FACTORS CONTRIBUTING TO JOINING AND DROPPING OUT OF COMMUNITY HEALTH FUND IN MUFINDI DISTRICT

By

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CERTIFICATION (For examination)

The undersigned certifies that has read and hereby recommends for acceptance by **Muhumbili University of Health and Allied Sciences** a dissertation entitled **Factors Contributing to joining and dropping out of Community Health Fund in Mufindi District,** in fulfilment of the requirements for the degree of Mater of Public Health of the Muhimbili University of Health and Allied Sciences

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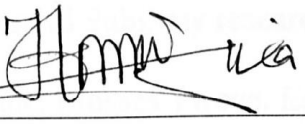
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DEDICATION

This dissertation is dedicated to my wife Subira, my children Mariam and Mussa. and also to my parents Mr. and Mrs. M. H. Mahingika.

ABSTRACT

Objective: Shortly after gaining Independence, free health care was a constitutional right in Tanzania. The public health care system was entirely tax financed. The government dominated in provision and funding of health care services. By the mid-1980s, Tanzania like many African states faced economic constraints. Following these economic constraints the Government of Tanzania (GoT) decided to undertake a general development policy reform within which Health Sector Reform (HSR) was recommended. Among the areas addressed in HSR were financial reforms which were complementary in nature. They included cost sharing at government units, the National Health Insurance Fund, Community Health Fund and private payment (Cash and carry basis). The health care financing system is one of the factors determining access to quality, affordable and sustainable health care to the majority of Tanzanians. Community Health Funds constitute one of the avenues to finance health care services to rural communities. It is a district level pre-payment scheme targeted at the rural population. The CHF scheme was piloted in 1996 in Igunga district. As a result of the pre- test at Igunga the government decided to roll out the experiment to other districts. In 2001, a policy decision was reached to cover all districts through an Act of Parliament. In spite of the good objective of the CHF the enrollment rate in most of the roll out districts including Mufindi is low. More over the trend to date has been for members to drop out rather than enroll. So there is a need to find out the reason for that poor performance of the CHF scheme.

Methodology: A cross-sectional study to determine factors contributing to joining and dropping out of the Community Health Fund in Mufindi was conducted. The study employed both quantitative and qualitative data collection methods. Catchments areas of nine dispensaries and two health centers were studied. A total of 226 heads of households were interviewed and 34 key informants were recruited for in-depth interviews. These key informants were purposely selected from the health facility governing committee.

Results: Findings from this study show that 98.7% of the studied population is aware of the CHF scheme, while membership rate is 28.7%. Perceived benefits mentioned were assurance of treatment, reduced cost of treatment services, drugs availability in health facilities, rehabilitation of the health facilities and getting matching grant from the government. Perceived problems includes extra cost for the members apart from the premium paid (buying drugs), lack of referral system, shortage of drugs, lack of laboratory services and shortage of health workers .Factors contributing to not joining and dropping out of the scheme were almost similar which includes lack of money, shortage of drugs, inadequate sensitization, lack of referral system and not frequently falling sick for the family members. Other factors are lack of laboratory services and unskilled health personnel.

Recommendations: The district council should ensure that CHF scheme improve the quality of health services so as to attract community to join and access health services. CHF scheme sensitization should be improved. The council also should consider provision of incentives to the Wards Health Committee and health workers.

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ACRONYMS

AAR	American Air Rescue
CBHI	Community Based Health Insurance
CHF	Community Health Fund
DC	District Council
DHB	District Health Board
DMO	District Medical officer
FBO	Faith Based Organization
GoT	Government of Tanzania
HSR	Health Sector Reform
MOH	Ministry of Health
MRALG	Ministry of Regional Administration and Local Government
MUCHS	Muhimbili University College of Health Sciences
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
SHIB	Social Health Insurance Benefits
VC	Village Committee
VEO	Village Executive Officer
WDC	Ward Development Committee
WHC	Ward Health Committee

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Developing countries account for 84% of world population and 93% of the worldwide burden of diseases. However they account for only 18% of the global income and 11 % of the global health spending. Limited resources and administrative capacity coupled with strong underlying needs for the services pose serious challenges to governments in the developing world (Schieber et al, 1999). Health policy makers are faced with competing alternatives, and for systems of health care financing. The choice of a financing method should mobilize resources for health care financing and provide financial protection (Ekman, 2004). There is strong evidence that community based health insurance provide some financial protection by reducing out – of –pocket spending. There is evidence of moderate strength that such schemes improve cost recovery (Ekman, 2004).

Post – independence Tanzania gave high priority to education and health, with a prominent role for the government as a provider. In 1967 the government of Tanzania (GoT) through Arusha Declaration committed itself to a policy of providing essential health care services free at the point of use. This was to be financed through tax and donor resources (Kumaranyake et al, 2000; MOH 1999). For the subsequent fifteen years, through this type of financing, an elaborate health care infrastructure emerged in

the country, fairly accessible and penetrating most rural areas; it was dominated by primary health care units, managed by short term trained human resources. This type of health care approximated well to what is literally referred to as a comprehensive health care system. This is so because it provided a promotive, preventive and curative care under one roof.

Following the economic reforms of the 1980s the Government of the United Republic of Tanzania decided to undertake a general development policy reform within which Health Sector Reform (HSR) was recommended.

The process of health sector reform started with the Health Strategy Note (1993), which emanated from the country's need to re-examine the then health services financing and delivery system .This note led to development of the Health Sector Reform (HSR) document . In this Health Sector Reform document it was clearly shown that the health service delivery system had the following problems:

(i) Inadequate financial and human resources managerial capacity at all levels especially at district level, (ii) Poor implementation, (iii) Split (dual) responsibilities of the District Medical Officer (being answerable to both central and local government), (iv) Lack of appropriate research policy. On further consideration these issues were basically grouped as Ideological, Organizational, Managerial and Financial (MOH, 1994; 1996).

Various options were developed to address the financial reforms. These options were mainly complementary in nature; they included cost sharing at government units, the National Health Insurance Fund, Community Health Funds and private payment.

1.2 Financial reforms

A major financial issue was identified as under- funding at all levels of the health services which had led to a shortage of drugs and other supplies, deterioration of the physical infra-structure and low staff morale. Following the 1994 Health Sector Reforms, various categories of financing mechanisms were developed to complement government financing. These mechanisms were:

1. Community Health Fund
2. Drug Revolving Funds
3. Social Health Insurance Funds e.g. National Health Insurance Funds (NHIF)
4. Private Health Insurance e.g. American Air Rescue (AAR)
5. Out of pocket payment (User fees) for communities having no any Insurance Schemes.

The Social Health Insurance Fund (NHIF) is meant for people employed in the formal sectors. Private Health Insurance is mainly used by private sectors as well as private well to do families because of the high cost needed to join this type of Insurance. Out of pocket payment (User fees) is used by some people who are not insured in any of the

schemes for health care. For the majority of rural community the major option for them to be assured access to affordable and sustainable health care is Community Health Fund.

1.3 Community Health Fund (CHF)

In the year 1994/95 the Government of Tanzania (GoT) collaborated with the World Bank to design a new approach to improve the financing and provision of health care to households in rural areas. The new approach Community Health Fund (CHF) was introduced in Tanzania as part of the government's health sector reform measures. It was intended to contribute to the generation of revenue in the health sector as well as strengthening the government's commitment to decentralize health care planning and financing, not only to the district but also to the community level (Kiwara and Kapinga, 2000; Munishi, 2000; Shaw, 2002).

The objectives of CHF were to:

(a) To establish a complementary financial resource base for the basic curative and preventive health care, primarily to fill the financial gap in government funding (not to replace public or private modes of health financing and provision), and

(b) To ensure security of access and equity to health services to the community members.

(c) To provide quality and affordable health care services through sustainable financial mechanism

(d) To improve health care management in the communities through decentralization.

Strategies to ensure that the CHF was acceptable to the communities include: ensured adequate medical supplies at all facilities, strengthened capacity of health facilities to deliver health care, enhanced the skill of the health workers in the health delivery system, increased involvement and participation of communities in the management of health requirement and services (Kiwara and Kapinga, 2000; Munishi, 2000; Shaw, 2002).

CHF is intended to cover basic essential health care at the health centers and dispensaries. There are no limits set for the number of visits to the health facility per member per year.

Piloting the scheme was first done in 1996 in Igunga district followed by Singida Rural district in Singida Region in 1998. As a result of the piloting at Igunga and the subsequent performance of the scheme, especially the ability to mobilize financial resources, the government decided to roll out the experiment to other districts. The ability and willingness to start up the CHF programme was the criteria used to pick the roll out districts, as determined by the respective local district councils (Kiwara et al, 2000; Munishi, 203). In 2001, the Community Health Fund policy decision was reached to cover all districts through an Act of Parliament (Baraldes, 2003; Chee et al, 2002).

1.3.1 Motivation to join the CHF

The motivation for households to join the CHF was three folds: First, there was wide spread dissatisfaction with the financing of publicly operated health services, resulting to

poor quality of services and limited supplies especially drugs. While every one agreed that revenue from direct and indirect taxes had to be supplemented, the idea of pre-paying for quality health services when people could afford it sounded more attractive than paying out of pocket at time of injury or illness. Second, cost sharing by the government meant that pre-payment by the household would be effectively doubled. Thirdly, management of the CHF revenue in closer proximity to where members lived was seen as the way of improving control over resources assuring greater value –for – money and improving accountability to households. Each household has the opportunity to contribute to the CHF system by purchasing a health card at a flat rate. The membership fees for rollout districts ranged from 5,000/= to 15,000/= (Munishi, 2003).

1.3. 2 Defining household and benefits

A household was defined as a nuclear family including father, mother, and children under 18 years .In a polygamous situation each wife with her children below 18 years constitute a separate household unit. Unmarried individuals qualify to be members upon contribution. The card entitles the household to the basic package of curative and preventive services through out the year. A household unwilling to join was required to pay a user fee (out of pocket) at health facilities each time family members attended the health facility (Baraldes, 2003). The premium from the households is pooled at district level. This fund is matched by the central government by an amount equal to the total pre-payment collected. The communities in conjunction with the district decide the use of the fund, based on the need of the health facilities. An extensive review concerning

poor quality of services and limited supplies especially drugs. While every one agreed that revenue from direct and indirect taxes had to be supplemented, the idea of pre-paying for quality health services when people could afford it sounded more attractive than paying out of pocket at time of injury or illness. Second, cost sharing by the government meant that pre-payment by the household would be effectively doubled. Thirdly, management of the CHF revenue in closer proximity to where members lived was seen as the way of improving control over resources assuring greater value –for – money and improving accountability to households. Each household has the opportunity to contribute to the CHF system by purchasing a health card at a flat rate. The membership fees for rollout districts ranged from 5,000/= to 15,000/= (Munishi, 2003).

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not for profit voluntary health Insurance schemes for people outside formal sector employment in developing countries observed that these schemes do cover only a small proportion of the eligible population (Carrin et al, 2005). In Tanzania as well, low membership rate of the CHF, has been observed in many of the roll out districts (Baraldes, 2003: Munishi, 2005)

1.3.3 Low uptake

Adequate membership will ensure that CHF is one of the major complementary means in financing health care system in Tanzania. In the original design, CHF membership was expected to be 60 to 65% of all households in each district ((Kapinga and Kiwara, 1999; Baraldes, 2003; MOH, 2005)

Membership of CHF across all roll out districts is low. To date enrollment per district ranges from 3% to 28% of total households where CHF is implemented, and the majority of the districts are around 4% (Baraldes, 2003).

More over the trends to date has been for members to dropout rather than joining the scheme. Enrollment of CHF membership in Igunga district was 4.9% in 1996, 5.9% in 1997,6.1% in 1998 and rose significantly to 22.5% in 1999 (Ongwae, 2000). Singida (Rural) was 4.1% in 1999, while the trend in Hanang district was 2% in 1998, it rose to 24% in 1999, but then declined significantly to 4% in 2000 and appear to have dropped even further to 3% in 2001 (Chee et al, 2002).

1.4 Problem statement

There is increasing advocacy for the community based health insurance as part of broader solution to health care financing problems in low-income countries (Bennet, 2004). It is a clear fact that CHF is a viable avenue to achieve the intended objective of improving access to appropriate, affordable, promotive, curative and rehabilitative health care services in the country. But currently the CHF enrollment rate in many of the roll out districts is still low (Kapinga and Kiwara, 1999; Baraldes, 2003; Munishi, 2003). In this context Mufindi district is not exceptional.

Currently enrollment rate per district ranges from 3 – 28% of the total households where CHF is in operation (Baraldes, 2003; Munishi, 2003). For majority of the districts the average enrollment rate is around 4%. More over the trend to date has been for members to drop out rather than to enroll (Baraldes, 2003).

Low CHF enrollment and drop out has a negative effect on the scheme as it reduces the amount of revenue collection, the Idea of risk pooling as well as ability to purchase and provide health care in intended rural Community. On top of that it also reduces the number of poor people to be exempted, since the design for the scheme is that approximately 5 % of household members that are very poor or indigent would be exempted from paying any fee i.e. CHF or user fees (Ongwae, 2000;Shaw, 2002).

In the original design of the CHF in Tanzania, the percentage of members was estimated to be 60 to 65% of all households in each district (Kapinga and Kiwara, 1999; Baraldes, 2003; MOH, 2005).

In Mufindi district, CHF has been in operation since 2004.
Preparations to initiate CHF involved community sensitization / mobilization, renovation of the health facilities and improvement of the medical supplies and equipments. Despite the above facts and efforts CHF enrollment rate in Mufindi district is low, currently only 4,260 (7%) households out of 60,058 eligible households have been enrolled which is low compared to the expected 60% of all households.

Hence there is wide discrepancy between the existing enrollment rate and expected enrollment rate. It is not known why the response is poor. On top of that, there is no any study so far which has been done in Mufindi district to establish factors contributing to CHF enrollment and drop out. There fore there is a need to known reasons for this low enrollment and the said trend of drop out in this district if the meaning full improvement of the scheme is to be achieved. And we cannot explain the situation through literature generated in other areas which have different socio-economical and cultural context which may influence enrollment as well as drop out of the scheme. It is in this context that this research is being proposed.

1.5 Rationale

CHF aimed at improving access to appropriate, affordable, promotive, curative and rehabilitative health care services to the rural community. Since enrollment rate in many of the roll out districts is low, there are negative effects to the scheme and the rural population in general

In order to counter the negative effects of the scheme (low enrollment and drop out), identification and prioritization of the underlying causes is important. Findings from this study therefore will facilitate the formulation of interventions aimed at improvement of the CHF scheme by minimizing low enrollment rate and drop out.

A good performing CHF will establish financial resource base for basic curative and preventive health care, will ensure security of access and equity to health care services to the community, and provide quality and affordable health care services through sustainable financial mechanism

This study is expected to contribute to the improvement of CHF performance and sustainability in the Mufindi district and the country at large. The results from this study may be used by the policy makers to improve CHF performance in the country. Apart from that, result from this study will be used as a base line data for future studies of similar nature since there is no study of this kind which has been conducted in this district.

1.6 STUDY OBJECTIVES

1.6.1 Broad objectives:

To determine factors that affect the joining and dropping out of the CHF scheme in Mufindi district.

1.6.2 Specific Objectives

1. To assess the awareness on CHF scheme among the community members
2. To determine the proportion of the CHF scheme members in the community
3. To determine the perceived benefits of the CHF scheme among members of the community.
4. To determine the perceived problems of the CHF scheme among members of the community
5. To assess the factors contributing in joining the CHF scheme in the community
6. To assess the factors contributing in dropping out of the CHF scheme in the community

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Health care financing context

While much of the debate on health spending and reform has focused on developed countries, these issues are of even greater importance to developing countries, which have significantly higher disease burden, severe resource constraints, limited administrative capacity and numerous competing critical priorities pose serious challenges (Schieber and Maeda, 1999).

When African states gained their independence, free health care was a constitutional right and public health care system were supposed to be entirely tax financed (Criel, 1998)

In most of them, governments have previously dominated in provision and funding of health care services. Tanzania like many other developing countries, post Independence gave high priority to education and health with a prominent role for the government as a provider. Through Arusha declaration in 1967 Tanzania committed itself to provision of essential health care services `` free'' at the point of use. This was financed through government (Tax financed) and external donor resources (Kumaranyake et al, 2000) .Under this policy private practice in health sector was actively discouraged, and in 1977 was prohibited by law. This prohibition had the intention of remaining with the

government as the sole provider of the health services for the purpose of removing inequalities to access affordable and sustainable health care services to the Tanzanian community. This rapidly proved to be an illusion. Economic growth was low and decreased to a level below 1% per year in early seventies. In the mean time, the post – independent period was characterized by rapid population growth. In 1973, the price of oil raised and the world economy slowed .As the demand for products from developing countries declined the price for those products began to fall and tax and export revenue reduced. Developing countries had to borrow on the international market just to make the end meet. This crisis had dramatic effects on the government budget allocated to health (Criel, 1998).An increase in international aid was unavoidable if the ambitious goal formulated by at the 1978 Alma Ata conference on primary health care were to be achieved .By the mid-1980s, Tanzania like many African states faced economic constraints .In 1985-1986 Tanzania embarked on policy of economic liberalization and by the end of the 1980s , resources for the health sector had been substantially reduced (Kumaranyake et al, 2000). Due to these events the government could no longer afford to fund the growing public dominated health services. So apart from the government funding for the health care services other complementary means had to be speculated. Their primary purpose was to complement declining government tax financed funding and to improve quality of care within the public health sector through an increased availability of essential input like drugs (Criel, 1998). These complementary mechanisms will make people responsible for more rational health care utilization and involving the population in the management of their health services.

2.2 Systems of health care financing in Tanzania

Achieving efficient, equitable and sustainable health systems aimed at the reduction of burden of disease is the ultimate goal of all stake holders in the health sector and particularly the government through the Ministry of Health. This goal is a response to the now known facts that the current health systems in Tanzania suffer from inefficiencies with gross inequalities and lack of financial sustainability. These problems aimed to be addressed through Health Sector Reforms (HSR) by improving supply side efficiency, creating an environment which allows equitable access to health services, a much more broad based and sustainable health care financing mechanism with full participation of those beneficiaries in the form which empowers them. Due to these facts today apart from tax based health care financing mechanism, complementary health care financing mechanisms do also exist.

a) Tax based health care financing system

Health care financing system through general taxation is generally recognized to be powerful to achieve universal coverage with adequate financing protection for all against health care cost (Carrin et al, 2005). This system intends to respond to the goal of fairness in financing health care services. In this system the population contributes indirectly via taxes .The benefits of this system is that contribution is collected indirectly, the communities do not fill the direct impact of the money collected for health care and every one supposed to contribute normally does so. This system removes

inequalities in access to affordable and sustainable health care services since there is no direct payments from the individuals. The problem with system is that, a tax funded health system may not be easy to develop, due to lack of robust tax base and a low institutional capacity to effectively collect taxes. The challenge with this system is that under poor political or economic instability usually interfere with steady development of the health sector, like what happened in 1980s. As such developing country like Tanzania cannot solely rely on tax based health financing alone, rather complementary systems have to be in place for sustainability of health care

b) Complementary health care financing mechanisms

This type of health financing can be grouped in different categories as follows:

(i)Formal health financing

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

National Health Insurance Fund (NHIF)

The introduction of NHIF was planned to take place at the same time as that of cost sharing in 1993. However its implementation was delayed until 2001 following enactments by the act of parliament as NHIF Act No 2 of 1999 for all public sector employees (Mujinja and Kwesigabo, 2007). NHIF covers public sectors employee

including spouse and up to four children or legal dependants. For the employees it is obligatory to contribute to the NHIF. The contribution which is 6 percent of the salary is divided equally between the employee (3%) and the employer (3%). NHIF offers a benefit package that has all the primary health care services and other diagnostic services. The NHIF accredits public, FBO and private for profit health facilities and pharmacies, in both rural and urban areas, to provide care to their members and their dependants. After retirement members receive benefits for up to three months (Steinwach, 2002: Kabanywanyi, 2006)

Social Health Insurance Benefit (SHIB)

It is under National Social Security Funds (NSSF) benefits. It was established under NSSF Act.No.28 of 1997 provides Health Insurance Benefits for NSSF members, their spouse and up to four children. It provides crucial support to the government efforts of increasing access to health care services to the poor majority of the country (NSSF 2005).It started to operate in 2005. The scheme covers all active members and their dependants (one spouse and up to four children) provided that the principle beneficiary is up to date in remittance of contributions. The contribution to any SHIB is divided between employer and employee where by the benefit is accessible for the employee and their immediate family. After retirement members receive benefits for up to three months

(ii)Private health financing

Private health financing is mainly used by the private sectors, Non Government Organization as well as private well to do families. Example is American Air Rescue (AAR).Under this system it also includes Faith Based Organization (FBO) as well as Private for Profit.

Faith Based Organizations (FBOs)

FBOs facilities operate more or less the same as the government facilities although they are not owned by the government. They complement government efforts in provision of affordable and sustainable health services. They are widely distributed compared to private for profit facilities. FBOs own more than 40 percent of the total national hospital beds, and mostly operating in the rural areas (Mujinja and Kwesigabo, 2007)

Private for profit

They were initially prohibited to operate in 1977. Following the country economic constraints of 1980s and the subsequently policy of the economic liberalization the practice of private sector prohibition was removed in 1991 as part of the government policy reform (Kumaranyake, 2000). This followed by legislation to effect in 1992 , then communities , qualified persons and organization were allowed to participate in private health services in Tanzania. The private for profit health facilities are mainly located in urban areas, where most of the people who could afford to pay at the point of seeking

care reside (Mujinja and Kwesigabo, 2007). There fore private for profit facilities are not accessible to the poor Tanzanian majority.

(iii) User fees (Out of pocket payment)

The deterioration of the quality and quantity of health services, due to among other things, the declining financing of the health sector made it necessary for the government to introduce user fees in government health district, regional and referral hospitals in 1993 (Kapinga and Kiwara, 1999: Steinwach, 2002: Kabanywanyi, 2006: Mujinja nad Kwesigabo, 2007). User fees had the objective of complementing the government efforts in finance health care services with the purpose of improving performance of health care services. Since most Tanzanian especially rural community have low and irregular incomes, which result in periodic shortage of money for the family health care, then user fees are not sustainable for them to effectively access appropriate health care services at any time of the year. With the introduction of Community based health financing scheme like Community Health Funds this category of complementary health financing (user fees) had to be extended to dispensary and health center level where a family will decide to join in the community health fund or to remain in the out of pocket payment. It is therefore argued that user fees have not met the intended expectations, including fostering of equity, rationalization of the demand for and supply of health commodities and services; improvements of health workers' availability, performance, and motivation and increase in revenue (Mujinja and Kwesigabo, 2007)

(IV) Community Health Fund (CHF)

The failure of payment at the point of use (user fees) mechanism to significantly generate enough revenue, improve the quality of care, and make health care universally accessible, especially by the poor, necessitated the searching for an alternative and comprehensive health financing mechanism., which would minimize the risk of loosing much more money and/or failing to seek care when the illness happens (Mujinja and Kwesigabo, 2007). One of the government devised risk pooling mechanisms is Community Health Fund (CHF) .The concept of Community Heath Fund (CHF) was first introduced in Tanzania in 1996 in Igunga district, Tabora region as a pretest district. Later on rolled out to involve other districts upon which in 2001 the policy enacted by the Parliament to involve all the districts in the country.

The Community Health Fund was designed with the intention of providing an alternative to paying fees for service. The scheme promotes community participation and empowerment through establishment of the Facility Health Committees and Council Health Boards which assist in administering the Fund. It is was also expected that with CHF communities, community would realize the value of health, and be willing and ready to contribute complementary resources at the local level to respond to community-defined health needs.

CHF is a tool of decentralizing decision making and management of health services beyond the district level .It strengthen community participation and ownership of health

care services in monitoring quality of services offered to them through health committees CHF is a risk pooling among families in the informal sector .In this respect each household pay a pre-determined premium once for the medication per year and is issues a membership card .Payment is often is made at the time of harvesting or when the season of income has arrived (MOH, 2005) .

Non members of the fund pay user fees in return for health care services because CHF was introduced together with user fees system which extended to influence first line health services i.e. dispensaries and health centers ,which originally when introduced for the first time in 1993 user fees was for the district, regional and referral hospitals (Kapinga and Kiwara, 1999).When CHF scheme introduced health care services were no longer free, one had to access health care services either by being a member of CHF i.e. pay once in a year for all visits or through user fees paid for every illness episode.

CHF aimed at providing alternative to user fees for the majority of low income earners to access health care at any time of the year. It also aimed at reducing health care service inefficiencies, gross inequalities and lack of financial sustainability. The implementation of community financing is a way to ensure that those who can afford to contribute towards health services do so. The Fund ensures that the poor are offered an improved waiver system; as people who can not afford to pay are identified by the community themselves and are provided with membership cards. This was a good strategy since it aimed at achieving efficient , equitable and sustainable health services for the reduction

of the burden of disease being the ultimate goal of the stake holders in the health sector and in particular the Government through the minister of health.

This scheme provides both curative and preventive cares I its packages, examples: Reproductive and child health, well baby services (Immunization and micronutrients supplementation), basic trauma, malaria, diarrhea, opportunistic infection and other local infections. Also provides services like Sexually transmitted diseases (STD), family planning and limited chronic diseases (Shaw, 2002; MOH, 2005)

The principle stakeholders in the CHF include the community, ward and district leadership, local authorities, health providers and central government.
CHF organizational structure builds on the existing structure of the government operations to avoid building up new and parallel structures.

At ministerial level, two ministries are involved; the Ministry of Health (MOH) and the Ministry responsible for local government which is currently the Ministry of Regional Administration and Local Government (MRALG). The district is the centre of CHF activities.

At district level CHF is managed by district council (DC) through a District Health Board (DHB). At ward level, CHF is managed by Ward Development Committee (WDC) through it Ward Health Committee (WHC). At village level CHF is managed by

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village council (VC) through it village government, which is advised by a village Primary Health Committee (VPHC) (MOH, 2005)

Poor performance

Despite the good intention and effort to help the Tanzania community to access affordable and sustainable health care services , its uptake has been low in may districts including Mufindi.

Reasons given by other literature for the poor uptake includes:

Perceived low quality of services delivered by health services than what the community expected to be in exchange for their financial participation, the expenditure of the collected funds was not properly planned to improve the quality and quantity of the health care services, members expect to receive full range of services at all levels in the district referral system, including private health services but this is not the case in the real implementation in most of the districts, example in Hanang district some community members said they are not members of CHF scheme because the scheme did not includes mission health facilities which the believe to provide higher quality health services (Chee, 2002). Others includes increased availability of high quality competitive private health facilities, shortage of drugs as chronic problem which affect the quality of care, low community voice in decision making on how health services should be managed and removal of the government bureaucracy in CHF implementation, the undermined risk pooling benefits of joining CHF scheme e.g. in some community

member find paying 1,000/= per service is too low to be effective incentive to join CHF in area where household often pay in the vicinity 2,500/= for out patient visit at private health facilities (Shaw 2002).Other reason given includes poor health staff attitudes and high membership fees. CHF in Tanzania though to be good alternative for the access to affordable and sustainable health care services for the rural poor community where majority are living.

But as it was seen before the uptake is still low, this shows the need for the further research in this area to find the solution and subsequent improvement of the scheme for the benefit of the majority.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Description of the study area

This study was conducted in Mufindi district-Iringa Region. Mufindi district is one of the seven districts of Iringa region. It is located about 80 kilometers south of the region capital of Iringa. It is located geographically between 30 - 60 degree longitude east and 8 degrees latitudes south, with an area of 7,122 square kilometers.
Other districts in Iringa region are: Iringa Urban, Iringa Rural, Makete, Njombe, Ludewa and Kilolo. Mufindi district has a total population of 283,032 of which 133,828 are males and 149,204 are females. The total number of household is 66,058 (NBS, 2002)

Administratively, the district has five divisions namely, Malangali, Sadani, Ifwagi, Kibengu, and Kasanga. It is further divided into 28 wards, 132 villages, and 582 hamlets. It is bordered by Iringa district council on the North, Mbarali district council on the West, while in the East, borders Kilombero district and south, borders Njombe district.

The district has a total of 51 Health facilities. Among these, two are hospitals (one being Government owned which is a district hospital, and the other is privately owned),

There are total of five health centers, four been Government owned and one privately owned. There are 44 dispensaries, of which 30 owned by the Government, 10 by Faith based Organizations (FBO) and the remaining four are privately owned.

Agriculture is the main economic activity in the district; it employs more than 90% of the population and provides more than 85% of the people's incomes. Most of the agricultural households are small-scale farmers with average land holdings of 3 - 5 acres. The most commonly used farm implement are hand hoes followed by animal drawn.

The main ethnic groups are the Hehe who comprised about 85% of the district population; the remaining 15% are the Bena, Pangwa, Kinga and others.

3. 2 Study design

The study employed a cross –sectional design and used both quantitative and qualitative data collection methods where structured questionnaires (as data collection instruments) were used to collect information from the study units in the community and In-depth interviews were used to collect information from the key informants.

3.3 Study population

The whole Mufindi community where CHF scheme has been in operation since 2004. But the head of the selected households and the selected key informants were my study units.

3.4 Study sample and sample size calculation

(a) Study sample

The study samples were selected households for quantitative design and members of health facility governing committee in qualitative design. Households were obtained in catchments areas of selected health facilities in the district. Members of health facilities governing committees in the selected facilities were used as key informants.

(b) Sample size calculation

A minimum sample size in community obtained using sample size estimation formula of single proportion. This is given by:

$$n = \frac{Z^2 P (100 - P)}{\varepsilon^2}$$

Where: n = estimated minimum sample size of households interviewed

Z = 1.96 approximated to 2 (at 95% confidence interval)

P = Proportion of CHF members in Mufindi district (Currently joining rate estimated to be 7%)

ε = Is the accepted margin of error (In this study taken to be 4%)

From the Formula: $n = \frac{2^2 \times 7 (100 - 7)}{4^2}$

$$n = \frac{4 \times 7 \times 93}{16} = 162.75 \text{ approx } 163$$

n = 163 households as minimum sample size.

However in this study, the minimum sample size was exceeded .The total number of the household interviewed were 226.

For qualitative design, key informants were members of health facilities governing committee. In each facility three key informants were selected which comprised of Chairman of the committee (from the community), Secretary of the committee by the virtue of his / her position (health facility in -charge) and other member of the committee who is not a leader (from the community). These were purposely chosen
The District Medical Officer (DMO), District CHF coordinator and the Chairman of the District health board were also recruited as key informants for the in – depth interview by the virtue of their position. The In-depth interview used to enrich the collected quantitative information.

3.5 Sampling procedures

Since CHF services are offered in government health facilities, then being government owned was inclusion criteria of the facility and non government owned was exclusion criteria. The catchments areas of selected facilities were studded. Data were collected from the community living in these 11 catchments area of the selected health facilities. In these communities head of the house holds were interviewed using structured questionnaires.

To get the households to be interviewed the following procedures were used. Upon reporting to the office of the village executive officer (VEO) in which a particular

selected health facility belongs, a random sampling method was employed to get the households to be interviewed. One after another willing head of the household were interviewed until the required number of respondents obtained.

Key informants were purposefully selected from the health facilities governing committees and the district health management.

(a) Selection of the health facilities

Cluster sampling method was used to obtain the health facilities in which their catchments areas were used for data collection.

Among 34 government health facilities, 11 (32.4%) were randomly selected .The selected health facilities were: Mninga, Igowole, Isalavanu, Sadani, Igomaa, Nyololo, Kwatwanga, Sawala and Kibao dispensaries as well as Malangali and Kasanga health centres. The catchments areas of these 11 health facilities were studied. Data were then collected from the house holds in these catchments areas of each health facility.

(b)Health facilities governing committee members

A purposeful sampling method was used to get these personnel in selected catchments areas of health facilities. In each facility three key informants (thought to be knowledgeable) were selected which comprised of Chairman of the committee (from the community), Secretary of the committee by the virtue of his / her position (health facility in -charge) and other member of the committee who is not a leader (from the community).

The District Medical Officer, District CHF coordinator and the Chairman of the District health board were also selected as key informants for the in – depth interview by the virtue of their position at the district level.

Total of 36 key informants planed to be recruited as key informants for In-depth interview. However only 34 key informants were available for the interview .The two key informants were missed as they were not around in their areas on the day of interview.

3.6 Data collection method and procedure

Structured questionnaires were used to collect the required information from the head of the selected households or their representative's in quantitative part of the study.

In qualitative part of the study in -depth interview guide were employed to collect information from the key informant's in-depth view.

Questionnaires and In-depth interview guide were translated to Kiswahili language (version) for the study unit easy understanding.

Recruitment of the Research assistants

Five research assistants (Interviewer) were recruited to assist principle Investigator in Data collection. Four Interviewers were recruited from the local setting (Mufindi district) and one from Dar es Salaam. The training of assistants was conducted for one

day and emphasis was made on understanding the aim of the research and questions in questionnaires for accuracy in data collection.

Pre - test of the questionnaire

Pre- testing was done before the actual data collection started. Areas in questionnaires and in the in depth interview guide that were not clearly understood were identified and amended. Pre – test was done at Changalawe village in Mufindi district so as to get as close as possible to the real community where actual data collection was planned. The pre–test also gave opportunity to interviewers (Research assistants) to get used to the type of work.

3. 7 Data presentation and analysis

The data collected by questionnaires were given identification numbers, checked for completeness then entered in Computer (Epi 6) for presentation and necessary analysis. Information from the in depth interviews were translated coded and summarized for reporting.

3. 8 Variables

I. Independent variable

These are: Age, sex, education level, economic activity, perceived benefits of CHF, and perceived problems of CHF

II. Dependent variables

These are: Joining the CHF scheme, dropping out of the CHF scheme

3.9 Ethical considerations

Ethical clearance was obtained from Muhimbili University College of Health Sciences (MUCHS) Research committee.

Local authorities (District) were also consulted for permission to conduct the study.

Participants were asked for willingness to participate in the study, information related to the aim of study (academic requirement) and their right to participate or not were clearly explained to them. They were also assured that their responses will be kept confidential.

Voluntary participation

The right of the respondent to participate in the study or not were respected. All respondents voluntarily participated after they were explained about the objectives and the aim of the study.

3.10 Study biases and limitation

Since the study collected information from both members and non members of CHF scheme, some non members of the scheme may feel accused when asked reasons for not joining the scheme .Hence they may just jump to a simple answer of lack of money or any other response they think to make sense instead of expressing their internal feelings which may not be the truth.

CHAPTER FOUR

RESULTS

4.1 Introduction

This study was conducted in Mufindi district of Iringa Region. A total of 226 heads of the household were interviewed. A total of 34 In-depth interviews for key informants were conducted. Among them 22 were males and 12 were females.

4.1.1 Socio- demographic characteristics of the respondents

The study involved a total of 226 respondents of which 120 (53.1%) were males and 106 (46.9%) were females. The mean age of the respondents (head of the households) was 40.2 years with median age of 36 years and the range was between 20 and 80 years.

The majority of the head of the respondents were Christians which consisted of 210 (92.9%) respondents of which 111 (25.9%) were males and 99 (47.1%) were females. The study also interviewed of 15 (6.6%) Muslims of which 9 (60%) were males and 6 (40%) were female .The remaining 1(0.4%) respondent was a pagan who was female.

A total of 185 (81.9%) respondents were married, among them, 110(59.5%) were males and 75 (40.5%) were females. The remaining percentage distributed between cohabiting/not married, separated/divorced and widowed respondents.

A total of 181 (80%) of the respondents has the primary education of which 104 (57.5%) were males and 77 (42.5%) were females. The remaining percentages were distributed between no forma education and secondary education.

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Table 1: Socio- demographic characteristics of heads of the households by sex

Socio - demographic variable	Male		Female		Total	
	No.	%	No.	%	No.	%
Age distribution						
20 - 29	22	41.5	31	58.5	53	23.5
30 - 39	46	55.4	37	44.6	83	36.7
40 - 49	19	52.8	17	47.2	36	15.9
50 - 59	14	70	6	30	20	8.8
60 - 69	12	52.2	11	47.2	23	10.2
70+	7	63.6	4	36.4	11	4.9
TOTAL	120	53.1	106	46.9	226	100
Religion						
Christian	111	52.9	99	47.1	210	92.9
Muslim	9	60.0	6	40.0	15	6.6
Others	0	0	1	100	1	0.4
TOTAL	120	53.1	106	46.9	226	100
Marital status						
Married	110	59.5	75	40.5	185	81.9
Cohabiting /Not married	3	30	7	70	10	4.4
Separated/Divorced	3	50	3	50	6	2.7
Widowed	4	16	21	84	25	11.1
TOTAL	120	53.1	106	46.9	226	100
Education level						
No formal education	8	23.5	26	76.5	34	15.0
Primary education	104	57.5	77	42.5	181	80.0
Secondary education	8	72.7	3	27.3	11	4.9
TOTAL	120	53.1	106	46.9	226	100

Occupation of the head of households, spouses and the main source of income.

Among 226 head of the household about 201 (88.9%) were small scale farmers, the remaining percentages were distributed between those employed, engaged in business/petty traders and other occupations. Among 186 spouse, 160(86%) were small scale framers, the rest were business/petty trader people as well as employed and other economic activities. A total of 179 (79.2%) respondents reported that small scale farming was the main source of household income. Others reported business / petty trading, employment and other economic activities as their main source of income. See Table 2 below.

Table 2: Occupation of the head of the household, their spouse and the main source of income.

Social economic variable	No. of the respondents	%
Occupation of the head of the household		
Small scale farmer	201	88.9
Business /Petty traders	16	7.1
Employed	5	2.2
Others	4	1.8
TOTAL	226	100
Occupation of the spouse		
Small scale farmer	160	86.0
Business /Petty traders	10	504
Employed	11	5.9
Others	5	2.7
TOTAL	186	100
The main source of income		
Small scale farmer	179	79.2
Business /petty trader	21	9.3
Employment	7	3.1
Others	19	8.4
TOTAL	226	100

4.2 Awareness of CHF scheme among the community members.

Out of 226 heads of households interviewed, 223(98.7%) were aware of CHF while 3 (1.3%) were not aware. Out of 223 about 118 (52.9%) were males and 105 (47.1%) females' head of the households (Table 3).There is no significant statistical difference in awareness between males and female respondents (p = 0.55)

Table 3: Awareness of CHF by sex of the head of the household

Sex	Aware		Not aware		Total	
	No.	%	No.	%	No.	%
Male	118	52.9	2	66.7	120	53.1
Female	105	47.1	1	33.3	106	46.9
Total	223	98.7	3	1.3	226	100

*Fisher exact test: p = 0.55

The health facility was identified as the source of CHF information by 159 (71.3%) of the respondents' a total of 145(65%) respondents reported village meeting / leaders as their source of information. Other mentioned were neighbors as well as friends (Table 4)

Table 4: Source of CHF information

Source of information	No.	%	(N=223)
Village meeting /leaders	145	65	
Neighbors	7	3.1	
Friends	3	1.3	
Health facility	159	71.3	

4.3 The proportion of CHF scheme members in the community

Table 5 shows that among 223 respondents, 64 (28.7%) were members of CHF while 159 (71.3%) were not members. Among members 47(73.4%) were small scale farmers, 10(15.6%) were businessmen/ petty traders (Table 5) .There is no significant statistical difference between members and non members with respect to economic activities (p = 0.13)

Table 5: CHF membership according to main income generating activity of the household

Activity	Member		Non member		Total	
	No.	%	No.	%	No.	%
Small scale farmer	47	73.4	130	81.8	177	79.4
Business/petty traders	10	15.6	10	6.3	20	9
Employment	1	1.6	6	3.8	7	3.1
Others	6	9.4	13	8.2	19	8.5
TOTAL	64	28.7	159	71.3	223	100

p value = 0.13

4.4 CHF Drop out

Table 6 shows that among 159 interviewed non members 30 (18.9%) had dropped out of the scheme. Among them 11 (36.7%) were males and 19 (63.3%) were females (Table 6)

Table 6: Drop out status

Previous membership status of non members	Sex					
	Male		Female		Total	
	No.	%	No.	%	No.	%
Member	11	36.7	19	63.3	30	18.9
Non member	71	55	58	45	129	81.1
Total	82	51.6	77	48.4	159	100

P = 0.07

4.5 Perceived benefits of CHF scheme

The reported perceived benefits included assurance of treatment for the whole year for the members; this was mentioned by 168(75.3%) respondents. Reduced cost incurred for the treatments services was mentioned by 107 (48%) of the respondents and availability of drugs by 36 (16.1%) respondents. Other mentioned perceived benefits are rehabilitation of the health facility buildings as well as getting matching grants from the government (Table 7)

Table 7: Perceived benefits of CHF scheme

Benefits	Member N =64		Non member N =159		Total N =223		P- value
	No.	%	No.	%	No.	%	
Assurance of the services	58	90.6	110	69.2	168	75.3	<0.001
Reduce cost incurred for the treatment services	31	48.4	76	47.8	107	48	0.9
Availability of drugs	23	35.9	13	8.2	36	16.1	<0.001
Others	1	1.6	5	3.1	6	2.7	-

*Other mentioned includes: Rehabilitation of the facility buildings, getting matching grants from the government.

4.6 Perceived problems of CHF scheme

The reported perceived problems of the CHF included extra cost incurred by members after paying premium for example buying drugs, this was mentioned by 91(40.8%) respondents. Other respondents mentioned lack of referral system, shortage of drugs, lack of laboratory services, shortage of health workers, long waiting time to get services, to be attended by low skilled personnel as well as non members non members are given better services than members and 97 (43.5%) they did not know any problem (Table 8).

Table 8: Perceived problems of CHF scheme

Problems	Member		Non member		Total	N =223	P- value
	No.	%	No.	%	No.	%	
Extra payment for the members e.g. buying drugs	24	37.5	67	42.1	91	40.8	0.5
Non members get better services than members	-	-	5	3.1	5	2.2	0.18 (Fisher exact)
I don't know	28	43.8	69	43.4	97	43.5	0.96
Others	16	25	28	17.6	44	19.7	-

*In others there are: Lack of referral system, shortage of drugs, lack of laboratory services, shortage of health workers, long waiting time to get services, to be attended by low skilled personnel, no services at night,

4.7 Factor affecting joining the CHF scheme

Factors affecting the joining the CHF scheme were reported to be reduced cost incurred for the health services (139 (66.8%), adequate sensitization and understanding about the CHF (37 (17.8%) and other respondents financial ability, drugs availability in health

facilities, assurance of treatment at any time of the year, frequently falling sick for the family member and good staff attitude (Table 9)

Qualitative interviews reported reasons to join the CHF scheme as assurance of the treatment at any time of the year which means a particular family being assured of treatment for the whole year after paying a premium package (28 out 34 key informants). Other reported reason was reduced cost of treatment is incurred by the members for the health services than nom members who are paying out of pocket for every visit (22 out of 34 key informants).The other mentioned reason was improved accessibility to health services for and this reduces severe cases for CHF members' example: "*the scheme prompts members to attend hospital even with minor health symptoms or problem, thus severe cases are reduced among members, said key informant.*

Table 9: Factors affecting joining the CHF scheme

Factor	**Member N = 64**		**Non member N=144**		**Total N =208**		**P- value**
	No.	%	No.	%	No.	%	
Adequate sensitization and understanding about the scheme	27	42.2	10	6.9	37	17.8	< 0.05
Financial ability	6	9.4	13	9	19	9.1	0.9
Drugs availability in health facilities	6	9.4	4	2.8	10	4.8	<0.05 (Fisher exact)
Reduced cost for the health services	58	90.6	81	56.3	139	66.8	<0.001
Others	2	3.1	10	6.9	12	5.8	-

* 15 respondents did respond to this question.

* Other mentioned includes assurance of treatment at any time of the year, frequently falling sick for member of the family, good health workers attitudes, short distance from the health facility

Table 10 shows that the general overview from the head of the households on the contributing factors in joining the CHF scheme included; Assurance of treatment for the whole year(167(75%)), reduced cost of health services incurred than out of pocket payment (94(42.2%)). Others mentioned were drugs availability, adequate sensitization, frequently falling sick, financial ability and good health workers attitudes and knowledge. A total of 6 (2.7%) they did not know any factor ((Table 10)

Table 10: General over view on contributing factors in joining the CHF scheme

Factors	No.	% (N=223)
Assurance of treatment for the whole year once you have paid	167	75
Drugs availability in h/facilities	19	8.5
Adequate sensitization	26	11.5
Reduced cost for the health services than out of pocket payment	94	42.2
I don't know	6	2.7
Others	20	9

*Others includes: Frequently falling sick for member of the family, good health workers attitudes and knowledge, financial ability.

4.8 Reasons for the majority not joining the CHF scheme

Table 11 shows the main reasons given for the majority not joining the CHF were lack of money 107 (48%) of the respondents, shortage of drugs given 84(37.7%) of the respondents, and inadequate sensitization 51 (22.9%) of the respondents .The some did not know the reasons while 3(1.3%) reported habit of the health workers.

In in-depth interviews, the key informants reported that in ability to pay (lack of money) is one of the main factors for the community not joining the scheme (25 out of 34 key informants). For example this key informant reported that ``*poor economic status, difficult to get money some people real do not have money to join the scheme*". while other key informant said " *in fact majority is poverty which make them not to join, when one gets 5000/= he or she has many needs , even children want this or that in fact some of them fails to join* " Reported key informant.

Other factors mentioned by majority of the key informants were shortage of drugs in health facilities. A key informant said "*it is discouraging when patients go to the hospital they are told no drugs go and buy*", also lack of referral system, inadequate sensitization, and some people staying longer without falling sick.

Other factors mentioned are lack of laboratory services, attendance to the traditional healers, perceived poor quality of services in government facilities, bad language of health workers and in some area availability of private or company facilities that believed to give good quality services.

Table 11: Reasons for not joining the CHF mentioned by head of the households

Reason	Member N = 64		Non member N=159		Total N =223		P- value
	No.	%	No.	%	No.	%	
Bad habit of the health workers	1	1.6	2	1.3	3	1.3	P=0.64 (Fisher exact)
Lack of money	29	45.3	78	49.1	107	48	P=0.6
Shortage of drugs	15	23.4	69	43.4	84	37.7	P<0.01
Inadequate sensitization	21	32.8	30	18.9	51	22.9	0.02
I don't know	10	15.6	18	11.3	28	12.6	0.38

4. 9 Factors contributing to dropping out of CHF scheme

Table 12 shows factors contributing to drop out of the CHF members as mentioned by those who dropped out. Lack of money (inability to pay) was mentioned by 16 (53.3%) of the respondents. 5 (16.7%) mentioned shortage of drugs (Table 12).

Majority of the key informants (19 out of 34) reported that lack of money (inability to pay) as the main factor causing dropping out of the CHF members . Some key

informants reported that staying for the whole year without falling sick for some families contribute to dropping out.

"you may find that one has contributed 5000/= but the whole family has never fallen sick for the whole year then he say aaahhh! next year I will not contribute". (Reported by a key informant, aged 41 years).

Others reasons mentioned were shortage of drugs, shortage of staff, in adequate sensitization and lack of referral system in CHF, as one key informant said "when *we give them referral to the higher health facilities for instance (in case one has a fracture) upon reaching the higher referral centre he or she is told we don't recognize your card you must pay to get service. People has complained about this a lot and even in the village meeting".* (Reported by health facility governing committee member age 32 years).

Lack of laboratory services, perceived poor quality of services, poor infrastructures, and bad language of health workers were also mentioned.

Table 12: Contributing factors in dropping out of the CHF scheme

Factors	**No.**	**%**	**(N=30)**
Lack of money (In ability to pay)	16	53.3	
Shortage of drugs	5	16.7	
Others	9	30	

*Others includes: Not falling sick frequently, lack of referral system

Table 13 shows that lack of money (in ability to pay) was mentioned by 75 (33.6%) of the respondents as the main reasons for the dropping out of the CHF, while shortage of drugs mentioned by 76 (34.1%) of the respondents. Other respondents mentioned in adequate sensitization and understanding of the CHF 30(13.5%). Surprisingly 69 (31%) of the respondents did not know any factor.

Key informants had some advice for the CHF to attract people. These advices include: Improved drug supply in health facilities, to introduce referral system in CHF, to reduce bureaucracy in getting back the CHF contributions for different facility use when need arises, to introduce laboratory services in government health facilities, rehabilitation of the facilities.

Other advises from the key informants were: to introduce allowances to the health facility governing committees so as to improve sensitization, the district health board should increase the visit to the facilities and to supply electricity in facilities with no electricity. One respondent advised community should be forced to join the CHF as what used to be in paying the development levy or what it is now in car insurances.

Table 13: General overview on contributing factors in dropping out of CHF scheme

Factors	No.	% (N= 223)
Lack of money (Inability to pay)	75	33.6
Lack of drugs	76	34.1
In adequate sensitization	30	13.5
I don't know	69	30.9
Others	53	23.8

* Others includes: Not falling sick frequently, lack of referral system, lack of laboratory services, lack of qualified personnel, bad health workers attitudes.

CHAPTER FIVE

5.0 DISCUSSION

5.1 Awareness of the CHF scheme in the community

The results show awareness of 98.7% at the household level in the population .This indicates high level of success in information dissemination on the CHF scheme in the district. Male and female respondents were equally aware of the scheme. Under this high level of awareness, then one would expect a high uptake (high membership rate) of the scheme in Mufindi district.

Despite awareness being high uptake is low and some of the CHF members in Mufindi district are getting out of the scheme. This partly expresses community dissatisfaction with the CHF scheme. This also indicates that awareness alone does not guarantee that the community will join the scheme but, the community need to be satisfied with the health services provided.

The big difference between awareness and membership rate on one hand underlines the need for further finding out the main reasons, with the purpose of improving CHF performance in this district and the country at large. It does not need to rely on the willingness and ability to pay for the community to join the CHF scheme as the only reason; there are other factors which as well may determine such decision of paying for health care (health insurance scheme). Willingness to pay is a function of the value judgment, including cultural factors, perceived seriousness of the illness , perceived benefits of the insurance scheme as well as risk pooling (risk sharing) consciousness.

Even the most destitute people are willing to pay for the treatment of illness if only they can find the necessary means even if they have to sell their property (Stierle et al, 1999). Weakness in supply side as well may influence community not to join a particular health insurance scheme. This may continue to deny poor people health care services. In this study this weakness expressed by many of the perceived problems of the scheme such as shortage of drugs in health facilities which results in to members to incur extra cost for buying them. Other mentioned problems were shortage of health workers, long waiting time for the services, to be attended by unskilled health personnel as well as to provide better services to non members other than CHF members. This type of weakness was reported in other study which said: many poor people lack access to effective and affordable drugs and to surgery and other interventions largely because of weakness in financing and delivering health care (Preker et al, 2002).

High level of awareness of CHF scheme found in this study differs with that found in study done in Igunga. In the later study awareness was 55.6% (Ongwae, 2000). The difference in awareness between the two studies can be explained by the fact that community sensitization on CHF scheme in Mufindi district which was done through health facilities and village leaders has proved to be effective in CHF information dissemination. This showed by the responses from the study participants who identified health facilities and village leaders / meeting as their main source of CHF scheme information. In this study health facilities identified by 71.3% and village meeting by 65% of the respondents as their main source of CHF information while in Study done in

Igunga health facilities and village meeting were identified by 26.1% and 23.4% of the respondents respectively (Ongwae, 2000)

Health facilities and village meeting to be identified as the two main sources of CHF information in Mufindi district indicates good cooperation between health workers and village leaders in this matter. The good performance of these two agencies of CHF information dissemination was expected, since under rural environment theses two means (health facilities and village meetings) are the main ways expected to perform well in information dissemination .Mass media like Television and News paper are not much used by rural community due either to low income which hinders majority from buying news papers, distance which reduces daily accessibility from the news papers agents and lack of electricity for some places thus cannot use television.

Although majority of the rural communities depends on radio to access different types of information, for this particular purpose and type of information it has not proved to be effective not only in Mufindi but even in other areas. The other study which had similar results of information sources was done in Igunga. It reported that radio accounted for 0.3% of the information source (Ongwae, 2000). The strategy to disseminate CHF information through health facilities and village meeting has been very successful in Mufindi district.

5.2 Proportion of CHF membership in the community

At the household level the proportion of the CHF scheme membership in the community was found to be 28.7%. The majority of the CHF members were in small scale farming as their main income generating activity which comprised of 73.4% of the members.

This 28.7% of CHF members at the household level in Mufindi community is higher compared to the 7% initially recorded (DMO, 2006). This can be explained by the fact that, the district estimate of the membership rate is based on the membership recruitment data which may have change in between.

Although CHF membership rate was found to be 28.7%, but this is still low compared to 60% to 65% which was expected in the original design of CHF scheme in Tanzania (Kapinga and Kiwara, 1999; Baraldes, 2003; MOH, 2005).

The low uptake of CHF membership also was found in other studies which recorded that: to date enrollment per district ranges from 3 – 28 percent of total households where CHF is implemented (Baraldes, 2003). So still there is a need to find out the reasons for that low uptake and possible remedy if CHF is to perform successfully in the future for the benefits of the health of the rural poor community in Mufindi district, and the country at large.

The other low uptakes were also found in Hanang district, Tanzania where it was stated that membership ranged from 2.4 to 22.8 % (Chee, 2002). Low percentage of enrolment were also observed in a study of five Community Based Health Insurance Scheme in east and southern Africa, in four schemes the enrollment percentage varies between 0.3 to 6.5 % of the target population (Musau, 1999) and other study showed that: from available information on beneficiaries and target population one Community Based Insurance in Benin reached enrolment rate of 24 % in 1998 where as another achieved an enrolment rate of 8 % (Carrin et al, 2005).

These low enrollments which were recorded by different studies in different countries shows the need for further finding out the main reasons of poor performance of these community health insurance schemes. Among the reasons given in this study for the poor performance of the scheme was vertical approach used in introducing it to the community. There was poor community involvement in designing the scheme, as the result the community regards the scheme as the means of collecting money to run the health services. They compare this CHF scheme with other money collected by the government from different types of levy.

This shows lack of conceptual clarity on what is meant by health insurance and risk pooling in general. Thus indicates the need for the community education on importance of this community health Insurance scheme.

5.3: Perceived benefits of CHF scheme

Respondents in Mufindi district identified assurance of treatment for the whole year, reduced cost of treatment incurred with CHF scheme, availability of drugs in health facilities, rehabilitation of health facilities as well as getting matching grants from the government as the perceived benefits of the CHF scheme. Assurance of treatment and availability of drugs were mentioned more by CHF members than non CHF members. These perceived benefits may act as incentives to attract people to join the scheme.

The above mentioned CHF benefits were also mentioned in Community Health Funds (CHF) design given by the Ministry of Health (MoH) of the United Republic of Tanzania. The document spells out that CHF members will be entitled to curative and preventive services (MOH, 2005) .The nature of the benefits that are likely to be made available to CHF members include Reproductive Health and Child Care, control of communicable diseases, non communicable diseases and trauma, as well as Clinical Support Services (MOH 1999) .Because they are mentioned in the CHF design, they were expected to be provided to members. The reduction of the cost incurred for the treatment services as a benefit to joining the CHF scheme has been reported by other studies like the following : reduced cost of treatment was expected to improving accessibility to equitable , quality and cost effective health services to the rural community (Munishi, 2000; Kiwara and Kapinga, 2000; Shaw, 2002).

The aim of CHF scheme was to attract large numbers of people to the scheme and do away with out – of –pocket payment which is thought to be not affordable to the low income rural community, and thus may deny them with health care services. The other benefits like drugs availability and health facility rehabilitation were mentioned by few people although it is one of the major expectations of the CHF scheme by the community.

Although matching grant has been one of the benefits mentioned here its availability has been a problem. This is because it was mentioned by key informant that Mufindi CHF scheme has received matching grant from the government only once since the scheme started to operate in Mufindi district in 2004

Denying the matching grants to the districts may be taken as one of the national level contributing factors in poor performance of the CHF scheme at district level. This is due to the fact that , when the district collects a certain amount of money for CHF scheme, the government is supposed to top up the district collection with the same amount of money (MOH, 1999), which is called 'matching grant'. Now when this is not done, the community efforts to improve the scheme performance are minimized.

5.4: Factors contributing to joining the CHF scheme

The main factors which contribute to joining the CHF scheme included: adequate sensitization, financial ability, drugs availability in health facilities as well as reduced cost of health services.

These identified factors are said to attract the community to join the CHF scheme and are reflecting the perceived benefits of the CHF scheme. Reduced cost of services, drugs availability and adequate sensitization mentioned more by CHF members than non members. The benefits are the means to attract people to join a particular scheme. However, there are other additional factors which are mentioned here that contribute joining the compared to previous mentioned benefits of CHF scheme, these includes adequate sensitization and understanding about CHF scheme, frequent falling sick for the family members, financial ability and good health care facility staff attitudes and knowledge.

For a particular individual or community to decide to join in particular health Insurance scheme a number of factors are considered. Acceptability or perceived benefits of the particular insurance scheme as well mater quite a lot. However, it has also been argued / found, that price is not only the factor related to willingness to join the CHF scheme but complex human behavior, choice and motivation can also determine it (Baraldes, 2003). Also it has been indicated that in voluntary health insurance it is important to minimize the preferential selection of high risk individuals, a phenomenon the insurance industry calls adverse selection, because this may be one of the causes of insurance scheme to fail to meet its objective. Adverse selection occurs when those who anticipate needing health care choose to buy health Insurance more often than others (Criel and Kegel, 1997).

For individual to decide to join the scheme several factors are contributing, it can not be only one, but a combination of them. Also individuals may decide to join the scheme not because of the above mentioned reasons (reduced cost, adequate sensitization, drugs availability) but he or she consider his or her family need health more often. Therefore the knowledge of Insurance or risk pooling has not been properly internalized by this individual.

In Mufindi it seems the CHF scheme has not been successful in attracting the majority of the community as it was expected by the original design. This is expressed by the fact that, since 2004 when the scheme started in Mufindi district, it has only attracted 28.7% of the eligible community although awareness is 98.7%. This is contrary to Bwamanda hospital Insurance scheme in Zaire (Now Democratic Republic of Congo) which managed to attract 28% of the eligible population within four weeks when the scheme started and membership rate increased to between 60 % - 65 % within a year (Criel and Kegel, 1997).

The Rwanda case above shows high degree of social acceptability which need to be learned by the Mufindi CHF scheme and the country at large where acceptability seems to be a problem. Reduced cost of treatment although influence individuals to join the scheme but cannot be enough incentive to attract the whole community to join the scheme .There are other factors as well like knowledge of risk pooling and social acceptability need to be considered.

5.5: Perceived problems of the CHF scheme

The main identified problem of the CHF scheme extra cost incurred apart from the premium. The other mentioned were lack of referral system, shortage of drugs, lack of laboratory services , shortage of health workers, long waiting time for the services, unskilled health personnel as well as non members are getting better services than members.

These perceived problems show the need for the immediate improvement of supply side of the CHF scheme if the better performance is to be attained. These problems were anticipated even in the original design of the scheme (MOH, 1999). Clearly defined efforts should have been done so that these problems could have not existed when the CHF affected its operations. Unfortunately these are the major problems of the scheme today. They are anticipated being the main causes of the poor performance of the CHF scheme. For example, the design suggested the following: membership cards would be purchased at any time when people are most able and willing to pay, thus providing security of access to a dispensary or health centre and first referral hospital throughout the year (MOH, 1999). Contrary to this there is no referral mechanism at all in the currently operating CHF in Mufindi diatrict.

Also it was narrated further that to capture the benefits of the CHF scheme, the supplier of the services must be able to respond in an efficient and cost effective manner, the gap in performance and quality of services, lack of essential supply particularly drugs and

renovation of the facilities must be taken care of (MOH, 1997). In actual fact shortage of drugs is one of the major perceived problems of the CHF scheme which necessitate patients to incur extra cost of buying drugs.

Poor performance or low uptake will continue to exist in CHF scheme until these perceived problems are taken care of. These are purely supply side problems and the needs to rectify them are there so that CHF scheme can perform as expected

5.6: Contributing factors in not joining and / or dropping out of the CHF scheme

Lack of money (inability to pay), shortage of drugs, inadequate sensitization were the main reasons given for not joining the CHF scheme. In adequate sensitization and shortage of drugs were given more by non- CHF members than members.These reasons reflect perceived problems of the CHF scheme which seem to be the main cause of low uptake of the scheme by the community.

For the community to decide to join in the health insurance scheme like CHF, they need to be attracted by the benefits package, management, quality and sustainability of services which seem to be lacking in the current Mufindi CHF scheme and many of the rollout districts in the country faced with poor performance (Chee, 2002

According to previous members of the CHF (now non members) the main reasons for dropping out of the scheme was identified to be lack of money (inability to pay),

shortage of drugs, lack of referral system and not frequently falling sick for the family member.

The above mentioned reasons with exception of lack of money, inadequate sensitization and not frequently falling sick for the family members actually conform to perceived problems of the CHF scheme. What can be said is that; lack of money (inability to pay) seems to be taken as excuse for not joining and dropping out of the scheme and hides other reasons which may be important but not easily mentioned or some community members are afraid to expose them.

The results show that, the scheme suffers low social acceptability. Thus many have been looking for reasons for not joining and dropping out of the CHF scheme from demand side (community) where as problems as well may be caused by supply side. In the original design CHF scheme, it was expected that much of the so called poor quality of services would be rectified, like reducing gap of poor performance of publicly owned health facilities by improving the quality of services, improving essential supplies particularly drugs ,training and have qualified health personnel (MOH, 1997). But these have not been done.

The perceived poor quality of health services have been recorded in other studies like one done in Mufindi and outlined as one of the factors contributing in low uptake and dropping out of CHF scheme (Chee, 2002).

Inadequate sensitization to be mentioned as the reason for the dropping out of the scheme may be explained as that, some community members have not understood the conceptual clarity of risk pooling idea in Insurance scheme. The want to see or make sure that, they spend what they have contributed. Failure to that they decide to drop out of the scheme or they ask for a refund of their contribution.

This type of findings were also expressed in Bwamanda health insurance scheme where some community members raised a question concerning the possible situation of families who joined the scheme but did not under go any hospitalization , would they get a refund? (Criel and Kegel, 1997). This explain the similar reduced risk pooling / sharing concept by some community members who decide not to join the scheme or dropping out of the scheme simply because they are not frequently falling sick. In this case to impart the idea of risk pooling to the community is important.

The response of inadequate sensitization here is contradicting because it was earlier mentioned that one of the reasons contributing to joining the scheme was adequate sensitization and understanding about the scheme

Lack of referral system, lack of laboratory, shortage of drugs, unskilled health personnel have been much mentioned as the cause of low performance in the CHF performance.

So there is a need to work on for the betterment of the CHF scheme in Mufindi district and the country at large.

A bureaucratic procedure to get back the requested money from the CHF contributions for different health facility expenditure was also mentioned as the cause of poor performance of the CHF scheme. CHF members said to be disappointed with this bureaucracy and some decide to drop out of he scheme.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 Conclusion

The level of awareness on CHF scheme in Mufindi district is high. This is an indication of cooperation between health workers and village leaders on health matters. However, the uptake of CHF scheme among community members is low, despite the fact that, the CHF scheme is mainly targeted to rural communities. Therefore, there is a need of work to be done to fill the gap of the discrepancy between awareness and membership rate.

Since the main identified sources of CHF information were health facilities and village meetings, then these types of information dissemination shows to be working properly in rural setting?

Joining the CHF scheme was perceived to be beneficial by the substantial number of the respondents. Among the identified benefits were assurance of treatment at any time of the year, reduced cost of treatment incurred for the health services, drugs availability in health facilities, rehabilitation of the health facilities buildings and the promise of getting matching grants from the government. But these benefits have not been strong enough, to attract majority to join the CHF scheme that is why membership rate is still low.

There perceived problems of CHF scheme were extra cost incurred by members apart from paying premium package, lack of referral system, shortage of drugs, lack of laboratory services, and shortage of health workers, unskilled health personnel, and long waiting time for the services as well lack of financial ability.

CHF scheme is unlikely to succeed if these problems are not taken care of. Therefore there is a need to address these problems for the CHF scheme to be successful in this district and the country at large.

6.2 Recommendations

- Despite the high level of awareness on CHF scheme, the district council should further educate the community on the conceptual clarity of the risk pooling, so as to increase their understanding on risk sharing pooling which can help to attract majority of the community.

- The district council should improve the quality of services by ensuring availability of necessary drugs, equipments and medical supplies throughout the year. This can help to attract majority of the community in the scheme.

- The district council should consider provision of incentives to the ward Health committee members and health workers who are doing community sensitization and services provision to the CHF scheme members. This can encourages them to improve sensitization and provision of better services.

- The Ministry of Health and Social Welfare should ensure that matching grants are timely released upon district request. This can encourage the districts and the rural community in general to increase their efforts on CHF contribution.

- The district council should ensure that the CHF members access health services when referred to a higher level of health care.

For further research

It is recommended to do research on possibility of having different packages according to ability to pay in CHF scheme so as to reduce complaints from the community.

Also research is needed in the level of Community involvement in CHF scheme, especially in decision making in relation to the CHF performance.

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