3.6 Data collection technique

This followed standardised approach, using IDIs and FGDs. Question guides for each method were used for purposes of focusing discussions on the same areas of family planning and insurance issues in each discussion, but providing flexibility for in-depth exploration of emerging ideas.
The FGDs lasted between 60 and 80 minutes. FGDs consisted of 6 to 9 participants. At the District level only 1 FGD was conducted to the CHMT members to get an overview of the program implementation. 4 FGD was conducted with male partners at the community level. Two groups were formed: young men aged 15 to 25 years and adult men aged 26 to 49 years. The separation was done as discussion of family planning would involve talks on sexuality, discussion would be free among people of the same group.Disproportionately more men than women were purposed at widely exploring men’s views regarding use of family planning. It is widely documented that low male involvement affected use of family planning methods (Kabagenyi, et al. 2014); so this higher number created the opportunities

to assess various views of men and how they involved in the program and decisions making towards use of family planning services by women.

3.7 Data collection procedure

The procedures aimed at collecting data in reference to the study objectives. For the single broad objective and its four specific objectives, data were collected by both IDI and FDGs.

An exploratory approach was used to collect data in both IDIs and FGDs. This involved free expression of participant's views according to their understanding of the questions pauses to them. As much as possible, RAs and the Researcher maintained neutrality in discussions to encourage participants to provide as much information as they could.

The settings of the discussions depend with the respondents. The NHIF managers and health facility providers all discussion was done in the office room, well ventrated and no interructions. The FGDs for men, were done in one of the rooms at the village office, this is because of making participants to free contributing to topics without hestation.

The IDIs with women were done in there respective homes, two of them were done under the tree and 4 of them were done in the sitting room of the respondent's houses. There were no interferences.

All discussion in the IDIs and FGDs recorded were tape recording. Each discussion was managed by two people, one taking notes while the other asked questions and management the tape recording. Each interview of FGD was given a unique identification number for anonymity and also to identify responses by type of participant—provider or recipient, and by type of data collection method (IDI or FGD).

The data collection took 12 days in total; number of IDIs and 1 FGDs per day based on availabilities of participants (See Schedule in Appendix 3). At end of each discussion, the tape record was stopped, and one member of the research team thanked the participant(s) for participation.

3.8 Data Quality management and analysis

Data collection was conducted by Social Scientist and Public Health experts with initial Bachelor degree in the subject matter. Each RA had more than two years' experience in qualitative research methods. The RAs were given three days training on the study tools, interviewing techniques, communication skills and inter-personal relations skills.

Pilot – testing

To ensure practical application of the study tools, a field pilot was conducted jointly by Researcher with RAs, on one FGD and two IDIs. The field testing was followed by sharing experienced regarding participants ease of understanding the questions, and also to review the techniques of asking questions by the research team. From this experience, the tools were revised to include questions on male involvement.

At end of each day, the team reviewed recorded notes and by consensus, updated information. Saturation of data to this study was reached as the study used purposive approach to undertand the role of health insurance scheme in promoting family planning services, from all level of implementers and beneficieries of the program.

Transcription of tape recorded information was conducted after field data collection. This involved listening to tape records and transcribing the recorded information. The transcribed data was then compared with the written notes, ensuring that the two sources had similar recordings.

Analysis:

Analysis was made in NVIVO 9 software. A hybrid approach involving inductive and deductive techniques was used for analysis of data (Strauss and Corbin, 1994; Fereday and Cochrane, 2006). Initially, major themes were identified manually from the data; this followed by coding ideas based on code book, and categorisation along the themes. The categorical ideas form the content for detailed description of each theme.The data was coded by Researcher and assisted by Research Assistant. This was followed by comparative discussions and consensus on the coding and themes. This consensus ensured reliability of the analysed data. Emerging themes were matched with the research questions. Using inductive analysis, we established associations of coded data in thematic categories.

3.9 Ethical Consideration

The study was approved by the MUHAS Institutional Review Board, permitting to conduct research on all the targeted participants and health facilities.

To all participants, verbal explanation of the study was provided, that included information on purpose of the study, benefits to individual participant and service delivery, as well as their confidentiality. To those who were able to read, written information sheet was also provided to them to read. It was made clear to each participant that there was no individual benefit, but the findings would be beneficial for improving service delivery to their communities. Assurance of confidentiality and anonymity was given to each participant; and it was made clear the participants names will not be tagged to information or even no to appear in the final report. It was also made clear that they were free to decline participation or to withdraw any moment during interview, if they felt uncomfortable. Each participant who chose to participate signed a written consent, and those who were unable to write provided finger-print on consent forms.

Permission to conduct the study was also sought from the DMO (District Medical Officer), in-charges of each facility and Village Chairpersons. The DMO in consent to the study provided introductory letters to the research team, asking the health facility leadership to permit the team to conduct the study in their faculties and provide corporation in providing information for to the team. Upon reaching each facility, the team verbally introduced the study, provided copies of ethical of letters and introduction from the DMO. Finally, the team requested for permission to access records and staff for interviews. To create confidentiality and trust, interviews with women and FGDs with men were deliberately conducted at a village office out away from health care providers. This created an environment for freecomments about services provided by the health providers.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the findings of the study about the role of health insurance program in promoting family planning services. A total number of 55 participants participated in this study. 17 participants were female aged 18 to 40 years and the remaining 38 were men aged 19 to 46 years. The majority of the respondents (76.9%) were residing in village where the study was conducted. The (23%) were residents of Rujewa Municipal and 0.1% residents of Mbeya region.

The detailed results are presented in themes emerging from the findings corresponding to each research question. The main themes include; Choice of family planning service provider using insurance card, Choice of contraceptives methods using health insurance, male involvement in decision making in use of health insurance and family planning and barriers faced in use of health insurance for family planning services.

4.1 Choice of family planning service provider using insurance card

This theme, is exploring insights of where the beneficiaries go to seek family planning services from the health facilities of their choice within the District. At first most women were getting contraceptives from the public services as it is free of charge and most of the times the services is not available because of its demand. With findings from this study portray that the prepaid health insurance has motivated beneficiaries to choose the desired family planning outlet of the choice within the district and also has empowered health care workers through trainings and incentives in respective health facilities.

Emerged subthemes in this include; Increase accredited family planning outlet, skilled personnel as a pull factor, quick services provision and promote use of family planning to insured

4.1.1 Increase accredited family planning outlets by NHIF

The health insurance has enabled beneficiaries to access family planning services from both public and private providers within the district by using the insurance card. Payment for family planning services was the main hindrance to access care in the private health

facilities. Participants overwhelmingly expressed the view. This is supported by the statement below.

> *'.....I can now get pills without pay at the drug shop, after showing my ID card,' (IDI, woman, May 2015).*

> *'..... My wife use to get a injectable contraceptive at the District hospital but now it is very much easy , she does not need to go all the way there , because she can even get the services at a Dispensary **** [it is a private dispensary]'* (FGD, Men, May 2015).

Young men participants, supported the theme by commenting that they demand much condoms and once you use today and next day you will need another one, therefore the program has facilitated them to get as much condoms as possible even at nearby family planning outlet which accredited by NHIF.

> *'.....We have high number of condom use in this District, we no longer luck of condoms as our procurement office order them more than before to meet the demand. We place condoms in all areas here at the hospital example in the toilets, at the receiption desks and at the pharmarcy desks……' (FGD, CHMT, May 2015*

The NHIF managers advocated this fact by saying they normally reimburse all the claims on time to make sure that demanded services are available.

4.1.2 Skilled personnel as a pull factor for choice of family planning services provider

The results of the study revealed that the choice of family planning service provider depends on the availability of skilled personnel and performance of health workers in the family planning units, as before more clients were going at Public health facilities as they feel the health workers in the family planning units are more skilled than from private providers. In the program family planning providers have been given refreshers training on the program for better services provision. Every week the health workers in the RCH unit have meetings sharing the challenges been faced in the enrolment of the beneficiaries.

It was reported by the CHMT members, that the RCH unit personels are given cash incentives to motivate them. This empowers the providers in the Unit to perform better in a way of delivering safe family planning services to beneficiaries. The FGD with CHMT

members supported this by saying he has seen some improvement in women enrolment in the program compared when the program started in 2011.

Family planning provider confirmed that the program has increased providers capacity of working.

> *'The insurance scheme is noteworthy to women in this community, more are coming for family planning services and generates a lot of income to our health facility. The money redeemed use for training and some incentives for our wellbeing' (IDI, family planning provider, May 2015).*

Women interviewed also supported that most of them like to go at the public health facility because they trust and are confident to the RCH unit providers in the public health facilities compared to private profit health facilities as they seem to have less qualification in terms of years of working. The below quote testify this;

> *'The nurses at private health facilities seem to have less experience, because most of the times you find new nurse and young and their counselling is different from public health facilities and in public health facilities most of them are old women seem to know much on family planning issues and their counselling one understand better and make decision easily' (IDI, Woman, May 2015).*

4.1.3 Quick service provision at the health facility encouraged more family planning clients

In this study the health insurance scheme has been linked directly to the good quality of services in terms of quick services provision. Before the introduction of the free health insurance, the family services were very slow but due to trainings and availability of contraceptives commodities made the provision of the services to be quick. Male partners testified to have seen improvement of family planning service provision at the health facility. Currently family planning clients wait for a short time to get family planning services compared to the past. The following quote testify that;

> '*My wife is a member of health insurance, when she went at the hospital, she is no longer spending much time, and the nurse examines her hasty and advice a better method ……' (FGD, Men, May 2015).*

Family planning providers also reported that they give priorities to women who are escorted by their partners to family planning clinics, as they believe that less men are

taking part in family planning issues, therefore the hospital management is encouraging to RCH providers to take more initiatives involving male in the clinics. Therefore CHMT also supported this refer the quote below;

> '*We are giving priority first to men who comes with their wives in the clinics, we do attend them first so that they can explain to other men in the community so that more men should also come with their wives, as we understand their role is big in family planning issues….' (FGD, CHMT, May 2015).*

4.1.4 Promoting use of family planning among insured in the public health facilities mostly

The FGD with CHMT members revealed an increase number of program client's in reproductive units and family planning which might have been motivated by the availability of financial support from the NHIF substantiate. The quote below support the fact;

> *'Enrollment of women in the RCH unit has increased in all health facilities in the District, if you compare when we started the program. This might be influenced by availability of family planning commodities in the units, despite there are some shortages of some modern contraceptives but is minor factor, as it is under control….' (FGD, CHMT, May 2015).*

4.2 Choice of contraceptives methods using health insurance card.

Beneficiaries of the health insurance have been empowered to choose any family planning methods of their choice for free despite that fact that some of the services are charged. In this theme, the choice of contraceptives methods using health insurance card has been discussed in four subsections namely; choice across range of family planning providers,preferable contraceptive method by beneficiaries , overcoming cost barriers by using health insurance, accessible long acting contraceptives methods and Illegal family planning services provision

4.2.1 Choices across range of family planning providers

Availability of family planning services varies across different levels of health care facilities including hospitals, health centres and dispensaries. They also vary depending to the ownership such as public, private for profit and non-profit.

The CHMT participants reported that with the expansion of the health insurance in the district has increased availability of family planning commodities and working instruments in all range of health care facilities.

> *'Previously more women were coming at the public health facilities for free family planning services but shortages of the family planning commodities made more women to be astray. Now women have been empowered to get the free family planning services at any health care provider within the district even at the private hospital as long as she is entitled to the health insurance.' (FGD, CHMT, May 2015).*

The community members supported the fact that the introduction of health insurance has increased the choice of contraceptives methods among users.

> *'Now when we go at any near by health facility for family planning services, we are able to get contraceptives and been advised to choose any methd of the choice without pay and been advise if you have any side effects to comeback for a change' (IDI, Woman, May 2015).*

4.2.2 Preferable contraceptive method by beneficiaries.

Most of participants interviewed in the study reported that injectable contraceptive is the most preferred method. Women acknowledged injectable contraceptive as it last longer and not frequently repeated. Injectable contraceptive could last for three months. Further it was revealed that most women prefer injectable contraceptive.

> *'I prefer injectable contraceptive because it is easy to take and my husband will not know that I am using family planning methods since I need to rest and he wants more children' (IDI, Woman, May 2015).*

The introduction of the health insurance in the district motivated the availability of family planning commodities in all health care facilities in the district. The family planning providers reported that the family planning methods are available almost all the times. It has been observed that injectable contraceptives are run out fast than any other methods.

> *'More women like to use Injectable hence they run out so fast and if you find the nurse are not careful in checking the stock, you will find you are not giving a client*

what she desire, therefore the procumentent unit is making sure to have them available . (IDI, family planning provider, May 2015).

Women reported that possessing health insurance has permitted them to get free family planning injectable and rescuing them from buying it from the drug shops and private hospitals.The below quote support this;

'Most women here like injectable contraceptive method, but now we get this service in the health facility all the times. Sometime back we were forced to buy in the private facilities if you find you can't access at public health facility, therefore women are now saving money from buying contraceptive' (IDI, Woman, May 2015).

4.2.3 Overcoming cost barriers by using health insurance.

In private hospitals people do incur costs for the services they get, due to the different supply chain system existing in private and public health care facilities. Lack of money for the services has subjected some of women and men to consult, public health care facilities for free family planning commodities. According to family planning policy guideline, family planning services are provided freely to all women and other people who seek care at public facilities. The health insurance have rescued the vulnerable group to prosper the availability of free family planning services in all facilities despite of the ownership type (Public, private or faith based organization). Women and partners now can select any type of family planning methods without worrying about costs.

'Most of the times when I go at the hospital (refers to public facility) for family planning service like injectable contraceptives, a nurse always tells me to take pills instead. But now I heard my friends, saying now they are injectable contraceptives without problem at the hospital' (IDI, Woman, May 2015).

4.2.4 Accessibility of long acting contraceptives methods

The health insurance scheme enable the beneficiaries of the program to access all contraceptives methods of the choice. Some of the family planning methods example those which need major operation are accessible to beneficiaries who are in need. The FGD with adult men mentioned that costs of some of family planning methods hindered some of

them who need the family planning services and become hesitant in seeking the service. They believe that with health insurance if will be a big support and relief to the community, more clients will be visiting the clinics for the free services.

The family planning providers have reported that, few clients are coming for intrauterine device (IUD) and implant in the district compared to other methods available. But with health insurance scheme beneficiaries have opportunity to access the methods in all health facility levels within the district.

The interview with NHIF managers, reported that, there are few, reimbursement made for the family planning methods that need operations, but there is an opportunity for the services to beneficiaries in the Mbeya region.

> *'I have made very few payment of services like IUD since the project started, and non on vasectomy but we do reimburse if health facility is claiming on the item and if the service been itemized properly'* (IDI, NHIF, May 2015).

4.2.5 Illegal family planning services provision

According to Family planning policy of Tanzania, only public and private health facilities levels are certified to provide all long and short family planning methods. In this study, women have reported that, before the health insurance, more women were accessing injectable contraceptives from drug shops, because the services were not available at the health facility. Therefore the introduction of the health insurance scheme, made the availability of family commodities hence prevent illegal services provisions. They further reported that the family planning service they got from drug shop was provided secretly.

> *'I have experience of getting injectable contraceptive at the drug shop, before this child, I had injected the contraception at the drug shop, but later on I got pregnant before three months of use' (IDI, Woman, May 2015).*

> *'If you go at the drug shop you will get the injectable contraceptive for five hundred shillings and most of the times the shop does not run out of stock' (IDI, Woman, May 2015).*

The CHMT members as well are aware of the issue of drug shops illegally administering the injectable contraceptives, and reported that, some of the drug shops been reported of and been reported for action. Before the health insurance program, there were shortages of supplies and misconception on the side effects on injectable contraceptives and if you intervene most of the clients were getting from drug shops where by an assistant is not well equipped on the administration of the service.

The interview with drug shop attendants refused that the only services provided in the shops include pills, condoms and counselling. And added that most family planning commodity does not last long, the best sale commodity are the condoms. The quote below reported by drug shop attendant;

> *'I have experience of getting injectable contraceptive at the drug shop, before this child, I had injected the contraception at the drug shop, but later on I got pregnant before three months of use' (IDI, Woman, May 2015).*

4.3 Male involvement in decision making and use of health insurance for family planning services

According to the Health insurance program scheme design, male partners were entitled to CHF for a period of one year. At the first antenatal visit women were obliged to go with their partners to fill the NHIF health insurance enrolment forms and CHF forms for her partner and 4 other dependents. The role of man in the program is to take part in family planning services as a beneficiary as well as to encourage wives/partners in accesing the family planning services.

The following subthemes will be presented under this include; men's power on the use of health insurance for family planning,Social factor for male participation in the health insurance scheme ,financial domination, male prioritization in health facilities as a pull factor, the quest of free services and low participation of males.

4.3.1 Power relations on the use of health insurance for family planning

Men were given priority in this study because they play a big role in decision making as far as family planning is concerned. The design of this project provides opportunity for the male involvement from the beginning when partner's wives are enrolled to the program.

The family planning providers have reported that, some of the women refused to fill the enrolment form before having their husband's permission. In order to complete the enrolment forms there is a demand of physical address and telephone numbers. Findings showed that most of the women did not have their own decisions and need permission from their partners. *'Some refuse to fill the enrolment forms and ask the permission from the nurse in charge to involve their partners/husband on the matter'*. It was reported that male power in use of family planning services is high. The following quote support.

> *'In this community men have supremacy in making decisions, they can decide whether the mother to use or not use family planning methods, people are bided by their culture that women cannot do anything without involving their partner/husband. Therefore when you enroll women most of them, they request to call their partners/ husband so that you can give information when they are all together. And if you call them together the male partner/husband has a last say .....' (IDI, family planning service provider, May 2015).*

4.3.2 Male participation in the health insurance scheme

Family planning providers reported that men are most influential to the program if they are fully involved from the very beginning when their wives are being enrolled. In the community men are the heads of the households and in most cases have control over their wives. For male partners who accompanied their wives to family planning clinics, their wives were reported to be as attentive to instructions show up for their next visits as advised. This was compared with women who come by themselves at the first visit; they even forget to collect their insurance cards when they are ready at the health facility. The following quote support this;

> *'When the program started we were giving health insurance education to only women who were coming for the antenatal first visit. But later we have been noticing that most of the prepaid health insurance cards are remaining at the health care facility without being picked by the owners. Well! Along we decided to involve their partners fully, each woman had to come with the partners and hence we observed most of the womens health insurance cards are picked on time and we are no longer remaining with bulk cards here at the hospital. Also more benefited families came to understand that they are as well entitled to CHF when prepaid health insurance expires and many partners/husbands are later coming to request for their CHF cards as well' (IDI, family planning provider, May 2015).*

4.3.3 Financial domination

Men are the ones who have full control over the income of the family; therefore most of the times are looking on the best ways to generated more money for the family. In one of the group discussion some of men mentioned that, they were not escorting their wives to the hospital because they are always at work. As a result they just give cash support and let their wife go by themselves. But after being educated about health insurance, they see the benefit of the insurance scheme as it will help them to save some money when they are sick unlike in the past where they would spend a lot of money when they access health care. This resulted men to be participatory and like to know more about the program since it is a beneficial to them as well.

'Last week I was called by the doctor incharge to collect our CHF insurance card, but I did not know that I can use as well to get family planning services. As my wife is using injectable contraceptive method, therefore this is an opportunity for me to save the money for other needs' (FGD, men, May 2015).

4.3.4 Male prioritization in health facilities as a pull factor

The results of this study show that male have much power in the community. The CHMT participants reported that, giving priorities to men who are coming with their wives at the RCH has increased number of women who are coming in all health services. Hence the use of contraceptive services has increased as compared to before the program started. The health insurance coverage being higher compared to past years especially on the side of CHF. The quote below, support this;

'Since we started to involve male partners for the reproductive health visits, we have been noticing an increase number of family planning clients in the RCH clinics and even the CHF coverage have been boosted since 2013 up to now. Our district has become number three in the region with higher health insurance clients'. (IDI, family planning provider, May 2015).

4.3.5 The quest for free service

The situation of having health insurance card for free encouraged male to know more about the program. Men positively perceived the program as they it helps them to cover the cost of getting health care services when their family members when sick or needs family planning services.

'The fact that, the government have introduced this insurance, life has become simple since we are no longer afraid of going at any health facility here in Mbarali , we only choose the health facility which is near us' (FGD, men, May 2015).

4.3.6 Low participation of males

The FGD from CHMT members have reported that male participation in the District is still lower to family planning services. The district score card indicators testify of achieving red on male participation in the district. They further reported that, there much efforts on option where they emphasise male to accompany their wives to the RCH units as they do for the Prevention of Mother to Child Transmission Units(PMTCT).

The drug shop assistants had different opinion on male participation in family planning services; they argued that it is difficult to convince male partner on family planning services.This is because in the community majority are pastoralists and having more children is a prestige.

FGD with men participants, reported that for those men who are not attending RCH clinics is due to varying factors include, the cultural of the society that women are the ones who stay home with children and when children are sick or herself, is supposed to go by her self as long as given money by a partner to incur health services costs. Also some are afraid to escort their partners because of testing HIV, this led to some refrain going for family planning services as well.

Furthermore, the findings show that the CHMT members, NHIF managers, family planning providers and women interviewed , supported the fact that men have a great role to influence family planning method use, if are given education ,more will participate.

> *'If men are involved fully in the family planning sessions, it will bring much power and will have high turn over of the family planning clients, since men have good memories , once involved fully'* (FGD,CHMT,May 2015).

4.4 Barriers that hinder the use of the health insurance card in family planning services

Five sub themes presented to show barriers which emerged as hindrance for the use of the health insurance card to use family planning methods in Mbarali district.The following subthemes presented here, include; Unawareness of the existence of the health insurance for family planning, top down implementation of health insurance scheme, health facility infrastructure for family planning services, Social cultural factors and financial factors

4.4.1 Unawareness of the existence of health insurance for family planning services

Interview with women, some did not know the existence of the health insurance scheme and this resulted to some of the women fail to get family planning methods of the choice.

> *'What I do remember, when I visited the clinic when I was pregnant, the nurse told me that I am entitled to free health services, I filled the forms and said I will not pay anything regarding to deliver or referral of if I may be given scissor, but she did not mention family planning, as I know are supposed to be given for free' (IDI, women, May 2015).*

FGD with men also confirm that almost all of them, during the discussion, was their first time to hear that they are also entitled to CHF, and few who knew the insurance scheme was because, they stay close to health facility and few because they escorted their partners to clinics when they become to know the insurance scheme but nit in details. The men as well did not know that the CHF card can as well be used to get any modern family planning contraception.

4.4.2 Top down implementation of health insurance scheme

However the study observed that, the program design, used the top down model, where by the health management leaders were the ones who introduced the program by the NHIF Implementers. Then the knowledge should be given to RCH providers on how to enroll the women for the program. This has led to more women to be left out in the villages and some come last minute and benefit less from the program.

> *'I can say managers knew much on the program implementation than us here. Indeed there were no formal training, the Coordinator was passing in the RCH units and direct us what to do, then become difficult on the first place to remember everything'*(IDI, family planning providers, May 2015).

> *'…And most of us did not even know how to fill the claiming forms, we were not involve men in the beginning at that made them not to participate in the program and most miss their insurance benefits'* (IDI, family planning providers, May 2015).

4.4.3 Health facility infrastructure for family planning services

The men and women interviewed, reported that, family planning units in the health facilities available in the district been reported to lack of confidentiality when providers are administering family planning services to the clients. Some men reported that they are not happy to get family planning services in the same room with other women who are coming for antenatal and others are coming with babies at the clinic. They further reported that one feel not comfortable to talk about family planning, because when one hears you talking about family planning they see as a taboo.

However, the family planning providers supported that, the family planning services in the health facilities are not provided privately and that is because there is one room where by all the RCH services are provided there. And that made a lot of women to feel shy and hesitate to demand the family planning services, see quote below.

> *'It is true that, there is a need of isolating the family planning units in ours public health facilities, as we miss a lot of clients for family planning services especially young mothers and adolescent,as they are not confidence to discuss family planning issues in crowded despite having insurance'* (FGD, CHMT,May 2015).

CHAPTER FIVE

DISCUSSION

5.0 Introduction

The study set out with the aim of exploring the role of health insurance scheme in promoting family planning services in Mbarali district. The results of this study have testified that pre-paid health insurance to some extent has promoted the use of family planning services in the district. It has also motivated an access to family planning services of the choice to community, because of the free services to all pregnant women and their families widely from all range of health facilities available in the district. Pregnant women are able to use the health insurance even when given referral to the regional hospital. This has also encouraged male participation and community demand of contraceptives methods. The health insurance has improved the quality of health services in terms of reducing waiting hours, and skills of health providers.

The study findings show that the redeemed cash to specific health facilities after services provisions has motivated health care providers to enroll more women and partners as the time goes. Also the incentives have stimulated the improved working conditions in terms of availability of drugs, working tools and renovation of health facilities builds.

The health insurance however has shortened the distance to seek reproductive health services and family planning services. As the family planning services are now at the door steps, in profit and non-profit health facilities and drug stores within the district.

Some of the health facility system factors remained to be a challenge in implementing the health insurance scheme, example mixing all reproductive health services and family planning services clients in the same room.

The discussion in this chapter will be based on the four main themes and subthemes attached include; Choice of family planning service provider using insurance card, choice of contraceptives methods using health insurance, male involvement in decision making and use of health insurance for family planning and barriers faced in use of health insurance for family planning services.

5.1 Choice of family planning service provider using insurance card

The NHIF has simplified the access to reproductive, child health and family planning services to poor pregnant women and partners as a pilot study in two regions Tanga and Mbeya, and has rolled out to Mtwara and Lindi regions. The NHIF report of 2010, shows women and partners can get health services at the nearest health facility regardless of being for profit or nonprofit health facilities available in the district.

The NHIF is in agreement with various health facilities including faith based organization, pharmacies, private and public health facilities, to provide reproductive health and family planning services and later the health facility redeem to NHIF after service provision (NHIF, Report, 2010).

With choice of family planning services facility, the finding has portrayed that the prepaid health insurance motivated beneficiaries to choose the desired family planning outlet of the choice within the district. This implies that the pre-paid health insurance enables to address barrier to access demanded health services from all range of health facilities available in the district.

Finding from other study support that the type of facility to which women has access example Hospital, Health Centre, Dispensary or Community based voluntary health workers, were significant predictor of current use of contraception (Tuoane et al., 2004).

Furthermore, the health insurance has empowered health care workers through trainings and incentives in respective health facilities. The training given on insurance scheme has permitted health workers to provide better services due to skills gained from the trainings. Beneficiaries are appreciating the priorities given when visit desired health facility to demand health care services wanted including family planning services. This implies that the health insurance enhanced better services deliveries to community due to improved skills acquired by health providers. The beneficiaries are now comfortable to choose the health facility of the choice because they trust the services provided by the health worker.

Comparable study also looks on health insurance programs as associated with increased skilled birth attendants, uptake of long acting family planning methods to improve quality of care and improve access to health services (Schellenberg et al., 2003).

Furthermore, received cash incentives to the RCH providers have motivated them to work with passion in terms of services provision. This advocates that cash motivation, can help to improve quality of health services in terms of short waiting time and increase service coverage by enrolling more beneficiaries in the program. With reference to previous study, this finding is in agreement with (Rob and Alam, 2013) which shows poor motivation of providers and non-existence of financial incentives, have been a key challenge to improve the quality of reproductive health services in the public sector health facilities in rural Bangladesh.

5.2 Choice of contraceptives methods using health insurance

Tanzanian health policy directs that all reproductive health services including family planning services are exempted from cost sharing, (National Road Map Strategic Plan, 2008, Health Sector Strategic Plan IV, 2016-2020). With the implementation of this policy in Tanzania, there are health system factors adversely influence shortages of health care commodities in the health facilities and poor performance of health care providers. The finding from this study reveal that the insured clients are required to seek missing family planning commodities, using health insurance card, to get the contraceptives methods of their choice, at any health facility within the district regardless of it being public, private or pharmacy. This suggest that pre-paid health insurance has power to cover the unmet need gap of family planning which has been shown to be weakness in the health system. The findings of the study also show that if there are out of stocks in family planning commodities it is because of some very few health care providers who delayed to request the stocks. And this showed to be manageable at the district level. This implies that accountability at individual level is manageable if the management put much effort on monitoring the services. Consistent finding from other studies in Sub Saharan Africa illustrated that the constraints behind incomplete coverage of family planning services, influenced by weakness in commodities logistics managements, (Bongaartsand, 2009, Naik, et al., 2014, Ali and Okud, 2013). Previous study viewed on challenges to address unmet need for contraceptives reveal that societal, structural and organization environment are crucial and needed to be tailored (Baraka, et al., 2015).

The existences of health insurance card have facilitated women to access family planning services all the times from health facilities irrespectively being public, private, faith based facilities and /or pharmacies available in the region. A different study in Lesotho, found that the type of facilities to which women had access such as hospital, clinic, was a significant predictor of current use of contraception (Zainab at el., 2001, Bhatia and Gorter, 2007, Tekelabat el., 2015). With variety of choices of family planning service, beneficiaries in this study were motivated to increase use of family planning services at a door step, by facilitated health insurance at hand.

The results of this study show that, the most preferable method of family planning by women in the community is injectable contraceptive, and this reported to be available and accessible due to timely reimbursement from NHIF, hence this facilitated health facilities to purchase commodities and made available all the times. Similar study done by Brooking Institution found that Medicaid, a government-run program that provides health care coverage for low-income clients has significantly increased the use of contraceptives methods, due to availability of commodities (State policy beliefs, 2014). This suggests that if the health facility system is equipped there is a great opportunity to improve availabilities of contraceptives methods to community. Previous study has shown that there is growing evidence that health insurance programs can enhance access family planning method of the choice. The health insurance offer an opportunity to help fill the gap in unmet need by including family planning in health insurance benefits packages (Naikat el., 2014 and Paradise, 2015).

The health insurance has rescued women and partners to avoid out of pocket expenditures by owning health insurance for 12 months. Finding of this study show that young men were longing for some contraceptives methods, like condoms which reported to be costly because they use the commodity repeatedly. Therefore with health insurance advocates that men appreciated that the health insurance scheme that has simplified access and use of condoms and evade costs barrier. Previous study that implemented Navrongo project, which was distributing family planning methods at the door step showed to fostered attitudinal change towards family planning in a traditional sub-Saharan African setting (Dalaba, et al.,2016)

5.3 Male involvement in decision making and use of health insurance for family planning

With the health insurance scheme, men were comparatively low involved despite of availability of different contraceptive methods in varying health facilities in Mbarali district. For those who were visiting Antenatal clinics had opportunity to get introduced to the health insurance scheme. However, the PMTCT program (Berg, et al. 2015) has encouraged more men to escort their partners and this appeared to be an opportunity to learn about the health insurance scheme. Public health officials have advocated the involvement of men as a strategy for addressing depressing performance of family planning programs (Naik, et al. 2014). With the findings from this study has portrayed that for those women who came with their partners were reported to be as responsive compared by those who come by themselves. Therefore it implies that if there was enough sensitization on the free health insurance to men in the community the turn up of male partners could have been higher. Various studies have shown that providing men with information and involving them into counselling can led them to be supportive of contraceptives use and share decision making (Wells, 1997, Hartmann, et al.2012., Adelekan, et al. 2014). Many poor families fail to access family planning services, and this led to most males tends to distance themselves from family planning issues, especially when it involves costs. Since male partners appeared to be bread earner in covering costs of family planning, enabling families with insurance schemes to access family planning services could have great impression in terms of getting them closer to the scheme and support their female partners (Ir, et al., 2010).

A study in Kenya on voucher scheme in accessing family planning showed that men participated closely when they were sensitized and provided with the voucher (Bellows, et al. 2013). Study results highlighted that social cultural factors include male power in the society is associated with an increase to the clinics visit, after being educated on insurance they can push their wives and fellow men to go to the clinic. This implies if men involved into the program education, they will influence more female in the community to access health facilities for health care and increase use of services like family planning contraceptives. Reference from another study focused on male participation in the program

have influence a positive health behaviors to both male and female partners (Technical report, 1995).

5.4 Barriers faced in use of health insurance for family planning services

Implementation of the program and health facilities factors faced some challenges which were caused by the top down approach of the national implementer. In the first years of implementation of health insurance program there was inadequate training to health providers who were the key implementers of the scheme. And this led to lack of knowledge of the insurance scheme to some of women as well as to their partners, who were also part of the insurance. Findings from this study showed that most of the beneficiaries do not know much about the scheme and some do not know that they are part of the scheme despite receiving free reproductive and family planning services. This suggests that, the introduction of the program to the managerial people who do not interact with clients directly has affected the implementation of the intervention because most of the beneficiaries missed out some of the health services which were entitled to prosper hence steered to lower health service coverage. Studies which used bottom up approach showed sincere ownership and the key implementers own strong knowledge, since been involve from the initial stage (Wessells, 2015). This entails that, if the health insurance scheme implementation could involve community people in the initial stage, more women could have been enrolled together with partners hence high health service coverage and high access to family planning methods.

The RCH unit however in the health facilities have been facilitated to be more female oriented , hence male and family planning clients miss privacy for the services and hence failure to access the family planning methods despite are entitled to the health insurance scheme. A study in Cambodia has shown that the RCH nurses are not equipped hence fail to accommodate male clients (Walston, 2005). This suggest that if the family planning unit could have been separated with the maternal services and child health services could have been improving, family planning service coverage as now more family planning clients could have been free and confident to visit the units.

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.0 Introduction

This chapter presents the conclusion of the study. It provides the brief summary of the important findings to the objectives of the study together with recommendations thereon.

6.1 Conclusion

The results of this study have testified that health insurance to some extent has promoted the use of family planning services in the district. The beneficiaries motivated to access and use family planning services in all range of health facilities in the district. The health insurance has affected the cultural aspect and show clearly that male in the communities has great influence to facilitate women participating fully in health services.The beneficiaries increased confidence to health facility workers for the skills they acquired when providing family planning counselling and methods.

The study identified some key lessons. For the family planning services to be promoted there is a need that the benefit package and criteria for targeting beneficiaries are well understood by community.

Income earned through the health insurance scheme can be used to improve availability of contraceptives and quality of care to satisfy clients' needs and ultimately improving health seeking behaviours of the target population.The health care system in the health facilities should be more improved by making individuals accountable and own the interventions brought to health facilities hence improve quality of services, facility infrastructure and wellbeing of the health care providers.

6.2 Recommendations

The study has provided information on the various aspects on use, of health insurance scheme in promoting family planning use in Mbarali district. Therefore, the following recommendations if implemented may improve awareness of the existing health insurance scheme and timely use of contraceptives of preference.

i. There is a need to improve awareness of the health insurance scheme to beneficiaries, advocacy groups and community engagement needed, more emphasis on male participation as it is still crucial in the District. The District managers and health facility providers as implementers should participate in village meetings to introduce the health insurance scheme and services attached.
ii. Health education strategy is inevitable from RCH unit, inorder to provide proper and intensive health education including the introduction of the health insurance scheme to clients and available family planning methods hence encourage trust from clients to health care providers
iii. There is a need to improve accountability to the health care providers; this can be through refreshers trainings to RCH units by the District management team on how to own intervention programs to health facilities to improve quality services.

REFERENCE

Abebe, G and Nigatu, R. (2011). Family Planning Service Utilization in Mojo town. Journal of Geography and Regional Planning, 4, 355-363.

Ali, A. and Okud, A. (2013).Factors affecting unmet need for family planning in Eastern Sudan.BMC Public Health, 13, 102.

Babalola, S. (2004). Perceived Peer Behaviour and the Timing of Sexual Debut in Rwanda: A Survival Analysis of Youth Data. Journal of Youth and Adolescence, 33, 353-363.

Baraka, J., Rusibamayila, A., Kalolella, A. and Baynes, C. (2015).Challenges addressing unmet need for modern contraception – voices of family planning service providers in Rural Tanzania.African Journal of Reproductive Health (AJRH).

Becker, S. (1996). Couples and reproductive health: a review of couple studies. Family Planning, 27, 291-306.

Bellows, B., Kyobutungi, C., Mutua M. K., Warren, C. and Ezeh, A. (2013). Increase in facility-based deliveries associated with a maternal health voucher programme in informal settlements in Nairobi, Kenya. Health Policy and Planning, 28, 134-142.

Bellows, N. M., Bellows, W. and Warren, C. (2011). Systematic Review: the use of vouchers for reproductive health services in developing countries: systematic review. Trop Med Int Health, 16, 84-96.

Bellows, B., Conlon, C., Higgsl, E., Townsend, J., Nahed, M. and Cavanaugh, K. (2013). Taxonomy and results from a comprehensive review of 28 maternal health voucher programmes. J. Health Popul Nutr. 2013; 31(4 Suppl 2):106–28

Bhatia, M. and Gorter, A. (2007). Improving access to reproductive and child health services in developing countries: are competitive voucher schemes an option? Journal of International Development, 19, 975-981.

Borghi, J., Gorter, A., Sandiford, P. and Segura, Z. (2005). The cost-effectiveness of a competitive voucher scheme to reduce sexually transmitted infections in high-risk groups in Nicaragua. Health Policy Plan, 20, 222-31.

Borghi, J., Maluka, S., Kuwawenaruwa, A., Makawia, S., Tantau, J., Mtei G, Ally, M., and Macha, J. (2013). Promoting universal financial protection: a case study of new management of community health insurance in Tanzania.

Borghi, J., Ramsey, K., Kuwawenaruwa, A., Baraka, J., Patouillard, E. and Manzi,F. (2015). Protocol for the evaluation of a free health insurance card scheme for poor pregnant women in Mbeya region in Tanzania: a controlled-before and after study, Jul 2015: BMC Health Services Research 12/2015; 15(1):258.

Bunce, A., Guest, G., Searing, H., Frajzyngier, V., Riwa, P., Kanama, J. & Achwal, I. (2007).Factors affecting vasectomy acceptability in Tanzania. Int Fam Plan Perspect, 33, 13-21.

Burgard, S. (2004). Factors associated with contraceptive use in late- and post-apartheid South Africa. Stud Fam Plann, 35, 91-104.

Campbell, M., Sahin-hodoglugil, N. N. & Potts, M. (2006). Barriers to fertility regulation: a review of the literature. Stud Fam Plann, 37, 87-98.

Char, A., (2011).Male Involvement in Family Planning and Reproductive Health in Rural Central India [dissertation]. School of Health Sciences: University of Tampere.

Chikovore, J., (2004). Gender power dynamics in sexual and reproductive health.

Chomi, E. N., Mujinja, P. G., Enemark, U., Hansen, K. and Kiwara, A. D. (2014). Health care seeking behaviour and utilisation in a multiple health insurance system: does insurance affiliation matter? Int J Equity Health, 13, 25.

Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., Innis, J. (2003). Family planning: the unfinished agenda.

Cleland, K., Jeffrey, F. P., Westhoff, C., Scott, S., and Trussell, J. (2016). Family Planning as a Cost-Saving Preventive Health Service. The New England Journal of Medicine.

Dalaba, M.,Stone, A.,Krumholz, A.,Oduro, A., Phillips,J. and Adongo,B. (2016).A qualitative analysis of the effect of a community-based primary health care programme on reproductive preferences and contraceptive use among the Kassena-Nankana of northern Ghana.

Das, N., Mishra, V. and Saha, P. (2001). Does community access affect the use of health and family welfare services in rural India? Mumbai, India, International Institute for Population Sciences.

Samuel, K., (2001) Obstacles to male participation in family planning, a study in Kiyeyi - Tororo district.

Emanuel, E. and Fuchs, V.R. (2005). Health care vouchers–a proposal for universal coverage. N Engl J Med. 2005; 352(12):1255–60.

Ensor, T.and Cooper,S. (2004).Overcoming barriers to health service access: influencing the demand side. Health Policy Plan, 19, 69-79.

Evaluation of the impact of the NHIF MCH insurance card on improving access to maternal and new-born care services in Tanzania- (BIMAWAZAZI). (2015).Report

Fuller, S. (1993). Data use: Selection of a stratified random sample. Marketing Research, Inc., Highland Park, Ill. http://www.quirks.com/articles/a1993/19931005.aspx

Gizaw,A. and Regassa, N. (2011).Family planning service utilization in Mojo town, Ethiopia: A population based study. Journal of Geography and Regional Planning Vol. 4(6) 2011.

Goldman, A.E. and McDonald ,S. (1987). The group depth interview: principles and practice. - See more at: http://www.popline.org/node/350193#sthash.ia2TK9yj.dpuf

Gwatkin, D. R., Guillot, M. and Heuveline, P. (1999).The burden of disease among the global poor.Lancet, 354, 586-9.

Halcomb, E. J. and Davidson, P. M. (2006) Is verbatim transcription of interview data always necessary? Appl Nurs Res, 19, 38-42.

Hamid, S. and Stephenson R., (2006) International Family Planning Perspectives, Volume 32, Number 2, June 2006 Provider and Health Facility Influences on Contraceptive Adoption in Urban Pakistan.

Hanson, K., Marchant, T., Nathan, R., Mponda, H., Jones, C., Jane Bruce, J., Mshinda, H., and Armstrong Schellenberg, J.A, (2003). Household ownership and use of insecticide treated nets among target groups after implementation of a national voucher programme in the United Republic of Tanzania: plausibility study using three annual cross sectional household surveys.

Hatt, L., Nguyen H.A., Sloan, N., Miner.S, Magvanjav, O., Sharma, A., Rezwana, J. C., Paul, D., Islam, M., and Wang, H. (2010).Economic Evaluation of Demand-side Financing (DSF) Program for Maternal Health in Bangladesh.

Http://fbattorneys.com/legal-update-june-2016/

Kaida, A., Kipp, W., Hessel, P. and Konde-lule,J. (2005) Male participation in family planning: results from a qualitative study in Mpigi District, Uganda. J Biosoc Sci, 37, 269-86.

Keesara, R.S., Juma, A.P. and Harper, C. (2015). Why do women choose private over public facilities for family planning services? A qualitative study of post-partum women in an informal urban settlement in Kenya.

Kululanga, LI., Sundby, J., Chirwa, E., Malata, A., and Maluwa, A. (2012). Barriers to husbands' involvement in maternal health care in a rural setting in Malawi: a qualitative study. J Res Nurs Midwifery [Internet] 2012 [cited 2015 Mar 15] 1: 1-10. Available from: http: //www. interesjournals. org/full-articles/barriers-to-husbands-involvement-in-maternal-health-care-in-a-rural-setting-in-malawi-a-qualitative-study. pdf? view=inline.

Kuwawenaruwa, A., Mtei ,G., Baraka,J., Binkin, N., Charlet ,D., Williams, K. and Kassimu, T., (2016).The effects of MCH insurance cards on improving equity in access and use of maternal and child health care services in Tanzania: A mixed methods analysis :Journal of Health, Population and Nutrition.

Liesbeth, E., Anna, C., Arnold, D., and Andre, K., (2006). Does a competitive voucher program for adolescents improve the quality of reproductive health care? A simulated patient study in Nicaragua. BMC Public Health

Lindsay M., (2012). Can Incentives Strengthen Access to Quality Family PlanningServices? Lessons from Burundi, Kenya, and Liberia in Health Systems 20/20 project. Bethesda: Abt Associates Inc; 2012.

Macellina, Y. I, Titilayo, M.Y., Abiona ,C. ,Kayode, T. I. ,Olusegun, T. A.Olapeju, A. E., and Funmilola,M.O.(2010). Male Involvement in Family Planning Decision Making in Ile-Ife, Osun State, Nigeria.

Mackenzie, H. D., Pallikadavath, S., Stones, W., Dean, T. (2010).What kind of family planning delivery mechanisms increase family planning acceptance in developing countries? A mixed methods systematic review.

Mbizvo,M.T., Chou,D., and Shaw,D. (2013). Today's evidence, tomorrow's agenda: Implementation of strategies to improve global reproductive health.

Mburu, K.T., Okech, C.T. and Wawire, W.N. (2011).Empirical Analysis of Determinants of Demand for Family Planning Services in Kenya's City Slums.

Michael, E.J. (2012). Use of contraceptives methods among women in stable marital relations attending health facilities in Kahama district, Shinyanga region, Tanzania.

Moultrie, T., Sayi, T. and Timaeus, I. (2012). Birth intervals, postponement, and fertility decline in Africa: a new type of transition? Popul Stud (Camb) 66, 241-258.

Mutashobya,G., Baraka, J., and Kaim, B. (2014). Revitalizing the Use of Community Based Distributors for Improved Family Planning Services in Bukiriro Village, Ngara District, Tanzania. Third Community Meeting: Review and Way Forward. (Report). http://ihi.eprints.org/2751/1/pra_report.pdf

Mwaikambo, L., speizer, I. S., Schurmann, A., Morgan, G. & Fikree, F. (2011). What works in family planning interventions: a systematic review? Stud Fam Plann, 42, 67-82.

Olsen, B. E., Hinderaker, S. G., Kazaura, M., Lie, R. T., Bergsjo, P., Gasheka, P. and Kvale, G. (2000). Estimates of maternal mortality by the sisterhood method in rural nothern Tanzania: a household sample and an antenatal clinic sample. BJOG, 107, 1290-7.

Prata, N. (2009). Making family planning accessible in resource-poor settings. Philosophical Transactions of the Royal Society B: Biological Sciences, 364, 3093-3099.

Njuki, R., Obare, F.,Warren, C., Abuya, T., A., Okal, J., Mukuna, W., Kanya, L. and Bellow, B.(2013).Community experiences and perceptions of reproductive health vouchers in Kenya. BMC Public Health 13.

Naik, R., Morgan, L., Jenna Wright, J. (2014). The role of health insurance in family planning.

Richey, L. (1999). Family planning and the politics of population in Tanzania: international to local discourse. J Mod Afr Stud, 37, 457-88.

Robey, B., Piotrow, P. and Salter, C. (1994). Family planning lessons and challenges: Making programs work. . Population Reports, Series J, Number 40: Baltimore, Maryland USA: Johns Hopkins School of Public Health, Population Information Program. .

Sandiford, P., Rojas, Z., and Salvetto, M. (2005).A Guide to Competitive Vouchers in Health. Private Sector Advisory Unit, the World Bank Group: Washington, DC.

Sandiford, P., Gorter, A., Rojas, Z. and Salvetto, M. (2005). A Guide to Competitive Vouchers in Health. Private Sector Advisory Unit, the World Bank Group: Washington, DC.

Sekabaraga,C.,Diop,F., and Soucat,A.(2011). Can innovative health financing policies increase access to MDG-related services? Evidence from Rwanda.

Schellenberg, J.A., Victora, C.G., Mushu, A., De savigny, D., Schellenberg, D., Mshinda, H. (2003). Inequities among the very poor: health care for children in rural southern Tanzania. Lancet. 2003; 361(9357):561–6.

Tanzania Global Health Initiative Strategy. (2010-2015).

Tanzania Demographic Household Survey (TDHS). (2010).

Tanzania National Health Accounts. (2009/2010)

Tuoane, M., Madise, N. J. and Diamond, I. (2004). Provision of family planning services in Lesotho. Int Fam Plan Perspect, 30, 77-86.

The National Road Map Strategic Plan.(2008 – 2015).To Accelerate Reduction of Maternal, New-born and Child Deaths in Tanzania. East Afr, Med J 2008; 7(80):357- 60. PubMed /Google Scholar.

Wambui, T. (2012).Perceptions of family planning and sexually transmitted infections among low income men in Western Kenya.

WHO,National Health Accounts, website.

World Bank.(2005). A Guide to Competitive Vouchers. Washington, DC.

Zainab, B., Sharmin, S. and Islam, M. (2001).Factors affecting utilisation of MCH Services in Bangladesh.Journal of Family Welfare, 47.

APPENDIXIES

Appendix 1a: English Version guides and informed Consent Form

Guidelines for Women/Men with NHIF insurance card

I **Jitihada Baraka** a Masters student at The Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam. In partial fulfilment of the requirements of a Master's degree in Public Health (MPH), I am undertaking research on *Understanding the use of Health Insurance Scheme in promoting Family Planning services in Tanzania*: A case of KfW/NHIF insurance card for pregnant women in Tanzania

I wish to emphasize that the research is purely academics and all the information given and views expressed will be confidential. I believe the findings from this research will be useful for both academicians and the public as whole. I would appreciate if you spend some time to answer the questions.

Section 1: Participants Profile

After greetings, self-introductions and introduction of the subject of discussion fill the following information

District:_____Ward: _____

Name of Village/Township: _____

Date:_____/_____/_____Time start____/_____ Time Finish ____/____

Name of Moderator:_____

Name of Recorder: _____

Title of the Interviewee	Age	Sex	Marital Status	Number of children	Level of Education

Section 2: General questions on KfW/NHIF health insurance

2.1 What do you know about this insurance scheme and how it works?

- Probe where did she/he learn about the card—community sensitization activities, from the ANC staff, from friends, neighbours or family
- Probe whether she/he knows that they are enrolled, and if so, whether they were given a card or whether the enrolment was noted on the ANC card
- Probe what services the KfW/NHIFcard entitles her/him

Section 3: KfW/NHIF insurance card in relation to contraceptives methods selection

3.1 How do people perceive family planning services in the community [is it personal /cultural accepted?] Probe if is of beneficial/viable or acceptable

3.2 What different types of FP services are available from facilities and drug shops in your locality?

3.3 What type of FP methods do many people prefer to others? Why?

3.4 How does the KfW/NHIF health insurance motivate women to choose the FP method of the choice and why?

Probe (Think about different methods)

- Female sterilization, Male sterilization, Contraceptive pill, Intra-uterine device, Injectable, Implants, Male condom, Female condoms, Diaphragm, Lactational amenorrhea, Withdrawal
- Probe about access long term contraception methods
- Probe for the side effects of one method has influences her to use other method because of having the insurance
- Probe about the costs
- Probe if KfW/NHIF card enable her to choosing a certain type of contraceptive she/he desires

Section 4: Utilization of KfW/NHIF insurance card and choice of FP services

Since the program of NHIF enables the beneficiaries to access maternal and health services from private hospitals, referral hospital, regional hospital, pharmacies which are accredited by NHIF within the region, the beneficiaries has been empowered to have a wide range to select where they can go to get the services when holding the KfW/NHIF insurance.

4.1 What has been your experience using the KfW /NHIF card in different facilities mentioned?

Probe

- How and when she has used the card
- Which facility she was able to use a card for FP services
- Any problems using the card
- If she had to pay for anything when using the card
- Which FP services provider preferred most and why

4.2 How do you feel about the quality of the services (FP services) that you received when using the KfW /NHIF card with different services provider?

Probe

Probe if the FP services met her expectations

Probe for 'attitude' of the provider

……..**END**……

Guidelines for Implementers of NHIF insurance card

(CHMT, Family planning service providers, Pharmacy and drug shops)

I **Jitihada Baraka** a Masters student at The Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam. In partial fulfilment of the requirements of a Master's degree in Public Health (MPH), I am undertaking research on *'Understanding the use of Health Insurance Scheme in promoting Family Planning services in Tanzania:* A case of KfW/NHIF insurance card for pregnant women in Tanzania

I wish to emphasize that the research is purely academics and all the information given and views expressed will be confidential. I believe the findings from this research will be useful for both academicians and the public as whole. I would appreciate if you spend some time to answer the questions.

Section 1: Participants Profile

After greetings, self-introductions and introduction of the subject of discussion fill the following information

District:_____ Ward: _____

Name of Village/Township: _____

Date:_____/_____/_____Time start____/_____ Time Finish ____/____

Name of Moderator:_____

Name of Recorder: _____

Title of the Interviewee	Age	Sex	Marital Status	No: of children	Level of Education

Section 2: General questions on KfW/NHIF prepaid insurance

2.2 What do you know about this insurance scheme and how it works?

- Probe where did she/he learn about the card—community sensitization activities, from the ANC staff, from friends, neighbours or family

- Probe what services the KfW /NHIF card entitles

We understand that the NHIF has accredited some of the pharmacies /drug shops in the district to provided services to pregnant women using the insurance card

- Probe whether she/he knows the pharmacies /drug shops in the catchment area that are providing services using KfW/NHIF insurance
- Which services are provided using KfW/NHIF insurance

Section 3: KfW/NHIF insurance card in relation to contraceptives methods selection

3.5 How does people perceive family planning services in the community [is it personal /cultural accepted?] Probe if is of beneficial/viable or acceptable

3.6 What different types of FP services are available from facilities and drug shops in your locality?

3.7 What type of FP methods do many people prefer to others? Why?

3.8 How does the KfW/NHIF health insurance motivate women to choose the FP method of the choice and why?

Probe (Think about different methods)

- Female sterilization, Male sterilization, Contraceptive pill, Intra-uterine device, Injectable, Implants, Male condom, Female condoms, Diaphragm, Lactational amenorrhea, Withdrawal
- Probe about access long term contraception methods
- Probe for the side effects of one method has influences her to use other method because of having the insurance
- Probe about the costs
- Probe if KfW/NHIF card enable her to choosing a certain type of contraceptive she/he desires

Section 4: Utilization of KfW/NHIF insurance card and choice of FP services provider

Since the program of NHIF enables the beneficiaries to access maternal and health services from private hospitals, referral hospital, regional hospital, pharmacies which are accredited by NHIF within the region, the beneficiaries has been empowered to have a wide range to select where they can go to get the services when holding the KfW/NHIF insurance.

4.3 What has been your experience using the KfW /NHIF card in different health facilities?

Probe

- How and when she has used the card
- Which facility she was able to use a card for FP services
- Any problems using the card
- If she had to pay for anything when using the card
- Which FP services provider preferred most and why

4.4 How do you feel about the quality of the services (FP services) that received when using the KfW /NHIF card with different services provider?

Probe

- Probe if the FP services met her expectations
- Probe for 'attitude' of the provider

Section 5: Male involvement in using the NHIF insurance card in Family Planning services

After three month the KfW/NHIF insurance card expires, the family (father and other 4 children) join the mother on CHF for a period of one year as part of the coverage. The questions below target on how the male was involved.

5.1 What has been your experience using the CHF card?

Probe

- Probe for when and how she/he used the card (ask about FP services)
- Probe at which stage do men introduced to the program as beneficiaries

5.2 How have male been involved in making decision on family planning services for women who have received the card?

Probe:

- Waiting time at clinic
- Perception of FP
- Finance
- Attitude of health staffs
- Not being male-friendly

Section 6: Barriers in using NHIF insurance card for Family planning services

6.1 What are the challenges facing women/men with NHIF insurance card in using family planning services?

6.2 How do you think the NHIF insurance card can be utilized to address some of the health system barriers particularly on FP?

- How can male involvement be improved?
- Who are other stakeholders that can be engaged to improve the FP utilization?
- What roles can be played by those other stakeholders?

……. END…….

Appendix 1b: Informed Consent English Version

Introduction

Name _____ *from*_____ *facilitator*

Name _____ *from* _____ *Note taker*

We would like to invite you to participate in a research study of the utilization of health centers in Mbarali district, Mbeya Region. We have organized one to one interview as well as group interview from district level to community level in among selected harmlets.We are involving that particular groups so as to get insights and challenges among women and their families when they are getting health services using KfW/NHIF card.

The discussion will take forty five minutes during discussion you will be asked questions on the health insurance under NHIF also, you will talk about availability of family planning services in relation to the health insurance card. The discussion will be written and later on report will be produced.

Your participation in this research project is voluntary- this means you don't have to participate if you do not want to. Refusing to participate or stopping or withdrawing from this study will in no way result in a penalty or loss of benefits to which you are otherwise entitled. If you agree to participate, you can refuse to answer any questions that you don't feel comfortable answering. You can also withdraw from the study at any time.

The information you provide is confidential – that is, your information will be kept private and not shared. Only a code will be used to identify your answers without identifying you. This information will only be used for research.

There is no direct benefit to participation in this study; however, having a better understanding of utilization patterns and of who is able to access health care in Mbarali , may help to improve the health system in the future.

If you have any further questions about this study, you can contact **Jitihada Baraka** at jittybaraka@gmail.com

Consent

I have understood the study and I am ready to be asked any question. The participants have agreed to answer all questioned asked.

Name of the participant: _____

Participant Signature: _____ Date: _____

Interviewer Signature: _____Date: _____

Appendix 2a: Swahili Version guides & Swahili translated informed Consent form

Dodoso la kina mama na baba walio na bima ya afya

Naitwa **Jitihada Baraka**,ni mwanafunzi wa shahada ya uzamivu katika chuo kikuu cha afya Muhimbili, Dar es salaam, katika sehemu ya kutimiza shahada/masomo yangu, nafanya utafiti juu ya UELEWA WA MATUMIZI YA MFUKO WA BIMA YA AFYA KATIKA KUKUZA HUDUMA ZA UZAZI WA MPANGO TANZANIA. Rejea KFW/NHIF malipo ya kabla Kwa wanawake wajawazito Tanzania

Napenda kusisitizia utafiti huu ni kwa ajili ya masomo tu na taarifa yote iliyotolewa na maoni yote itakuwa ni siri.Naamini matokeo ya utafiti utakuwa na umuhimu kwa wanataaluma wote na jamii kwa ujumla. Napenda kujua Kama upo tayari kutumia muda wako kujibu maswali yangu

Sehemu ya 1: taarifa za mshiriki:

Baada ya salamu, jitambulishe na tambulisha mada husika ya mahujiano, jaza taarifa zifuatazo

Wilaya _____ Kata _____

Jina la Kijiji _____

Tarehe:_____/_____/_____Muda wa Kuanza____/___Muda wa Kumaliza ____/____

Mwezeshaji: MchukuaTaarifa:

Cheo cha Muhojiwa	Umri	Jinsia	Hali ya ndoa	Idadi ya watoto	Kiwango cha elimu

Sehem ya 2: maswali ya jumla juu ya BIMA YA AFYA (KfW/NHIF)

2.3 Unaelewa nini kuhusu huu mpango wa bima ya afya ya KfW ?Na unafanyaje kazi?

- Dodosa; Wapi alijifunzakuhusu hiyo bima---shughuli za uhamasishaji jamii,kutoka kwa marafiki, majirani, familia,au wafanyakazi wa kliniki,
- Dodosa kama anajua kuwa ameingizwa kwenye mpango wa bima ya afya,kama ndio je amepewa kadi? Au namba yake imenakiliwa kwenye kadi yake ya mahudhulio ya klinik
- Dodosa; ni aina gani ya huduma zinazotolewa kwa kutumia kadi ya bima ya afya ya KfW/NHIF

Sehemu ya 3: Uhusiano wa kadi ya bima ya afya Ya KFW/NHIF na uchaguzi wa njia za uzazi wa mpango

3.9 Je jamii wana mtazamo gani juu ya huduma za uzazi wa mpango?
(ni yakibinafsi/kiutamaduni umekubalika), dodosa kama unamanufaa/faida au kukubalika
3.10 Katika eneo unaloishi, Ni aina zipi za huduma za uzazi wa mpango ambazo zinapatikana katika vituo vya tiba na maduka ya dawa?
3.11 Ni njia ipi ya uzazi wa mpango ambazo watu wanapendelea kutumia tofauti na zingine? Na kwa nini?
3.12 Ni kwa kivipi bima ya afya ya KfW/NHIF imehasimisha/hamasisha (motivate) wanawake kuweza kuchagua njia ya uzazi wa mpango wanaoutaka/wanaoupenda, na kwa nini?

Dadisi (fikiria kuhusu njia zingine za uzazi wa mpango)

- Kitanzi,sindano,vipandikizi,vidonge,kutolea nje(kumwaga nje)
- Dodosa kuhusu upatikanaji wa njia za uzazi wa mpango za muda mrefu
- Dodosa madhara madogomadogo ya njia moja wapo ambayo imempelekea kutumia njia nyingine kwa sababu ya kuwa na bima ya afya
- Dodosa kuhusu gharama
- Dodosa kama kuwa na kadi ya bima ya afya inamfanya mwanamke achague aina flan ya uzazi wa mpango ambayo anaipenda/anaitaka

Sehemu ya 4: Matumizi ya kadi ya Bima ya KfW/NHIF na Kuchagua sehemu ya kwenda

Mpango wa KfW /NHIF umewafanya walengwa kupata huduma za uzazi na afya kutoka vituo vya afya vya watu binafsi, hospitali za rufaa, hospitali za mkoa, maduka ya dawa ambayo yamepewa kibali na NHIF ndani ya mkoa/wilaya. Walengwa wamekuwa na uwezo wa kwenda kupata huduma sehemu yeyote wakiwa wamebeba kadi za bima ya afya (KfW).
4.5 Nini umekuwa uzoefu wako wa kutumia bima ya afya katika vituo cha tiba tofauti tofauti?

Dodosa

- Kivipi na lini alitumia kadi
- Ni kituo kipi cha tiba ambacho aliweza kutumia bima ya afya kwa kupata huduma ya uzazi wa mpango?
- Tatizo lolote katika matumizi ya kadi
- Kama alitakiwa kulipa chochote pindi alipo kuwa anatumia kadi ya bima ya afya.
- Ni mtoa huduma yupi wa uzazi wa mpango ambaye unampendelea zaid na kwanini?

4.6 Unaonaje ubora wa huduma (huduma za uzazi wa mpango) ambazo unazipata pindi unapotumia kadi za KFW/NHIF kwa watoa huduma tofauti tofauti?

Dodosa

- Dodosa kama huduma za uzazi wa mpango zimekidhi matarajio yake
- Dodosa tabia za watoa huduma kwenye maswala ya Uzazi wa mpango
- Sehemu ya 4: Matumizi ya kadi ya Bima ya KfW/NHIF na Kuchagua sehemu ya kwenda kupata huduma

Sehemu Ya 5: Ushiriki wa wanaume katika kutumia kadi ya bima ya afya KfW/NHIF hasa katika huduma za uzazi wa mpango

Baada ya miezi mitatu, kadi ya KFE/NHIF inafikia kikomo ya matumizi yake, familia (baba na watoto wanne) wanajiunga na mama katika mfuko wa afya ya jamii(CHF) kwa kipindi cha mwaka mmoja kama sehemu ya huduma. Maswali fayuatayo yanalenga kivip wanaume wanajihusisha/wanashiriki

5.3 Nini uzoefu wako katika kutumia kadi ya bima ya afya(mfuko wa afya ya jamii)

Probe

- Dodosa ni lini na kivip alitumia kadi (Uliza kuhusu huduma za uzazi wa mpango)
- Dodosa ni katika hatua ipi wanaume wanatambulishwa/wanaambiwa huu mpango kama walengwa?

5.4 Kivipi wanaume wanajihusisha katika kufanya maamuzi juu ya huduma ya uzazi wa mpango kwa wanawake ambao wamepata kadi?

5.5 Dodosa

- Muda wa kusubili kupata huduma za klinik
- Mtazamo kuhusu uzazi wa mpango
- Gharama/fedha
- Hazina mazingira rafiki kwa wanaume

Sehemu ya 6: Vikwazo katika matumizi ya kadi ya bima ya afya (KfW/NHIF) katika kupata huduma uzazi wa mpango

6.3 Ni changamoto gani ambazo wanaume/wanawake wanakumbana nazo wakati wa kutumia kadi ya bima afya, hasa pindi wanapozitumia katika kupata huduma za uzazi wa mpango?

6.4 Je unadhani bima ya afya ya KfW/NHIF inaweza kutumika ili kuondoa baadhi ya vikwazo katika mfumo wa afya hasa huduma za uzazi wa mpango?

- Kivipi ushirikishwaji wa wanaume unaweza boreshwa?
- Ni washikadau gani wengine ambao wanajihusisha katika uboreshaji wa matumizi ya uzazi wa mpango?
- Majukumu gani yanayowezwa kufanywa na washikadau wengine

Nashuku kwa ushiriki wako/Wenu na huo ndo mwisho wa mahojiano yetu

……Mwisho…….

Guidelines for implementers of NHIF health insurance card

(CHMT, FP service providers, Pharmacy and drug shops)

Naitwa **Jitihada Baraka,**ni mwanafunzi wa shahada ya uzamivu katika chuo kikuu cha afya Muhimbili,Dar es salaam,katika sehemu ya kutimiza shahada/masomo yangu,nafanya utafiti juu ya *UELEWA WA MATUMIZI YA MFUKO WA BIMA YA AFYA KATIKA KUKUZA HUDUMA ZA UZAZI WA MPANGO TANZANIA*. Rejea KFW/NHIF malipo ya kabla kwa wanawake wajawazito Tanzania

Napenda kusisitizia utafiti huu ni kwa ajili ya masomo tu na taarifa yote iliyotolewa na maoni yote itakuwa ni siri.Naamini matokeo ya utafiti utakuwa na umuhimu kwa wanataaluma wote na jamii kwa ujumla. Napenda kujua kama upo tayari kutumia muda wako kujibu maswali yangu

Sehemu ya 1: taarifa za mshiriki: Baada ya salamu, jitambulishe na tambulisha mada husika ya mahujiano,jaza taarifa zifuatazo

Wilaya: _____Kata:_____

Jina la Kijiji:_____

Tarehe:_____/_____/_____Muda wa Kuanza____/_____ Muda wa Kumaliza ____/____

Mwezeshaji: Mchukua Taarifa:

Cheo cha Muhojiwa	**Umri**	**Jinsia**	**Hali ya ndoa**	**Idadi ya watoto**	**Kiwango cha elimu**

Sehemu ya 2: Maswali ya jumla juu ya BIMA YA AFYA (NHIF)

2.4 Unaelewa nini kuhusu huu mpango wa bima ya afya ya KfW/NHIF? unafanyaje kazi?

- Dodosa; wapi alijifunza---shughuli za uhamasishaji jamii,kutoka kwa marafiki, majirani, familia,kutoka kwa wafanyakazi wa kliniki,
- Dodosa; ni aina gani ya huduma zinazotolewa kwa kutumia kadi za bima ya afya

Tunajua kwamba kuna baadhi ya maduka ya afya katika wilaya ya mechaguliwa / yameruhusiwa kutoa huduma kwa wamama wajawazito kwa kutumia kadi ya bima ya afya

- Dodosa; kama anayajua maduka ya dawa ambayo yanatoa huduma kwa kutumia bima ya afya katika eneo analoishi/linalomzunguka
- Ni huduma zipi zinazotolewa kwa kutumia kadi ya bima ya afya?

Sehemu ya 3: Uhusiano wa kadi ya bima ya afya ya NHIF na uchaguzi wa njia za uzazi wa mpango

3.13 Je jamii wana mtazamo gani juu ya huduma za uzazi wa mpango? (ni binafsi/kiutamaduni umekubalika), dodosa kama unamanufaa/faida au kukubalika

3.14 Katika eneo unaloishi Ni aina zipi za huduma za uzazi wa mpango ambazo zinapatikana katika vituo vya tiba na maduka ya dawa?

3.15 Ni njia ipi ya uzazi wa mpango ambao watu wanapendelea kutumia tofauti na zingine?kwa nini?

3.16 Ni kwa kivipi bima ya afya imehasimisha wanawake kuweza kuchagua njia ya uzazi wa mpango wanaoutaka/wanaoupenda, na kwa nini?

Dadisi(fikiria kuhusu njia zingine za uzazi wa mpango)

- Kitanzi,sindano,vipandikizi,vidonge,kutolea nje(kumwaga nje) etc
- Dodosa kuhusu upatikanaji wa njia za uzazi wa mpango za muda mrefu
- Dodosa madhara madogomadogo ya njia moja wapo ambayo imempelekea kutumia kwa sababu ya kuwa na bima ya afya
- Dadisi kuhusu gharama
- Dodosa kama kuwa na kadi ya bima ya afya inamfanya mwanamke achague aina flani ya uzazi wa mpango ambayo anaipenda/anaitaka

Sehemu ya 4: Matumizi ya kadi ya Bima ya NHIF na Kuchagua sehemu ya kwenda kupata huduma

Mpango wa KfW /NHIF umewafanya walengwa kupata huduma za uzazi na afya kutoka vituo vya afya vya watu binafsi, hospitali za rufaa,hospitali za mkoa,maduka ya dawa ambayo yamepewa kibali na NHIF ndani ya mkoa/wilaya. Walengwa wamekuwa na

uwezo wa kwenda kupata huduma sehemu yeyote wakiwa wamebeba kadi za bima ya afya(KfW).

4.7 Nini umekuwa uzoefu wako wa kutumia bima ya afya katika vituo cha tiba tofauti tofauti?

Dodosa

Kivipi na lini alitumia kadi

Ni kituo kipi cha tiba ambacho aliweza kutumia bima ya afya kwa kupata huduma ya uzazi wa mpango?

Tatizo lolote katika matumizi ya kadi

Kama alitakiwa kulipa chochote pindi alipo kuwa anatumia kadi ya bima ya afya.

Ni mtoa huduma yupi wa uzazi wa mpango ambaye unampendelea zaid na kwanini?

Unaonaje ubora wa huduma (huduma za uzazi wa mpango) ambazo unazipata pindi unapotumia kadi za KFW/NHIF kwa watoa huduma tofauti tofauti?

Dodosa

- Dodosa kama huduma za uzazi wa mpango zimekidhi matarajio yake
- Dodosa tabia za watoa huduma kwenye maswala ya Uzazi wa mpango

Sehemu ya 5: Ushiriki wa wanaume katika kutumia kadi ya bima ya afya NHIF hasa katika huduma za uzazi wa mpango

Baada ya miezi mitatu, kadi ya KFE/NHIF inafikia kikomo ya matumizi yake, familia (baba na watoto wanne) wanajiunga na mama katika mfuko wa afya ya jamii (CHF) kwa kipindi cha mwaka mmoja kama sehemu ya huduma. Maswali fayuatayo yanalenga kivip wanaume wanajihusisha/wanashiriki

5.6 Nini uzoefu wako katika kutumia kadi ya bima ya afya (mfuko wa afya ya jamii)

- Dodosa ni lini na kivip alitumia kadi (Uliza kuhusu huduma za uzazi wa mpango)
- Dodosa ni katika hatua ipi wanaume wanatambulishwa/wanaambiwa huu mpango kama walengwa?

3.7 Kivipi wanaume wanajihusisha katika kufanya maamuzi juu ya huduma ya uzazi wa mpango kwa wanawake ambao wamepata kadi?

Dodosa

Muda wa kusubilia kupata huduma kliniki

- Mtazamo wa uzazi wa mpango
- Uchumi/fedha
- Tabia za wafanyakazi wa afya
- Hazina mazingira rafiki kwa wanaume

Sehemu ya 6: Vikwazo katika matumizi ya kadi ya bima ya afya (NHIF) katika kupata huduma uzazi wa mpango

6.5 Ni changamoto gani ambazo wanaume/wanawake wanakumbana nazo wakati wa kutumia kadi ya bima afya, hasa pindi wanapozitumia katika kupata huduma za uzazi wa mpango?

6.6 Je unidhani bima ya afya inaweza kutumika Ili kuondoa baadhi ya vikwazo katika mfumo wa afya hasa huduma za uzazi wa mpango?

- Kivipi ushirikishwaji wa wanaume umeboreshwa?
- Ni washikadau gani wengine ambao wanajihusisha katika uboreshaji wa matumizi ya uzazi wa mpango?
- Majukumu gani yanayowezwa kufanywa na washikadau wengine?

Nashuku kwa ushiriki wako/Wenu na huo ndo mwisho wa mahojiano yetu

……Mwisho……

Appendix 2b: Consent Form Swahili Version

Fomu Ya Ridhaa

Utangulizi

Naitwa _____ *Kutoka* _____ *Mwezeshaji*

Naitwa _____ *Kutoka* _____ *Mchukua taarifa*

Tunapenda kukualika/Kuwaalika ushiriki katika utafiti wa utumiaji wa vituo vya afya katika wilaya ya Mbarali, Mbeya. Tumeandaa mahojiano ya ana kwa ana kutoka ngazi ya wilaya mpaka kwenye baathi ya Vitongoji vya mbarali , tunahusisha walengwa hao ili kupata mwanga wa matatizo ambayo kina mama wanaweza kuwa nayo katika kupata huduma ya afya kwa wao wenyewe na familia zao kwa kutumia bima ya afya ya KfW/NHIF.

Majadiliano yatachukua muda wa dakika arobaini na tano. Wakati wa mahojiano utaulizwa maswali kuhusu mtazamo wako juu ya kadi ya mama katika mpango wa Bima ya afya chini ya ofisi ya NHIF.Vilevile utaelezea upatikanaji wa huduma ya uzazi wa mpango kwa kutumia kadi hiyo. Mahojiano haya yataandikwa na kunakiliwa kwa ukamilifu baadaye.

Ushiriki wako katika utafiti huu ni wa hiari – hii ina maana kuwa huhitaji kushiriki ikiwa hupendi. Kukataa kushiriki au kuacha au kujitoa katika utafiti huu hakutakusababishia adhabu au kupoteza manufaa unayostahili kwa namna nyingine. Iwapo unakubali kushiriki, unaweza kukataa kujibu maswali yoyote yale ambayo hujisikii huru kuyajibu. Hali kadhalika unaweza kuacha kuendelea na utafiti huu wakati wowote.

Taarifa unayoitoa ni siri – yaani, taarifa yako itawekwa kuwa ya binafsi na haitashirikisha watu wengine. . Taarifa hii itatumika kwa ajili ya utafiti tu. Hata hivyo, Bodi ya maadili, kamati iliyo na wajibu wa kuhakikisha kuwa utafiti ni wa kimaadili au maafisa wa chuo kikuu na serikali wanaohusika na ufuatiliaji wa utafiti huu wanaweza kukagua kumbukumbu hizi.

Hakuna manufaa ya moja kwa moja kwa kushiriki katika utafiti huu; hata hivyo, kupata uelewa mzuri wa miundo ya utumiaji na nani anaweza kupata huduma ya afya katika Mkoa wa Mbeya pia unaweza kusaidia kuboresha mfumo wa afya kwa siku zijazo. Vile vile,

wakati ambapo hatuwezi kujibu moja kwa moja maswali au hoja zako kuhusu afya, tunaweza kukupa taarifa juu ya kituo cha afya kilichopo karibu zaidi ambapo unaweza kupata msaada wa kiafya. Hatari za kushiriki katika utafiti huu ni ndogo kama tulivyokwisha eleza, unaweza kukataa kujibu maswali yoyote au kuacha kuendelea na utafiti huu wakati wowote. Unaweza kumwuliza mwezeshaji maswali yoyote wakati wote wa majadiliano.

Nitakuwa naandika maelezo na pia kurekodi kwa kutumia kinasa sauti, ili kunisaidia kukumbuka mambo muhimu ambayo tumeyajadili.

Kama una maswali yoyote zaidi kuhusu utafiti huu au kuhusu haki zako Kama mhusika wa utafiti, unaweza kuwasiliana na: Mtafiti mkuu **Jitihada Baraka** kwa jittybaraka@gmail.com

Ridhaa

Nimefahamishwa juu ya taarifa iliyotolewa hapo juu.Mchunguzi ameahidi kuyajibu maswali yangu kuhusu utafiti huu.Naridhia kushiriki katika utafiti huu.

Jina la Mhojiwa:_____

Sahihi ya Mhojiwa:_____ Tarehe: _____

Sahihi ya Mhoji: _____ Tarehe: _____

Appendix 3: Data collection Schedule

Date	**Task**	**Facilitators**
5 – 7/03/15	Data collection Training	Researcher
08/03/15	Travelling to Mbeya	Research team
09/03/15	Introduction of the project to the regional /district Appointments	Research team
10/03/15	Pilot tools for data collection at Mlimani village Revising research guide	Research team
11/03/15	**Dispensary level and catchment area** 1 FP in charge 4 women	Research team
12/03/15	**Dispensary level and catchment area** 2 FGD with men 1 Drug shop	Research team
13/03/15	**Health Centre level and catchment area** 1 FP in charge 3 women	Research team
14/03/15	**Health Centre level and catchment area** 2 FGD with men 1 Drug shop	Research team
15/03/15	**Sunday**	
16/03/15	**Hospital level and catchment area** 3 women 1 Drug shop	Research team
17/03/15	2 FGD with men	Research team

18/03/15	**District Interviews** 1 FGD _CHMT 1 FP in charge 1 Hospital pharmacy	Research team
19/03/15	**Regional interviews** 1 NHIF Zonal Manager 1 Quality Assurance Manager	Research team
20/03/15	**Returning Dar**	Research team