CONTRIBUTION OF SELF-HELP GROUPS TO ENROLLMENT IN IMPROVED COMMUNITY HEALTH FUND IN TANZANIA: *A CASE OF DODOMA CITY COUNCIL*

Lazaro Ernest, BASO

Master of Public Health Dissertation

Muhimbili University of Health and Allied Sciences

October, 2024

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

School of Public Health and Social Sciences

CONTRIBUTION OF SELF-HELP GROUPS TO ENROLLMENT IN IMPROVED COMMUNITY HEALTH FUND IN TANZANIA: *A CASE OF DODOMA CITY COUNCIL*

By

Lazaro Ernest

A Dissertation Submitted in Fulfillment of the Requirements for the Degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences

October 2024

CERTIFICATION

The undersigned certifies that they have read and now recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation titled: **Contribution of Self-Help Groups to Enrolment in Improved Community Health Fund in Tanzania: A Case of Dodoma City Council** in (partial) fulfillment of the requirements for the degree of Master of Public Health at Muhimbili University of Health and Allied Sciences.

_____

Dr. Amani Anaeli

(Supervisor)

_____

Date

_____

Dr. Malale Tungu

(Co-Supervisor)

_____

Date

DECLARATION AND COPYRIGHT

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

Signature…….. Date……

This dissertation is copyright material protected under the Berne Convention, the Copyright Act 1999, and other international and national enactments, on that behalf, of intellectual property. It may not be reproduced by any means, in full or part, except for short extracts in fair dealings, for research or private study, critical scholarly review, or discourse with an acknowledgment, without the written permission of the Directorate of Postgraduate Studies, on behalf of both the author and the Muhimbili University of Health and Allied Sciences.

ACKNOWLEDGEMENT

I have learned and come to understand that earning a master's degree requires teamwork and is made more possible by the love, support, and encouragement of several families, friends, and coworkers. I will always be appreciative of all these individuals in my life.

The following people need to be mentioned.

I would want to express my profound gratitude to the Almighty God, who has always been the source of my joy, hope, and strength through all of life's challenges. The credit and glory belong to him.

Thanks to the general advice and support from my supervisors, **Dr. Amani Anaeli** and **Dr. Malale Tungu,** I finished my degree almost on schedule, and your criticism of my drafts significantly enhanced the final product. I am grateful to you for providing me with general direction, knowledge, and guidance to ensure that my research questions were manageable and that the right data were collected and managed.

My wife, Caroline L. Nnko, and my daughters, Joan L. Tilito and Josephine L. Tilito, have been amazing sources of support and encouragement from the moment I learned about this program until the completion of my dissertation. You are truly amazing people, and I am grateful for your love and support. I appreciate you doing that for me, as well as all the extra work, chores, and alone time you committed to making our dream a reality. Last but not least, to my fellow MPH candidates, who helped me through words of encouragement, counsel, ideas, technical support, sharing of knowledge and experiences, research abilities, and reviewing drafts, among other things. To all of you, who made this work a reality in one way or another, I thank you very much. All your contributions will remain precious to me.

DEDICATION

To GOD, who is the source of happiness in all seasons and at all times. Thank you to my cherished parents, Ernest Zakaria and Eliikunda Mafie, who inspire me to embrace the present with happiness and look forward to the future with optimism. To my wonderful wife, Caroline Nnko, and our two gorgeous girls, Josephine and Joan Lazaro Tilito, who supported and loved me the whole way through this course. To my supportive and loving siblings Loveness, Irene, and Joyce Ernest, who have been a blessing to my family during the course, as well as my friendly classmates Suzana Daniel and Jacques Kahiura, my line manager Mwajuma Rwebangila, and my brothers Timothy and Agape Ernest.

ABSTRACT

Background: To encourage members to join in Tanzania's improved Community Health Fund (iCHF), the government and stakeholders have launched several programs. Among these measures are paying direct annual fees to destitute households and enrolling members in the iCHF. Individuals are encouraged to join Self-Help Groups (SHGs) to guarantee they can repay at the end of the year after being supported by yearly fee payments and registration in the program.

Objectives: This study aimed to explore the contribution of Self-help groups on household enrolment in the iCHF in Dodoma City Council, Dodoma Tanzania.

Materials and Methods: A qualitative case study design was employed during the study in Dodoma City Council. The population included supported individuals with annual iCHF subscriptions in the SHGs with multistage and purposive sampling techniques. Data were collected from November 2023 to January 2024 engaging 25 participants selected purposively from a list of the supported individuals shared by enrollment officer. During this study, 14 SHG members benefited from iCHF annual fee payment support were recruited for the two FGDs and 11 SHG members benefited from iCHF annual fee payment support enrolled for IDI during the data collection process. Colletcted data were subjected to thematic analysis using a deductive approach to analyze the collected information involving identifying, analyzing, and reporting patterns (themes) across the collected data through Nvivo 12 software.

Results: The study findings show that linking individuals in the SHGs has a high influence on individual enrollment in the iCHF scheme because it provides the opportunity to raise household income and motivate members to prioritize payment for the iCHF. Moreover, participants revealed that the SHG provides opportunities to take loans and pay for health services at the time of financial crisis paying the iCHF scheme. Most of the participants mentioned the SHG sharing out process period as most sustainable way of ensuring

individuals are enrolled in the iCHF because they have assurance to have enough money to plan and pay for the iCHF. Further, the participants perceived the iCHF as the most supportive and affordable way of assuring access to health services to its members compared to the use of out-of-pocket payment.

Conclusion: Based on the study findings above, ensuring individuals are enrolled in the iCHF, the use of the SHG is the right platform which enable individual enrollment in the iCHF scheme. The emphasis should be made during sharing out process where members whocul be encouraged to pay iCHF fee during this time. This is due to the revealed findings that taking loan from the SHG for the annial iCHF fee payment is a short term sustaining compared to the sharing out process. Moreover, there is positive perception from the members on the use of the iCHF since it provides assurance on access to health services with affordable cost.

Recommendation: Sharing out process is a sustainable way of enhancing capacity to pay for iCHF hence iCHF Enrollment Officers and stakeholders supporting those in need should use the SHGs as an entry point to sensitize individual enrollment in the iCHF. Moreover, iCHF requires further improvement hence the iCHF coordinators should engage the community in the improvement of the Community-Based Fund package to increase the ownership and commitment of the community in the utilization of the services. Also, during seeking health services most of the members fail to access services due to limitation of services in the scheme. The Enrollment officers should create awareness to the newly registered members on the services covered by the scheme and services not covered. The policy makers should introduce tiered premium systems based on income levels, where wealthier members contribute more while ensuring subsidies for the most vulnerable.

TABLE OF CONTENTS

CERTIFICATION i
DECLARATION AND COPYRIGHT ii
ACKNOWLEDGEMENT iii
DEDICATION iv
ABSTRACT v
LIST OF TABLES xi
ABBREVIATIONS xii
DEFINITIONS xiii
CHAPTER ONE 1
1.0 INTRODUCTION 1
1.1 Background 1
1.2 Statement of the problem 2
1.3 Conceptual framework 3
1.4 Rationale 4
1.5 Research questions 5
1.5.1 Main research question 5
1.5.2 Specific questions 5
1.6 Objective 5
1.6.1 Overall objective 5
1.6.2 Specific objective 5
CHAPTER TWO 6
2.0 LITERATURE REVIEW 6
2.1 The concept of health financing 6
2.2 Understanding the term community SHGs 7
2.3 The concept of the improved community health fund 8
2.4 Influence of referring individuals in self-help groups on their enrollment in iCHF 9
2.5 Influence of individual access to loan on enrollment into iCHF scheme 9

2.6 The contribution of shgs' sharing-out process on individuals' enrollment in an iCHF....11
2.7 The perceptions of the individuals supported the iCHF scheme....12
CHAPTER THREE....15
3.0 MATERIALS AND METHODS....15
3.1 Study design....15
3.2 Study population....15
3.3 Study area....15
3.4 Sample size and selection....16
3.5 Data collection methods....16
3.5.1 Data collection tools....16
3.5.2 Data collection procedures....17
3.6 Data management....17
3.7 Data analysis....18
3.8 Ethical Consideration....19
3.9 Trustworthiness....20
3.9.1 Credibility....20
3.9.2 Transferability....20
3.9.3 Dependability....21
3.9.4 Conformability....21
3.10 A Potential limitation of the study....21
CHAPTER FOUR:....22
4.0 RESULTS....22
4.1 Introduction and organisation of the chapter....22
4.2 The Influence of SHGs on enrolment in iCHF....23
4.2.1 A platform for raising household income and motivation to members on prioritization....23
4.2.2 Supportive experience sharing and learning environment....25
4.3 The influence of individual access to loans on enrolment in an iCHF....26

4.3.1 Alternative solutions at times of financial challenges. 27
4.3.2 Short period in loan repayment. 28
4.4 The contribution of SHGs sharing-out process on individual enrolment in an iCHF 29
4.4.1 Influences from the peer group members and leadership 29
4.4.2 SHG as a sustainable way of continued annual fee payment. 30
4.5 The perceptions of the supported individuals on the iCHF 30
4.5.1 Assured access to health services with limitations 31
4.5.2 Affordable and wilder application of the scheme. 31
CHAPTER FIVE 33
5.0 DISCUSSION 33
5.1 Overview 33
5.2 The influence of self-help groups on enrolment in an iCHF 33
5.2.1 Platform for raising household income and motivatation to members in prioritization. 33
5.2.2 Supportive experience sharing and learning environment. 35
5.3 The influence of individual access to loans on enrolment in an iCHF. 36
5.3.1 Alternative solutions at times of financial challenges. 37
5.4 The contribution of SHGs sharing-out process on individual enrolment in iCHF. 38
5.4.1 Influences from the peer group members and leadership. 38
5.4.2 Sustainable way of continued annual fee payment. 40
5.5 The perceptions of the supported individuals on the iCHF scheme. 41
5.5.1 Assured access to health services with limitations 42
5.5.2 Affordable with wider application of the scheme. 43
CHAPTER SIX: 46
6.0 CONCLUSIONS AND RECOMMENDATIONS 46
6.1 Conclusion 46
6.1. Recommendation 46
6.1.1 Recommendation of the study 46
6.1.2 Recommendation for future research 47

References....48
APPENDICES....59
Appendix A: INFORMED CONSENT (ENGLISH VERSION)....59
Appendix B; FOMU YA RIDHAA YA KUSHIRIKI KATIKA UTAFITI (KISWAHILI)....61
Appendix C: IN-DEPTH INTERVIEW GUIDE FOR ICHF SUPPORTED SHG MEMBERS (ENGLISH VERSION)....64
Appendix E: IN-DEPTH INTERVIEW GUIDE FOR SHG LEADERS (ENGLISH VERSION)....72
KIAMBATISHO F: MWONGOZO WA MAJADILIANO VIONGOZI WA VIKUNDI VYA KUSAIDIANA (KWA KISWAHILI)....75
Appendix G: IN-DEPTH INTERVIEW GUIDE FOR ENROLLEMENT OFFICERS (ENGLISH VERSION)....79
KIAMBATISHO H: MWONGOZO WA MAJADILIANO VIONGOZI WA VIKUNDI VYA KUSAIDIANA (KWA KISWAHILI)....80
Appendix I: FOCUSED GROUP DISCUSSIONS (FGDs) GUIDE (ENGLISH VERSION)....82
Appendix J: MWONGOZO WA MAJADILIANO KWENYE MAKUNDI LENGWA (KWA KISWAHILI)....84
Appendix K: ETHICAL CLEARANCE LETTERS....86

LIST OF TABLES

Table 1: Data analysis process table 19
Table 2: Themes description 22

ABBREVIATIONS

CBHI	Community-Based Health Insurance
CBHIS	Community-Based Health Insurance Scheme
CHF	Community Health Fund
FGD	Focus Group Discussion
ICHF	Improved Community Health Fund
IDI	In-depth Interview
LMICS	Low Middle-Income Countries
MUHAS	Muhimbili University of Health and Allied Science
MWH	Maternity Waiting Homes
NCDs	Non-Communicable Diseases
NHIF	National Health Insurance Fund
OOP	Out of Pocket
SDG	Strategic Development Goals
SHG	Self-Help Group
SLA	Saving and Landing Association
SSA	Sub-Sahara Africa
THE	Total Health Expenditure
UHC	Universal Health Care
VB	Village Banking
WHO	World Health Organization

DEFINITIONS

Self-Help Groups: are informal groups of people who come together to address their common problems. It implies a focus on the individual, one important characteristic of self-help groups is the idea of mutual support – people helping each other (1,2).

Health financing: is a core function of health systems that can enable progress toward universal health coverage by improving effective service coverage and financial protection.

Risk Insurance Pooling: is a group of individuals whose medical costs are combined to calculate premiums (3,4).

Financing Mechanisms: refers to how a business, organization, or program receives the funding necessary for it to remain operational (3).

Total Health Expenditure: this is the sum of public and private health expenditure, covering the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include the provision of water and sanitation (5).

Community-Based Health Insurance; is voluntary, non-profit health insurance, normally organized at the community level, mainly targeting those working in the informal sector.

Community Health Fund: is a type of CBHI scheme that is being implemented in Tanzania. CHF is a voluntary health insurance scheme mainly targeting informal and rural populations, and it was first piloted in Tanzania in 1996 (6–8).

Out-of-pocket is an expense or cost paid for directly rather than being put on account or charged to some other person or organization (9).

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Sustainable Development Goal (SDG) 3.8 advocates for universal health coverage (UHC), which ensures that everyone has access to high-quality healthcare they need without having to forgo financial resources (10). The most widely used strategy for attaining universal health coverage in the majority of emerging nations (2) is the implementation of community-based health insurance schemes. Healthcare service consumption has remained incredibly low despite major efforts to make it more user-friendly due to financial challenges faced by households and a lack of sustainable healthcare finance systems in underdeveloped nations (11–14). It is anticipated that financial constraints will prevent more than 1.3 billion individuals globally from accessing healthcare services (15). These people reside in low- and middle-income countries. Almost 3 billion people worldwide pay cash for their medical care (5). The best way to address the issue of high costs associated with service access is to develop and make efficient use of health insurance.

Based on estimates, about 95% of people in Sub-Saharan Africa (SSA) are believed to be uninsured (4,16). Few households in Low-Middle-Income Countries (LMICs) are registered in health schemes, even though OOP health expenses make up over 40% of Total Health Expenditure (THE) in these countries. To avoid catastrophic health costs, the World Health Organization (WHO) recommends that the overall out-of-pocket expenses (OOP) should not surpass 15% to 20% of the total national health expenditures (17,18). Increased enrollment in CBHI is essential to fortifying the community's assurance of access to healthcare.

Choosing internal resources as first resources to finance group lending is the aim of the Savings and Loan Association (SLA) and Village Banking (VB) models combined in SHG financing (19). The provision of insurance through women's Self-Help Groups appears to allay concerns over the inclusiveness and sustainability of CBHI schemes, and this creates additional opportunities for program expansion (20). Access to self-help groups was

associated with higher rates of MWH usage and hospital delivery when MWHs were made available (21).

To ensure that everyone has access to high-quality primary healthcare, Tanzania established the Community Health Fund in 1996 (22,23). The iCHF program, which is still a voluntary health insurance program that largely benefits the unemployed and rural people, is not utilized by all Tanzanians, despite these efforts. Due to the restricted number of households participating in iCHF, the load on the household while dealing with health-related challenges increases. Healthcare costs are covered entirely by savings for families in lower-middle-income countries.

Accessing quality healthcare services is impeded for the majority of Tanzanians by distance to the healthcare facility, with out-of-pocket service purchases being the next biggest obstacle (23). In Tanzania, just 25% of the population is enrolled in the iCHF. The main causes of this low participation are often attributed to low income levels in the majority of households, subpar healthcare facilities, and low iCHF awareness (11). Despite low household enrolment, a number of interventions assist low-income and marginalized households in enrolling in Tanzania's iCHF program. Households are urged to join Self-Help Groups (SHGs) in order to renew their cards at the end of the year, with a one-year subscription cost covered as part of the support. Over 1.2 million self-help groups (SHGs) with memberships ranging from 10 to 30 people may be found in Tanzania (17,24). Most Self-Help Groups (SHGs) function as a platform for imparting knowledge to the community on various life skills, such as maintaining excellent health, fostering sustainable economic growth, and practicing successful parenting (25). The study's goal is to ascertain whether involvement in SHGs raises the likelihood that someone will sign up for or re-enroll in the iCHF program.

1.2 Statement of the problem

SDG 3.8 identifies universal access to high-quality healthcare as a critical requirement. The ICHF is a workable solution for enhancing social-economic stability for low-income households. Merely 25% of Tanzanian households participate in the iCHF initiative (13). Many initiatives have been implemented to assist low-income and marginalized households

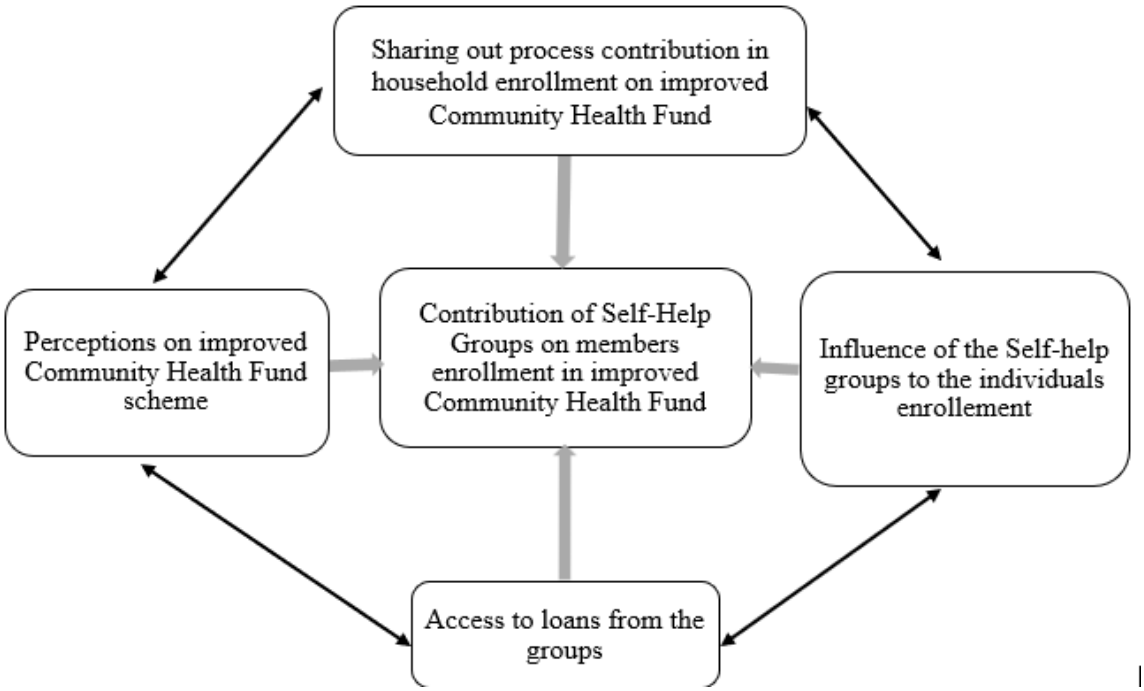
in Tanzania in enrolling in the iCHF program, guaranteeing them access to health care. One of these initiatives is the yearly assistance provided by several programs to around 201,000 Tanzanian families for the payment of the iCHF cost (26). These households are advised to become members of Self-Help Groups (SHGs) after enrolling in the scheme to ensure that they can renew their cards at the end of the year. If these households or individuals have ever been able to pay their iCHF annual fee, there has been no follow-up.

Numerous research studies have been carried out to investigate the impact of Self-Help Groups (SHGs) on health care accessibility and timely health service seeking habits among group members. Providing services via women's organizations seems to allay worries about the programs' viability and inclusivity while increasing the opportunity for program expansion (27). SHGs palys vital role in creating awareness and sensitization, access to them is linked to increased utilization of Maternity Waiting Homes (MWHs) and health facility delivery when MWHs were accessible (25). There are several SHGs formed to improve the household economy and awareness creation. The supported households on iCHF enrollment have been joining these SHGs intending to sustain their enrollment in the iCHF scheme. However, little is known about the contribution of SHGs in supporting individuals' enrollment and re-enrollment in the iCHF scheme in Tanzania. This study intends to explore the contribution of Self-help groups (SHG) in sustaining supported households on iCHF in Dodoma, Tanzania.

1.3 Conceptual framework

Providing sponsorship for the iCHF payment is one of several activities aimed at increasing the number of households enrolled in the iCHF scheme. The iCHF scheme participants are encouraged to become members of SHGs to maintain their enrolment in the program (26). The conceptual framework demonstrates the connection between participating in the iCHF scheme and belonging to a Self-Help Group (SHG). It does this by examining the impact of loans on enrollment, outlining the steps involved in influencing an individual's enrollment into iCHF, examining the relationship between belonging to a group and iCHF, and examining how supported individuals perceive iCHF.

Contribution of SHGs on individual enrollment in iCHF



1.4 Rationale

Tanzania Health Sector Strategic Plan V (2021–2026) prioritizes ensuring that no one is left behind by providing discounted iCHF membership depending on socioeconomic status, hence enhancing access to health services for the impoverished and disadvantaged. The implementation of various processes and efforts aimed at attracting and increasing household participation in health insurance schemes is vital as these schemes play a crucial role in improving and guaranteeing timely access to health care. Only 25% of Tanzanians are covered by the country's current health insurance program due to poor enrollment. The goal of the study is to determine whether household participation in community SHGs raises the possibility that a household will enroll in or re-enroll in the Improved Community Health Fund program. Understanding the role that SHGs play in iCHF enrolment will help to ensure that the program is sustainable and that access to iCHF is inclusive. In their interactions with governments and other influential actors, SHGs influence the developing field of social

health protection. They also can mobilize and bring about revolutionary change. Thus, self-help organizations offer a platform for community mobilization and advocacy for the social protection of social and health issues.

1.5 Research questions

1.5.1 Main research question

What is the role of Self-help groups which contribute to enrolment in the improved Community Health Fund in Dodoma?

1.5.2 Specific questions

1. How does refering individuals to the Self-help Groups influence their enrollment in the iCHF?
2. How does individual access to loans influence enrollment in the iCHF scheme?
3. How does the sharing out process in self-help groups contribute to individuals' enrollment in an iCHF scheme?
4. What are the perceptions of the supported individuals on the iCHF scheme?

1.6 Objective

1.6.1 Overall objective

To explore the way Self-help groups, contribute to the individual enrolment in improved Community Health Fund in Dodoma, Tanzania.

1.6.2 Specific objective

i. To explore the influence of refering individuals to the Self Help Groups on enrollment in iCHF.
ii. To explore the influence of individual access to loans on enrollment in an iCHF scheme.
iii. To explore the contribution of self-help groups' sharing-out process on individual enrollment in iCHF.
iv. To assess the perceptions of the supported individuals on the iCHF scheme.

CHAPTER TWO

2.0 LITERATURE REVIEW

Examining research findings from studies that are closely related to the one being reported is the process of doing a literature review (28). It provides a framework for evaluating the study's importance and serves as a benchmark for comparing the results to those of other investigations. This chapter contains a review of the literature on the effects of SHG members' loan availability on their enrollment in the iCHF program, how SHG members view their involvement in the program, how important the sharing out process is to household enrollment in the program, how an awareness-raising session for SHG member's influences program enrollment, and a summary of the chapter.

2.1 The concept of health financing

One of the most important roles that health organizations play in influencing and facilitating the move toward universal health care is health finance, which ensures that services are successfully delivered and that the public is financially protected. Millions of individuals globally lack access to health services because of the high expenses linked with their reduction (29). Ensuring that everyone has access to and receives high-quality care when needed is the aim of health financing. Regretfully, because there is little funding for those programs, many people still receive inadequate care even when they pay cash. By guaranteeing the availability of health financing, a well-crafted and executed set of regulations and procedures can greatly assist in making sure that these obstacles are handled (30). In order to ensure that households are better protected when accessing healthcare, the health financing system consists of purchasing to enable government and its agencies to guarantee that everyone can obtain and receive healthcare (31,32). It also involves mobilizing resources for the delivery of healthcare as well as other operations.

Africa, particularly Sub-Saharan African countries, are facing a number of challenges related to national health priorities. These include a dearth of national health accounts and other data that could guide the creation and execution of health financing policies and strategies, a lack

of investment in areas that address social determinants of health, a preponderance of out-of-pocket spending, inadequate prepaid health financing mechanisms, and sizeable informal sectors(18,33). Investment and multisector coordination amongst main health ministries are highly demanded in order to guarantee the existence of a dependable health financing system at the national level (30). This will ensure not just sustainability but also high-quality medical care and increased community involvement. The foundation of multisector cooperation should be the establishment and enforcement of successful policies with extensive community involvement, in order to guarantee that the policies represent community demands (34).

The majority of Tanzania's health financing system is derived from taxes and donor assistance, with just a small portion of the population having access to social, communal, or private health insurance. Since they lack insurance and a job due to being either extremely poor or employed in the unorganized sector, the remaining population is dependent on the public sector (35,36). Because there is a sizable portion of Tanzanians who do not have a guarantee that they will obtain health care, the government of Tanzania has been improving and modifying the Community Health Fund to meet the citizens' need for access to healthcare (37,38). Since health funding would be assured, most of the Tanzanians' access to Community health funds will increase the guarantee of high-quality medical care.

2.2 Understanding the term community SHGs

Self Help Groups are widely recognized as grassroots groups with a membership base that bring people together to discuss topics connected to improving socioeconomic conditions and ending poverty (39–41). SHGs play a major role in providing members with the platforms and organizing tools needed to collaborate for social, economic, and other advantages. Worldwide, but particularly in developing countries, women see it as the most successful approach to ending poverty. In order to address the same issue—the social and economic circumstances of the poor—the country is home to a variety of Self-Help Groups (SHGs), each with a distinct goal (42,43).

While being involved in self-help groups has benefits for the individual, organizations can also positively affect society. Interventions provided through Self-Help Groups (SHGs) may better stimulate positive development outcomes than approaches targeting individuals or mass mobilization campaigns, since groups can engage in collective bargaining, risk spreading, peer education, and social support (16).

The majority of these SHGs have characteristics in common, like voluntary membership, self-governance, and member participation in group decision-making. They also have the option of holding in-person meetings, and their goal is to improve the welfare of each member (33).

2.3 The concept of the improved community health fund

The Community Health Fund (CHF) was founded in 1996 with the goal of enhancing and improving everyone's access to first-rate primary healthcare in Tanzania (15,44,45). The goal of Tanzania's iCHF initiative is to facilitate beneficiaries' access to health finance options and services (24,46). The coordinators handle ensuring beneficiary enrollment at the regional, council, and facility levels, while the Regional Administrative Secretary office manages the enhanced Community Health Fund (iCHF) program. Although there have been initiatives, not all Tanzanians have enrolled in this program, which aims to ensure that they have access to healthcare.

The improved CHF insurance program continues to serve uninsured and rural residents as a volunteer health insurance option. The Ministry of Finance and Planning's National Financial Status Report states that 2,945,893 individuals have registered for the iCHF program for the 2020–21 fiscal year (47,48). Due to the low enrollment rate of households in iCHF, the cost of the home increases while confronting health-related challenges. Families in lower-middle-income nations spend all the money in their bank accounts on medical bills.

2.4 Influence of referring individuals in self-help groups on their enrollment in iCHF

Many types of support have been provided to households, especially low-income and marginalized households, to ensure their access to health care. Households are urged to join SHGs after receiving this support to guarantee that they will be able to renew their iCHF cards after the designated time has elapsed. Which households are qualified for the iCHF depends on several factors, such as marital status, median income, family size, the existence of chronic illnesses or impairments, and program understanding (32,49,50). It is recommended that newly joined iCHF members formalize their revenue-generating activities to sustain their enrollment in the insurance programs and improve their earnings (37,42).

Most households who participate in the community health insurance program periodically find it difficult to pay the whole enrollment cost. This means that to facilitate the registration process, they must have a system in place that will enable them to have cash gathered and ready. The removal of co-pays, the utilization of loans as a form of payment, and subsidized premiums are all tactics that can assist the underprivileged in signing up for and making greater use of CBHI (24,32).

Most of the study has focused on the variables and barriers influencing household participation in the iCHF program. The enrollment of sponsored families with different sponsors on iCHF and the reasons behind these households' decision to join SHGs have not been the subject of any research. The extent to which these self-help groups (SHGs) influenced and encouraged individuals to continue contributing to the iCHF program is unknown. The study's goal is to ascertain whether these households are associated with SHGs after they have further help in renewing their iCHF cards.

2.5 Influence of individual access to loan on enrollment into iCHF scheme

Social groups known as SHGs were established with the goal of improving household economic circumstances and providing socioeconomic support to one another. Addressing home economic concerns and barriers to iCHF enrollment can be done effectively through

SHG. To manage a range of financial concerns, such as guaranteeing access to healthcare by covering the cost through OOP or health insurance, members of SHGs can borrow money from one another and save money (1,16,17). Given that most SHG members are low-income individuals, iCHF becomes the best choice for them to support access to health care and help them find socially and economically viable solutions to life's problems (52,53).

In 15 SSA countries, estimates show that 30% of households pay for medical bills out of pocket. When a household is unable to pay for medical expenses, poverty may ensue (45,54). Issues with individuals' capacity to pay insurance premiums are associated with the given situation (42). Income level has a significant impact on both the level of participation of local leaders in the iCHF's implementation and the attitudes and behaviors of the community toward it (22,55). When straightforward loans with fair terms and conditions are available from the community level, there is a greater chance that members of the community will enroll in the program to receive health services. It has been shown that appropriate support management efforts to improve the performance of prepayment schemes are vital in enhancing household enrollment in the scheme (22,55). This is because managerial practices have an impact on policy implementation and scheme performance. Making health insurance accessible through women's SHGs increases the possibility of allaying concerns regarding the inclusion and sustainability of CBHI programs (17,21,31). Benefit packages offered by CBHI schemes must take into account recompense for lost pay and transportation expenses (56), as these factors have an impact on CBHI enrollment. This is in addition to merely having to pay for the facility's health services, as there are questions about how important proximity is in deciding which provider to use. Providing CBHI to groups that have come together for other reasons, thereby strengthening the social bonds that have already been formed for those reasons, reduces the likelihood of adverse selection in practice (such as involvement in SHG) (12,49).

The SHG members usually use the loans they are eligible for to pay for immediate needs, with the majority of these loans going toward giving households more financial stability and assets to buy. The degree to which household enrollment in iCHF is impacted by or made

easier by these loans. The purpose of this research is to find out how the availability of loans to SHG members influences their propensity to sign up their household for iCHF.

2.6 The contribution of shgs' sharing-out process on individuals' enrollment in an iCHF

The majority of SHGs are yearly organizations that work to support household income. The group usually divides the earnings from its operations, including fines and loan interest, after a year of operation (6,57,58). By addressing the primary challenges encountered throughout, many households choose to implement their intended goals during the sharing-out time, thereby improving their living conditions. The construction of a house or the purchase of any other noteworthy property is covered (25,46,59). A major factor influencing people who enroll in iCHF is the cost of the insurance under the plan for the services provided. Due to inadequate accountability and a lack of funds to promote awareness campaigns, the majority of family members do not prioritize health insurance services in their plans (33).

During the sharing-out stage, community people need to be fully informed about the importance of funding the iCHF and the operation of the program. Low community involvement and a lack of trust in the schemes' management are issues that hinder active and simple enrollment in the iCHF plan (14,17). It has been shown that effective support management efforts to improve the success of prepayment schemes are critical in enhancing household enrollment in the scheme by looking at managerial practices as an influence on policy implementation and scheme performance (20,54). Experience has shown that, in most communities, men tend to make the majority of choices regarding the house, despite the fact that women make up the majority of group members in these SHGs (17,53,60). As long as the iCHF program's healthcare services continue to develop and the public is informed about the services available and the scheme's effective administration, people will be willing to pay the necessary rates (61). Large structural and operational challenges plague community health insurance systems with roots in both rural and urban areas, which ultimately results in low program acceptability. The integration of services and utilization of the community-

based platform for development of sensitization and awareness is imperative to guarantee a higher level of commitment to members' engagement in iCHF (11,16,46).

We don't know much about how SHG members share out or if it helps explain why a household chooses to enroll in the iCHF program. Examining how this period is used to increase household iCHF enrollment is the goal of the study.

2.7 The perceptions of the individuals supported the iCHF scheme

Perception is the primary cognitive interface via which an individual interacts with his surroundings. Because all conceptual knowledge is based on or derives from this basic form of consciousness, the study of perception has always been particularly important for philosophy and science (14). Socioeconomic factors have a major impact on who and how is registered in the iCHF plan. The iCHF enrollment rate is quite low, which contributes to a substantial income gap between the rich and the poor. Low-income levels and inadequate information are the main causes of this disparity. SHGs are one of the unofficial associations that assist residents in pooling their resources and enhancing their financial situation (14,16). Renewing insurance policies is more likely for insured households with access to reliable information and robust social network information pathways, which might boost confidence in the insurance and eventual coverage (2,62).

SHGs have been recognized as an effective forum for information sharing and raising community awareness because they unite a bigger community of students from the same class and allow for greater debate on the same kind of sharing of like-minded experiences (2,62–64). In addition to other factors that influence household participation in iCHF, age and a combination of the sexes of the household head have influenced the decision to enroll or not (2,62–66). Despite variations in the way the advantages are articulated, men and women have about the same positive impressions of the CBHIS. This is particularly true for the elderly, pregnant women, and children under five who are among the vulnerable populations included in the program and are excluded from paying for access to health care

services. Additionally, contrary to common assumption, very few participants believed that the software was a desirable product worth any price.

There is no assurance that CBHI will be sustainable or that households would rely only on it to pay for healthcare, given the current trend and low enrollment rate. There is little evidence to back up the idea that voluntary CBHI can work as a workable long-term primary healthcare funding solution in low-income countries (67). Convenience, perceptions of expenses (including premium and registration fees), and the benefits of health insurance are elements of the plan that are highly correlated with enrollment and retention (40).

There exist distinct parallels and differences in the perspectives of households enrolled in CBHI compared to those who are not. Enrollment in CBHI is impacted by the perspectives of these two groups regarding the events and procedures they witness within the scheme. In terms of perceived community "health beliefs and attitudes," peer pressure and provider staff attitudes received the lowest ratings, while the advantages of the health insurance plan, quality of care, sufficiency of service delivery, and ease of health insurance administration were rated most favorably by both insured and uninsured households (20,68). Rising rates of care usage (20,68–70), along with decreased out-of-pocket expenses and increased access to healthcare, are two ways that CBHI provides financial security.

Empirical data suggests that a household's decision to join a community is influenced by peer pressure and health-related concepts and attitudes. Within a group, people pay attention to one another, information spreads quickly, and unfavorable experiences can lead to a cumulative influence in how people see one another (10,49). Perception plays a major role in household enrollment in the CBHI plan. Household attitudes have a role in the choice to enroll in CBHIs; these perceptions consider factors relating to providers, such as the quality of healthcare. It doesn't seem like affordability (income and premiums) plays a big role (71). The SHGs offer a useful forum for influencing public opinion and consciousness. The iCHF is easy to use when it is integrated into the group priorities, which facilitates the assessment of its sustainability and the guarantee of its existence through SHGs (11,23,26,72). SHG

members' perspectives on iCHF enrollment are not well understood, and more information is needed to properly grasp the opportunities for increasing household iCHF enrollment. Analysis will be done on how SHG members feel about enrolling in iCHF.

Generally, a several studies conducted, highleted the factors influencing individual enerollement in the iCHF, influence of SHGs in creating community awaness and sentitize them on the access to health services, community perception on the use of the iCHF cheme and challenges encountered in the use of iCHF scheme. Little is known on the contribution of SHGs on the individual enrollement in iCHF scheme.

CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1 Study design

To gather primary data, the study used a case study design using a qualitative methodology. A case study entailed a thorough investigation of an individual or group of individuals in order to gain a comprehensive grasp of the circumstances existing in the community being studied. Data for the case study design can be gathered in a variety of ways, including through written reports from the individuals, observations, interviews, and questionnaires (73) .

3.2 Study population

Participants in this study included men and women from Dodoma City Council SHGs whose homes received support from various projects, as well as group leaders and iCHF enrollment officers. It is estimated that Dodoma City has 700 self-help groups, with over 14,000 participants (74), and that over 3300 households receive yearly support of iCHF fee payments from various projects.

3.3 Study area

The study was carried out at Tanzania's Dodoma Region and City Council. Dodoma city is predicted to have 1.1 million people (74). The Dodoma region is one of Tanzania's fastest-growing regions, with a population of 3,085,625 (1,512,760 Males and 1,572,865 Females). Tanzania's national capital and the hub of the Dodoma Region is Dodoma City. The study set includes a rapidly increasing proportion of individuals working in the informal sector, with over 3300 households receiving yearly iCHF enrollment fees and being encouraged to join SHGs (26). In Dodoma City Council, there are around 700 Self-Help Groups (SHGs), with about 14,000 members, ranging from 10 to 30 each group (74). Numerous SHG models, including the Worth Yetu Model, VICOBA, and SILC groups, are in operation in Dodoma and are utilized by individuals. With respect to the entire population, Dodoma City Council's iCHF plan enrollment percentage is 19%. In Dodoma City, two wards of Chang’ombe and

Ipagala were sletected purposively due to large proportion of households supported to pay iCHF annual fee, out of 41 wards.

3.4 Sample size and selection

A total of 25 participants were selected purposively from a list of the individuals supported to pay for the iCHF annual fee payment from the ward enrollment officer. The researcher under support of the enrollement officer and community volunteer identified members who were supported to pay for iCHF and they are in the SHGs. After securing a list of the supported individuals, the particiapnts were visited and participated in the data collecting process where 14 were recruited for the FGD and 11 were recruited for IDI. Two FGDs, one from each ward with 8 and 6 participants from two wards were involved in the data collection process. The IDI involved 11 participants, 3 were the SHG leaders, and 8 SHG members supported with iCHF annual fee payments. The initial plan was to reach 30 participants in this study 16 FGD and 14 IDI. When the researcher reached 11 IDI participants managed to attain the saturation of the information where there was no new information coming out of the interviews. The 25 participants are within the recommended participants of the study as it is recommended sample size for qualitative research ranging from 20 – 30 participants (28).

3.5 Data collection methods

3.5.1 Data collection tools

Through focus group discussions (FGD) and an in-depth interview (IDI) interview guide, data were gathered. By getting a deeper grasp of more thoughts or impressions, the in-depth interview guide made it possible to gather detailed information beyond the initial and superficial responses. SHG leaders with thorough knowledge of enrollment in their communities and a chosen group of well-informed iCHF members within SHGs were the recipients of the IDI.

To get SHG members' opinions on the role the SHG plays in each individual's iCHF enrollment, a focus group discussion (FGD) was conducted with those members who were helped in paying the iCHF yearly fee. The purpose of the FGD questions was to investigate

the opinions of the group's supported members regarding the iCHF program, the enrollment procedure, the annual fee payment system, and the relationship between group membership and iCHF enrollment.

3.5.2 Data collection procedures

To aid in the process of gathering data, the lead researcher hired one research assistant. Before heading to the communities/SHGs, the lead researcher and research assistant made courtesy calls to the offices of the Mtaa Executive Officer, the District Executive Director, the Ward Executive Officer, and the Regional Administrative Secretary. Following the courtesy call, the researcher combined with Ward Community Development Officers to identify two organizations from the list that were specifically chosen based on the groups whose memberships had a high proportion of iCHF yearly fee payments from two wards. Once the regular meeting was over, the groups were visited to have a conversation with the chosen FGD participants. Meetings with SHG leaders took up one day in each SHG, while participants in FGD took up the second day. A total of 12 days were used for both FGD and IDI in all 2 wards.

The principal researcher collected the data with assistance from the research assistant, and both the research assistant and the principal researcher performed the data analysis to ensure accuracy and consistency. Interviews were held in the participants' homes, and focus group discussions (FGDs) were held at SHG meeting locations, particularly in Mtaa Offices to ensure a smooth discussion. Before the interview began, the participant was asked to sign a consent document that the researchers had read to them and provided their consent.

3.6 Data management

To guarantee accuracy, consistency, completeness, and preliminary analysis, data from IDI and FGDs were cleaned and examined every day. Through data-checking, unforeseen faults in data quality that surfaced in the field could be shown and early repairs could be made. The suitability of digital recorders was examined. Data collection was done with extreme confidentiality, with access to the acquired information restricted to those directly involved

in the project. Audio recordings and additional gathered data were stored in a secure box and on a secured computer that was only accessible by the lead researcher.

3.7 Data analysis

The data were analyzed using a deductive approach to thematic analysis, which involved identifying, analyzing, and reporting patterns (themes) across the collected data (75). The six steps of the thematic analysis approach were involved in this study. The researcher transcribed audio-recorded data from the IDI and FGDs verbatim into a Microsoft Word document using the manual process of listening to the audio and transcribing. The participants' original language is used to develop during the data analysis process and then translated into the language for publication (37). Thorough readings of the transcripts were conducted to comprehend key informants' portrayed concepts, which were then coded using predetermined codes. Predetermined codes were derived from the conceptual framework, research questions, and objectives (75–78).

The predetermined codes were organized into nine clusters, termed sub-themes, which were further condensed into four main themes: the influence of linking individuals in Self Help Groups on enrolment in iCHF, the influence of individual access to loans on enrolment in iCHF, the contribution of self-help groups' sharing-out process on individual enrolment in iCHF and the perceptions of the supported individuals on the iCHF. Notably, the sub-themes are "a platform for raising household income and motivating members to prioritization", "provides supportive experience sharing and learning environment", "provides alternative solutions at times of financial challenges", "Payment through a loan is a short-term plan", "Support and influences from the peer group members and leadership", "Sustainable way of continued annual fee payment", "perceived as it increases assurance of health services with limitations", "perceived as affordable and applied all over the country scheme" and perceived needs for improvement in the scheme". The systematic assignment of texts into codes into sub-themes and sub-themes into main themes was facilitated by modifying the coding scheme when new information emerged. The extensive volume of text data was managed

using NVivo version 12 computer software. The final analysis included report writing to convince the readers of the merits and validity of the analysis.

Table 1: Data analysis process table

Step	Action	Purpose	Method/Tool	Outcome
1. Data Familiarization	Review transcripts and notes repeatedly	Immerse in the data and gain an overview	Manual reading, transcription software	Familiarity with the data, initial thoughts
2. Generating initial codes	Assign codes to segments of data	Organize data into meaningful categories	NVivo	Initial codes for segments of data
3. Developing Themes	Group related codes into themes	Identify major themes	Thematic analysis	Emergent themes
4. Reviewing themes	Refine and focus on key themes and concepts	Narrow down the data to essential insights	Selective coding	Condensed set of key themes
5. Defining and naming the themes	Analyze and interpret the meanings of identified themes	Understand deeper implications	Qualitative interpretation, researcher insights	Thematic explanations, narratives
6. Reporting	Present findings with illustrative quotes and examples	Communicate insights effectively	Writing, illustrative quotes, narrative structure	Final report with themes and interpretations

3.8 Ethical Consideration

The Ethical Committee at Muhimbili University of Health and Allied Sciences (MUHAS) granted the researcher ethical clearance with IRB reference number MUHAS-REC-08-2023-1873. Through the Dodoma Regional Administrative Secretary Office, the District Executive Director, and the Ward Executive Officers, permission to conduct the study was requested from Community Development Officers. Every study participant completed an informed consent form after learning about the purpose of the investigation and the justification for its

conduct. At every stage of the study, including data collection, analysis, and report writing, participant confidentiality was guaranteed.

3.9 Trustworthiness

One strategy for convincing readers and oneself that study findings are important is to be trustworthy (76). By optimizing saturation and data management procedures, interpreting the acquired data well, and adhering to the protocols employed to guarantee study quality, the researcher established a better degree of confidence in the data. This was carried out since the IDI participants' discussions of the same subjects as the FGDs made triangulating the data easily. The researcher made sure that the results were reliable by adhering to the reliability standards of credibility, transferability, dependability, and conformability.

3.9.1 Credibility

The research made sure the appropriate people were contacted, made sure they understood the study's purpose and gave them a chance to contribute detailed information. To provide truthful answers for the interview and research guidance in this study, the participants were essential. The provision of comprehensive pre-study information facilitated the development of a positive, trustworthy rapport between the researcher and the participants, which in turn increased the participants' willingness to engage and provide accurate information. To make sure the information was not omitted or skipped, all interviews were audiotaped and notes were taken. To ensure that the research questions were understood and to encourage truthful responses, all interviews were performed in Swahili.

3.9.2 Transferability

The degree to which study findings can be adapted to a different location or sample than the one being investigated is known as transferability (61). By giving a thorough account of the study's participants and surroundings, the researcher made sure that the results were transferable. This allowed the results to be extrapolated to a different, comparable setting.

3.9.3 Dependability

Findings that hold true when the study is conducted again with the same subjects and in the same setting are referred to as reliable. The evaluation of the integrated data collecting and analysis processes' quality is part of this. The researcher employed various methodologies to ensure that comparable outcomes would be achieved upon replication of the same study under identical conditions, with identical methodology, and involving identical subjects. Therefore, by providing a thorough methodological explanation of the study, the researcher ensured appropriate use of the data collection tools, accurate data analysis, and accurate data interpretation. Throughout the interview, the researcher meticulously monitored all nonverbal cues and indicators from the participants to make sure no important information was overlooked.

3.9.4 Conformability

Conformability is a metric used to assess how well the data collected supports the findings. With the use of an audio recording made during an interview with consent, the researcher took thorough notes on every response that was given. To make sure there is a strong correlation and consistency between the data gathered and findings, a researcher used notes made during data collection as well as recorded interviews throughout data analysis and interpretatio.

3.10 A Potential limitation of the study

During the data collecting and analysis process, biases based on participant preconceptions and experiences were common. Data triangulation, which entailed gathering information from SHGs, several study participants, and various data collection techniques, was employed to reduce investigator bias.

Overly optimistic expectations on the side of the participants, believing that a particular type of response would lead to increased support. By outlining the study's objectives clearly and asking potential participants to be truthful, the constraint was lessened.

CHAPTER FOUR:

4.0 RESULTS

4.1 Introduction and organisation of the chapter

This chapter presents results from a study aimed at exploring the influence of SHGs on individual enrollment in iCHF in the Dodoma city council. The study included 25 participants from Dodoma City Council, consisting of 3 SHG leaders and 22 iCHF-supported SHG members. The participants' age ranged from 40 to 67 years, with household sizes varying from 3 to 6 members. More than half of the participants were involved in small businesses, while a smaller group were engaged in farming activities.

This chapter is divided into five sections including the following: 1) Introduction and Organisation of the chapter. 2) The influence of connecting individuals in SHGs on enrollment in iCHF 3) The Influence of individual access to loans on iCHF enrollment 4) The role of SHGs' sharing-out process on individual enrollment in iCHF, and 5) The perceptions of supported individuals on iCHF. Each section presents results based on main themes and sub-themes.

Table 2: Themes description

Theme number	**Main themes**	**Sub-themes**
Theme 1	The influence of linking individuals in Self Help Groups on enrolment to an iCHF.	A platform for raising household income and motivating members to prioritization
		Supportive experience sharing and learning environment
Theme 2	The influence of individual access to loans on enrolment in an iCHF.	Alternative solutions at times of financial challenges
		Short period in loan repayment
Theme 3		Influences from the peer group members and leadership

	The contribution of self-help groups' sharing-out process on individual enrolment in an iCHF	Sustainable way of continued annual fee payment
Theme 4	The perceptions of the supported individuals on the iCHF	Assured access to health services with limitations
		Affordable and wilder applied scheme

4.2 The Influence of SHGs on enrolment in iCHF

This part addresses the first objective which aimed to explore the influence of linking individuals in SHG on their enrollment in iCHF. This part is divided into two sub-themes namely, a platform for raising household income and motivating members in prioritization and a supportive experience-sharing and learning environment.

4.2.1 A platform for raising household income and motivation to members on prioritization.

The participants through IDI and FGD reported SHG as a life-sustaining platform providing the opportunity to raise household income where members save money and lend for different purposes.

It was reported that SHGs, members with different backgrounds, perspectives, and priorities meet and share individual annual plans encouraging more savings to go beyond individual initial thinking. The provided opportunity to save and lend money in the SHG increases confidence as it assures members the ability to pay for iCHF and access health services. One of the participants said,

> *"The enrolment officer linked me with a group facilitator who provided more emphasis and understanding of how SHG works, the way will help to change and support my life. When I joined the group initially was not easy due to my poor income but today, I can testify how it has helped me to become confident and able to secure my family's health" (IDIR03 – SHG member).*

Further, participants revealed being engaged in SHGs for long-term before receiving iCHF annual payment support. After being supported they were encouraged and sensitized to use their opportunity to pay for the iCHF scheme. The sensitization influences how members in SHGs use their opportunity effectively save more money and use to pay for the iCHF reducing dependency on stakeholders' support. One of the participants said,

> *"Before receiving iCHF annual support payment, I was a member of the SHG. During the registration process, I was encouraged to take advantage of being in the SHG to prioritize my health and my family by ensuring annual iCHF payments. I embraced this advice as an opportunity to support my family and change my perspective on SHG activities. I used to think SHG was solely for profit-making, but I realized I should also utilize its potential to cover other aspects of social life, including health services" (IDIR04 - SHG member).*

The participants showed that SHGs motivates members to prioritize access to health services in the SHGs where members are encouraged to prioritize assurance of access to health services. Most SHG members have managed to ensure their households are well protected by paying iCHF annually. This practice has been possible due to frequent emphasis provided by group facilitators on the importance of ensuring they pay iCHF. Testifying this one of the participants said,

> *"I have been an active iCHF member since I was supported, I have been paying annually to ensure I am assured of access to health services. I manage to pay for iCHF by setting my plans well ensuring among other annual priorities I prioritize health services. There are several ways I use to pay for iCHF one being my own money from my business and my money from our SHG during the sharing out process" (IDIR06-SHG member).*

Furthermore, participants pointed that SHGs motivate members to repay the iCHF annual fee with their ability to save money and lend for different purposes. This ability provides confidence and assurance that in any situation members are going through financially, they

still have alternatives to address the challenge. Narrating this story, one of the participants said,

> *"Despite saving and lending, we also donate to each other when a thing seems to be difficult, we tend to support one another. So, when an individual is in the group is more likely to be able to pay for iCHF each year because there are alternative sources of money" (FGD1R07-SHG member).*

This study finding show that connecting the eligible person receiving annual iCHF payment to an SHG is advantageous as they are motivated and encouraged by peers facing similar life challenges.

4.2.2 Supportive experience sharing and learning environment.

The participants view SHGs as a space that offers a conducive environment for sharing experiences and learning from their life experiences. These shared experiences and learnings motivate others to enhance their lives, including influencing individual enrollment and repayment for the iCHF annual premiums.

The participants revealed that one of the benefits of being in SHG is the encouragement gained from sharing experiences with other members about the steps they take to sustain their lives. This is facilitated by the opportunity given to each member to share their successes, challenges, and individual plans within the group. One of the participants stated:

> *"When I compare the current with the previous life, I have gained confidence due to the experiences shared by the group members which has influenced me on how I can plan and pay for iCHF in different ways including taking loans, sharing out balance or using of money from my businesses like how others do" (IDIR06-SHG member).*

Through experience sharing in the SHGs, members gain more confidence about their future because they are assured of financial resources and access to health services annually. This confidence increases their capacity to always pay for iCHF and families become secure. In narrating the story, one of the participants said,

> *"The experiences shared in the SHG have made me confident that my health is protected. The group facilitator plays a vital role in facilitating experience sharing and educating us on the importance of saving and how will help me to cover our health insurance too. Since then, I have been able to save a small amount weekly, and at the end of the circle, I can pay for iCHF and other planned priorities" (IDIR02 SHG member).*

The participants shade light that SHGs offer members an opportunity to share their experiences on the use of iCHF and the benefits they receive from the scheme. Members gain insights and knowledge from their peers on handling various life challenges, including managing payments for the iCHF. The best practices have influenced their approach to payment and prioritization of the iCHF. Highlighting the importance one of the participants said,

> *"Connecting individuals who have benefited from the iCHF to the groups, enabling them to share experiences and learn how to enhance their income, increase savings, and effectively pay for the iCHF without disruptions. Additionally, they can receive support and access loans in times of need. The participant observed significant improvements in people's ability to self-fund their iCHF since joining the SHG" (IDIR09 – SHG Leader).*

Our findings show that, SHG is a vital platform for members to share experiences and learning experience sharing, which gives more motivation to continue paying the annual iCHF fee.

4.3 The influence of individual access to loans on enrolment in an iCHF.

This section focuses on the second objectiveof the research, which is to explore the influence of loan access on individual enrollment in iCHF. Two sub-themes emerged from the primary theme including offering alternative options during financial difficulties and using a loan for short-term financial planning. The details of each sub-theme are elaborated in the following sections.

4.3.1 Alternative solutions at times of financial challenges.

The participants portrayed SHG as a platform offering alternative solutions to various challenges faced by household members, particularly in the financial aspect that influences requests for loans. SHG members borrow from the groups to address urgent issues during financial crises. Most of the requested loans are utilized for farming, business, construction, and enhancing access to healthcare services. In cases where members visit the hospital but are unable to receive all necessary services because of services not covered by iCHF, they lack the funds to cover the deficit. Narrating the story one of the participants said,

> *"Some members tend to take loans when they are experiencing financial deficit, and they need to top up on their medical bills. This happens when they have used their iCHF and yet did not cover all costs. At this point, we use social funds to support them" (FGD2R01 - SHG member).*

Further, the participants indicated that some members take loans to support access to health services when iCHF not yet repaid and individuals do not have a balances to cover the iCHF fee. This situation necessitates them to apply for the loan and pay the annual fee. Revealing the incidence, one of the participants said,

> *"I can take a loan to pay for iCHF is a good opportunity since we have seen some of our colleagues who have no iCHF consuming more than what can be paid in iCHF. If one can take the loan and pay for health insurance is the best option rather than staying with no insurance and later when a challenge occurs it becomes difficult to pay for the service. Last year I went to the hospital, and I did not know my insurance was expired and I had no money at that time, I requested an emergency loan from the group and used the loan to pay for iCHF" (IDIR01 – SHG Member).*

Moreover, the participants showed that SHG has an opportunity to provide social/emergency funds with no interest to support their health services needs. In this case, the SHG members use social/emergency funds to cover their financial needs, including paying medical bills, iCHF, or any other social challenges. One of the participants said,

"Most of the groups have got social/emergency funds which are taken with no interest and returned as it was taken. To me, this is a good opportunity for anyone who wishes to have iCHF and does not have enough money at once to take this kind of loan and pay for iCHF" (IDIR02 – SHG Member).

4.3.2 Short period in loan repayment.

The participants pointed that members take loans for different purposes based on their priorities which might not necessarily be health related. The use of loans is not a sustainable way of ensuring members pay for the iCHF. The behavior and level of income of the one who is taking a loan may affect this practice and lead to conflicts. When the loan requester has no good behavior/practice of paying back or has no economic capacity to pay back may lead to conflict among members. Revealing this story, one of the participants said,

"Loan is not the best option for sustainable iCHF payment because not all members will be able to pay back the loan taken. Also, if loan dependent will be many there will be no money to support those who will need the loan hence can paralyze other group activities" (IDIR10 – SHG Leader).

The participants reported that members with low-income capacity to pay for the iCHF they through loans is an additional burden in their life. The use of loans to pay for the iCHF is a burden to them because it is not for production, hence creating worries about the ability to pay back due to the low financial capacity of the household. One of the participants said,

"…taking a loan to pay for the iCHF is not a problem and can be a sustainable way to ensure people of low income who cannot earn large amounts of money at once can pay through loans. To achieve this there should be improvement in the services covered by iCHF and awareness should be provided to the group's members. People take loans more than what is paid in iCHF to pay for medical bills, so it is not a problem to take a loan to pay for the iCHF if all services will be covered" (IDIR05 – SHG - Member).

4.4 The contribution of SHGs sharing-out process on individual enrolment in an iCHF

This section addresses objective three of the study, on the role of the sharing-out process in encouraging individuals to participate in the iCHF scheme. It was noted that each SHG has its cycle, with some SHGs sharing funds every six months and others annually. The analysis of the responses is presented in two sub-themesincluding support and influence from peer group members, and leadership and a sustainable approach to annual fee payments. The following isa detailed description of each sub-theme.

4.4.1 Influences from the peer group members and leadership

The participants showed that peer SHG members and group leaders influence ensuring individuals are enrolled in iCHF. The group leaders and members support each other to ensure they are safe and secure through advice and guidance during the sharing-out process. The influences range from how they share experiences and benefits gained from the iCHF enrollment and how they manage to pay for the iCHF, and other contributions provided by members. One of the participants said,

> *"During the sharing out process is the right time if group members will be well influenced is the easiest way of ensuring people are paying for the iCHF. I have three members who pay iCHF annual fee after sharing out two of them were influenced by the one who was doing that way" (IDIR10 – SHG Leader).*

Moreover, participants reported that SHG members motivate and encourage others to pay for the iCHF and ensure they can pay for it during the process of sharing-out. This indicate that working together gives more strength and encouragement rather than being alone. One of the participants said,

> *"There is encouragement from group members that influences each other to contribute to the iCHF. During the sharing-out process, our group leaders invite the enrollment officer to register those who are willing to pay for the iCHF scheme. When*

this occurs, even if I or another member had no initial plan to pay for the iCHF, they find themselves contributing to the iCHF" (IDIR06 – SHG member).

4.4.2 SHG as a sustainable way of continued annual fee payment.

The participants during interviews and discussions revealed that the SHG distribution process is a sustainable method to ensure individuals are compensated for iCHF. Linking the share-out period and iCHF payment increases capacity and assurance to the individual to pay. This is possible because the SHG members have money with no conditions related to group rules which are easy to use to pay for the iCHF. Unleashing the story, one of the participants said,

"The sharing-out process, we normally pay for the iCHF because we have the assurance of our own money. During this time member and have the freedom to use their money to pay for the iCHF without conditions from the SHG" (FGD1R01 – SHG Member).

Moreover, the participants revealed that having a sharing-out period is a beneficial practice that improves payment for the iCHF scheme. Utilizing this period for iCHF payments encourages SHG members to plan and ensure timely implementation. The findings indicate that during the sharing-out phase, there is increased confidence in annual iCHF payments, as the amount required is manageable within members' savings. One of the participants said,

"*I believe it is a beneficial practice as it allows us the freedom to allocate funds for various family needs. This includes covering the iCHF expenses, which are relatively low on an annual basis"(IDIR03 - SHG Member).*

4.5 The perceptions of the supported individuals on the iCHF

This section focuses on objective four of the study, which is to evaluate the supported individuals' perception of the iCHF scheme. The study delves into various perceptions of the supported SHG members regarding the utilization of the iCHF scheme, which are examined and discussed in the following sections. These perceptions are categorized into two sub-themes: guaranteed access to healthcare services and affordability with broader implementation of the scheme.

4.5.1 Assured access to health services with limitations

The study participants reported that being supported with CHF by different stakeholders has increased assurance of health services. Most participants reported that the support they got on the iCHF facilitated them to access timely health services and improved their health conditions. This access to services is attributed to having no need for extra money for file openings or doctor consultations. Testifying the benefits one of the participants said,

> *"The iCHF services are good and useful in facilitating access to health services and I will keep paying for the iCHF membership every year to ensure my family is assured with access to health services. I will keep insisting my group members to ensure everyone is enrolled in the iCHF and use the opportunity of taking loans or share-out process and pay for the iCHF" (IDIR04 – SHG Member).*

However, some limitations were found in this study where not all services are covered by the iCHF scheme including some of the prescribed medicines and laboratory tests. This challenge is demoralizing beneficiaries' continuation to pay for the iCHF. Revealing the scenario, one of the participants said,

> *"Mostly it covers file opening, doctor consultation fees, and a few laboratory tests. With the scheme you cannot buy medicines or get more advanced laboratory tests" (IDIR01 – SHG Member).*

4.5.2 Affordable and wilder application of the scheme.

The study participants revealed another part of their view that iCHF is affordable and can be applied in different health facilities within the same region through the referral system. Payment for the iCHF has a lower cost compared to the OOP and gives freedom of registration in the iCHF at any time with very simplified criteria for registration. Narrating the story one of the participants said,

> *"The opportunity that I see in the iCHF enrolment now is that I can be enrolled at any time and become an active member with the capacity to get health services anytime when I am in need. It is very cheap when compared with paying directly from*

my pocket. The cost that can be used in a single visit is higher than I can pay for iCHF annually" (IDIR02 – SHG Member).

The participants showed there was a high relief attained by having the iCHF scheme as it saved most of the money to be used in health services. Despite it does not cover all services but provides relief to some extent. Providing this evidence one of the participants said,

"…. The iCHF is cheaper, only 30,000tsh is enough per year compared to when you go with no iCHF a bill can amount to up to 50,000 Tsh in a single visit. This is a great opportunity for me to be enrolled in iCHF and I will keep being registered" (IDIR06 – SHG Member).

Furthermore, the participants showed an increase in access to services in the region without the need to be physically present at the originally registered facility. Referrals can be made to the Regional Referral Hospital for services, reducing unexpected medical costs. Participants expressed satisfaction with iCHF covering essential health services as needed, especially since illness is unpredictable. Expressing this experience, one of the participants said,

"This iCHF is very beneficial now, as it allows me to access services at the regional hospital through referral. It has reduced the high costs I used to incur for healthcare services compared to when I did not have an iCHF card" (IDIR02 – SHG Member).

CHAPTER FIVE

5.0 DISCUSSION

5.1 Overview

This chapter discusses the findings of the study focusing on four research objectives. These objectives include the influence of SHG on individual enrollment in iCHF, the influence of loan accessibility on individual enrollment in iCHF, the role of the sharing-out period in individual enrollment in iCHF, and the perception of the supported individual regarding the iCHF scheme.

5.2 The influence of self-help groups on enrolment in an iCHF

This part will discuss the results showing the SHG's role in influencing individual enrollment in the iCHF scheme. The results indicated two influences of the SHG on individual enrollment, which are a platform for raising household income and motivating members in prioritization-related and a supportive experience-sharing and learning environment that encourages and builds confidence, increasing opportunities for sharing experiences and learning.

5.2.1 Platform for raising household income and motivativation to members in prioritization.

The study revealed that SHGs serve as a valuable platform for individuals to raise their income, which in turn motivates them to contribute to the iCHF scheme. Participants in SHGs benefit from the ability to save money and access loans, which enables them to invest in their businesses. These financial opportunities help to stabilize their income, allowing them to prioritize healthcare expenditures, such as the iCHF scheme. This finding underscores the dual role of SHGs in both economic empowerment and health-related financial security.

These results align with previous research that highlights the economic and social benefits of SHGs. According to studies by (79), SHGs have been shown to improve financial inclusion and create pathways for poverty alleviation. In addition to income generation, SHGs foster a culture of saving, which, as observed in this study, directly influences the ability and

willingness of individuals to contribute to healthcare schemes like the iCHF. This finding supports (25) who found that participation in SHGs increases members' access to health-related resources by improving their economic standing.

The study further discovered that SHGs have been a significant motivating factor for their members to pay for the iCHF. The structure of SHGs, which facilitates saving and lending for various purposes, plays a critical role in this motivation. Members who are able to accumulate savings through SHGs are better equipped to handle both day-to-day expenses and larger commitments, such as healthcare premiums. Additionally, the lending mechanisms within SHGs provide a financial safety net, allowing members to take loans when necessary to cover health-related costs, including contributions to the iCHF scheme. This finding emphasizes the importance of accessible financial resources in promoting health insurance participation, especially in economically vulnerable populations.

This result is consistent with prior research, which has demonstrated that financial empowerment through SHGs leads to greater health insurance uptake. For instance, (71) found that members of SHGs are more likely to invest in healthcare-related expenditures due to their enhanced ability to manage finances, whether through saving or borrowing. This aligns with the current study, which suggests that the dual financial functions of SHGs—savings and lending—are key drivers for members' willingness and ability to pay for healthcare schemes like iCHF. This dynamic, as observed by (25), also reflects the broader role of SHGs in improving access to financial services in underserved areas, which, in turn, supports better health outcomes

The role of SHGs in motivating individuals to participate in healthcare schemes like iCHF has significant practical implications. Policymakers and healthcare providers could consider expanding SHG membership as a strategy to increase health insurance uptake. Additionally, incorporating financial literacy training into SHG programs may further enhance members' capacity to manage healthcare costs, ensuring long-term sustainability of health schemes. This approach could be particularly beneficial in low-income or rural settings where traditional financial services are less accessible

While these findings are promising, there are limitations to consider. The data were collected from a limited geographical area, potentially limiting the generalizability of the results. Future research could explore how SHG participation influences health insurance schemes in different regions or among different demographic groups. Moreover, longitudinal studies could help in understanding the long-term impact of SHG participation on both income generation and healthcare expenditure behavior.

SHGs play a pivotal role in both financial and health-related empowerments. By improving income stability and offering financial tools like savings and loans, SHGs enable individuals to contribute to healthcare schemes such as the iCHF. This dual role highlights the importance of SHGs in fostering both economic resilience and health insurance participation, providing a compelling case for their expansion in community development initiatives

5.2.2 Supportive experience sharing and learning environment.

The findings of this study indicate that SHGs not only provide financial support but also create significant opportunities for learning and experience sharing among members, which influences individual decisions to enroll in the iCHF. Members benefit from the platform that SHGs offer to discuss their successes, challenges, and future plans, allowing them to exchange advice and strategies. This interaction fosters a sense of encouragement and confidence within the group, as individuals can draw on the collective experiences of others. The opportunity for experience-sharing reinforces trust in the iCHF scheme and promotes informed decision-making about healthcare investments.

This aligns with research by (80), which highlights the social benefits of SHGs as a space for peer learning and support. SHGs not only promote financial literacy but also serve as forums for members to discuss various life aspects, including healthcare decisions. According to (59), the collective nature of SHGs can lead to positive peer pressure, where members influence each other to adopt practices—such as enrolling in health insurance schemes—that they might not have considered independently. The findings in this study support these observations, showing that the shared experiences within SHGs contribute to increased confidence in paying for healthcare services like the iCHF.

The role of SHGs as a platform for learning and peer support offers practical insights for policymakers and health program implementers. By leveraging the existing structure of SHGs, health initiatives can introduce educational components that provide additional information about healthcare schemes, ensuring that members are well-informed. Additionally, encouraging peer-to-peer learning in SHGs can amplify the positive effects of shared experiences, making health-related behaviors, such as iCHF enrollment, more widespread. This could be particularly useful in rural or underserved areas where access to healthcare information is limited.

While the study highlights the importance of experience-sharing in SHGs, the specific dynamics of these interactions may vary across different groups or regions. Future research could investigate how different types of SHG activities (e.g., training sessions, formal discussions) contribute to individual healthcare decisions. Moreover, longitudinal studies could explore whether the effects of peer learning and confidence-building in SHGs persist over time or if they diminish after members leave the group.

SHGs not only provide financial benefits but also create a supportive environment for learning and experience sharing. These opportunities for discussion and mutual support are instrumental in building the confidence and encouragement needed for members to enroll in health insurance schemes like iCHF. By enhancing both financial security and peer-based learning, SHGs play a multifaceted role in promoting health insurance uptake and improving overall community well-being.

5.3 The influence of individual access to loans on enrolment in an iCHF.

The finding shows that the use of loans from the SHGs has provided alternative solutions at times of financial crisis to the household while at the same the study indicated that payment through loan is a short-term plan. Loans have been an urge relief to most of the members when things seem to be not moving well and have addressed many challenges including individual registration in iCHF though cannot be considered as a sustainable way of ensuring members are paying for the iCHF. The discussion bellow highlights the evidence on the way

SHGs provides alternative solutions at time of crisis and the way loan is considered as a short-term plan.

5.3.1 Alternative solutions at times of financial challenges.

This study also found that SHGs provide a critical financial safety net for their members, especially during times of household financial challenges. When faced with economic difficulties, SHG members often turn to their groups for support, particularly by taking out loans to address urgent issues requiring immediate attention. This ability to access funds during financial crises ensures that members can manage unexpected expenses, including contributions to the iCHF scheme or other essential needs. The availability of loans within SHGs not only alleviates financial pressure but also helps members maintain their health insurance coverage, even during difficult periods.

This finding is consistent with prior research that underscores the role of SHGs in providing financial resilience for their members. According to (25), SHGs have been shown to offer critical support in times of financial stress, allowing members to pool resources and access credit when traditional financial institutions may not be an option. This flexibility is particularly beneficial for low-income households, where unexpected expenses can derail contributions to healthcare schemes like the iCHF. By offering timely access to loans, SHGs help members avoid lapses in healthcare coverage, a finding that aligns with (79) work on the financial buffering effects of community-based lending systems.

The ability of SHGs to provide emergency loans has important practical implications for healthcare financing and social safety nets. Health insurance schemes like iCHF could be integrated more closely with SHG structures, ensuring that members can use loans not only for immediate needs but also to secure long-term health coverage. Policymakers could also explore mechanisms to formalize the role of SHGs in health insurance programs, allowing members to use SHG-based financial services as a means to ensure consistent contributions to health schemes. Additionally, expanding SHG membership and providing training on financial planning could further strengthen the role of SHGs in helping households manage crises without compromising their health insurance.

While this study highlights the role of SHGs in addressing financial crises through loans, further research is needed to explore how different types of loans (e.g., small vs. large loans, short-term vs. long-term repayment) impact health insurance participation. Future studies could also examine whether reliance on SHG loans during crises leads to long-term financial dependence or if it fosters sustainable financial independence. Additionally, research comparing SHG members with non-members during financial crises could provide further insights into the effectiveness of SHGs as financial safety nets.

Hence SHGs play a vital role in helping members manage financial crises by providing access to loans. This financial support allows individuals to address urgent issues without sacrificing their health insurance contributions, such as payments for the iCHF scheme. The capacity of SHGs to provide emergency funding reinforces their importance not only as platforms for financial empowerment but also as essential safety nets that ensure continued access to healthcare services during challenging times. Strengthening the connection between SHG financial services and health insurance schemes could further enhance the well-being of vulnerable communities.

5.4 The contribution of SHGs sharing-out process on individual enrolment in iCHF.

The study findings show that the sharing out process has high contribution to the member's capacity to pay for the iCHF on an annual basis. The SHGs have got a circle where there are SHGs which conduct their share-out after every six months and others after one year. During this sharing-out process it is viewed as appropriate time where members get influences from peer group members and leaders and being a sustainable way of continued annual fee payment.

5.4.1 Influences from the peer group members and leadership.

The results also highlight the critical role of peer support and influence within SHGs in ensuring that individuals are enrolled in the iCHF, particularly during the sharing-out process. This process, where SHG members distribute savings or earnings, is strategically used by SHG leaders and facilitators to encourage their followers to pay for the iCHF scheme. Leaders often leverage the influence they have within the group to emphasize the importance

of healthcare insurance and prompt members to allocate part of their share for iCHF contributions. This peer-driven encouragement is instrumental in fostering a collective responsibility toward health insurance, demonstrating the social dynamics that reinforce positive financial behaviors within SHGs.

This finding aligns with previous studies on the social influence of peer networks within SHGs. According to (13,36,79), SHGs not only facilitate financial independence but also foster an environment where peer pressure and leadership influence drive collective action. Leaders within these groups play a pivotal role in shaping the financial priorities of members, often advocating for investments in health and well-being, including health insurance. This peer influence, especially during key financial moments like the sharing-out process, is crucial in increasing participation in health schemes like iCHF, a phenomenon also observed by (79) in similar contexts.

The use of the sharing-out process as a strategic moment for iCHF enrollment has practical implications for the design of health financing strategies. Healthcare programs could collaborate more closely with SHG leaders to capitalize on these group dynamics, ensuring that moments of financial distribution, such as the sharing-out process, are used to encourage health-related spending. Moreover, training SHG leaders in health advocacy and providing them with resources on the importance of health insurance could further strengthen their ability to influence members' decisions. This could lead to higher enrollment rates in health insurance schemes, particularly in rural or underserved areas.

While the study shows the effectiveness of peer support and leader influence during the sharing-out process, it would be valuable to explore how this influence varies across different SHGs, particularly in terms of leadership style and group cohesion. Future research could also investigate whether members feel pressured by leaders or if they view this influence as supportive, and how these dynamics impact long-term health insurance participation. Additionally, a comparative analysis of SHGs with strong leadership influence versus those with a more democratic or decentralized structure could provide insights into the effectiveness of peer-driven health insurance advocacy.

The sharing-out process within SHGs offers a unique opportunity for leaders and facilitators to encourage members to enroll in the iCHF scheme. The peer support and influence exerted during this time play a critical role in ensuring that healthcare contributions are prioritized. This finding underscores the importance of leveraging group dynamics and peer influence to promote health insurance participation, particularly in community-based financial systems like SHGs. By integrating health advocacy into the financial operations of SHGs, stakeholders can enhance both financial stability and healthcare access in vulnerable populations.

5.4.2 Sustainable way of continued annual fee payment.

The results from the analyzed responses indicate that the SHGs sharing-out process is one of the most sustainable ways of ensuring individuals are enrolled in the iCHF.The sharing-out process, which involves the distribution of accumulated savings among SHG members, is a key moment when individuals have control over a significant amount of money. The link between this period and iCHF payments is crucial, as it increases members' capacity and confidence to pay for health insurance. Since members are financially empowered during the sharing-out process, they can freely plan and allocate their funds without immediate financial pressures. This period provides a sense of financial flexibility, which can be strategically harnessed to encourage iCHF enrollment before members enter the next financial cycle.

This finding supports prior research that emphasizes the importance of timing in financial decision-making. According to (18,79,81), individuals are more likely to make important financial commitments, such as enrolling in health insurance schemes, when they have access to liquid assets and fewer competing demands. The sharing-out process provides exactly this opportunity, aligning well with (26,68,82) observation that financial windfalls or distribution periods within SHGs can be used to influence health-related financial decisions. By strategically linking the timing of iCHF payments with the sharing-out period, SHGs leverage their members increased financial capacity to ensure consistent health insurance enrollment.

The finding that the SHG sharing-out process enhances members' ability and willingness to pay for iCHF has important practical implications. Policymakers and health program

managers can work alongside SHG leaders to align health insurance premium deadlines with the sharing-out periods to maximize enrollment. Additionally, providing financial literacy programs that encourage members to plan for health insurance payments during the sharing-out process can help ensure that these funds are allocated for healthcare needs. This approach could enhance the sustainability of health insurance schemes like iCHF by capitalizing on members' financial readiness during this key period.

While the sharing-out process appears to be a sustainable mechanism for promoting iCHF enrollment, future research could explore how consistently SHGs use this opportunity across different regions or demographics. Additionally, longitudinal studies could examine whether reliance on the sharing-out period for iCHF payments leads to long-term health insurance retention or if members revert to non-payment during financially lean periods. Understanding the relationship between cyclical financial events like sharing-out and sustained health insurance coverage will be important for designing more resilient health financing models.

SHG sharing-out process provides a sustainable and effective means of ensuring iCHF enrollment by capitalizing on members' increased financial capacity during this period. By linking the timing of health insurance payments with the distribution of funds, SHGs create an environment where individuals feel more confident and capable of making healthcare-related financial decisions. This strategy reinforces the importance of timing and financial planning in health insurance uptake, offering valuable insights for integrating community-based financial mechanisms with healthcare schemes in a way that promotes long-term participation and access.

5.5 The perceptions of the supported individuals on the iCHF scheme.

The study identified the perceptions of the SHG members on the iCHF scheme about their enrollment in the iCHF scheme. Several perceptions of the supported SHG members on the use of the iCHF scheme were explored and analyzed as discussed in subsequent sections. The findings show two major issues were identified including iCHF's assured access to health services with limitations and affordable with wide application of the scheme.

5.5.1 Assured access to health services with limitations

The findings also reveal that support from different stakeholders in covering the annual iCHF fee has significantly increased individuals' assurance of access to health services, although there remain certain limitations. Members who received financial support for their iCHF payments experienced enhanced access to healthcare, as the scheme allowed them to obtain services with minimal additional out-of-pocket costs. This small annual payment facilitated the opening of health service files, doctor consultations, and other basic services without requiring members to pay significant sums of money at the point of service. In the past, individuals lacked the assurance of timely access to healthcare due to financial constraints, often relying on OOP expenditures that left them vulnerable to unexpected medical costs. Now, being insured through the iCHF has provided greater financial security and easier access to essential healthcare services.

This finding aligns with existing literature on the positive impact of health insurance schemes in reducing out-of-pocket expenditures and increasing access to healthcare services. According to (8,22), health insurance schemes, particularly those that involve community-based contributions or external support, have been shown to improve access to healthcare by lowering the financial barriers that typically prevent timely service use. As (53,59) notes, households that previously struggled to afford healthcare due to the high costs of consultations or treatment are now able to access services more consistently when insured. The results of this study further confirm these trends, illustrating that individuals with iCHF coverage benefit from a reduced financial burden and greater peace of mind in accessing healthcare.

The increase in healthcare access for individuals supported by the iCHF scheme highlights the importance of continuous stakeholder involvement in health financing. Ensuring that vulnerable populations receive support for their health insurance payments could help bridge the gap between financial barriers and healthcare access. Policymakers and health planners should consider expanding support mechanisms for iCHF contributions, particularly for low-income households that may otherwise be excluded from the scheme. Additionally, public

awareness campaigns could emphasize the long-term benefits of health insurance in reducing out-of-pocket expenses, further encouraging enrollment and participation in schemes like iCHF.

While the study demonstrates that iCHF support has improved access to healthcare services, it also highlights certain limitations. Further research could explore the specific barriers that still exist, despite insurance coverage, such as hidden costs, availability of healthcare facilities, or the quality of services. Moreover, understanding how long-term support for iCHF payments impacts healthcare access and utilization patterns could provide valuable insights into the sustainability of such schemes. Future studies could also investigate whether individuals who receive external financial support for health insurance payments experience the same level of commitment to the scheme as those who contribute independently.

The support provided by stakeholders for iCHF payments has greatly increased individuals' assurance of timely and affordable healthcare access. By reducing the financial burden of healthcare costs, particularly through covering essential services such as file opening and doctor consultations, iCHF has helped shift members away from reliance on out-of-pocket payments. However, certain limitations remain, and ongoing efforts are needed to ensure that health insurance schemes like iCHF continue to offer comprehensive and accessible healthcare solutions, especially for vulnerable populations.

5.5.2 Affordable with wider application of the scheme.

The study findings demonstrate that the iCHF is perceived as affordable and is widely accepted across all government health facilities in the region, functioning within the referral system. SHG members discussed and appraised the cost-effectiveness of iCHF, highlighting that the annual fee for the scheme is significantly lower than the out-of-pocket expenses they would otherwise incur if they paid for healthcare services directly. This recognition of the financial advantage of iCHF enrollment reflects the growing acceptance of the scheme among members, who understand the long-term savings it offers compared to paying for health services on a per-visit basis. The affordability of the scheme thus plays a crucial role

in encouraging participation and ensuring that health insurance is accessible to a wider population.

This finding is consistent with the literature that emphasizes the cost-saving benefits of community-based health insurance schemes. According to (31,35), community health insurance models like iCHF offer a more manageable payment structure, where the cost of an annual premium is spread out over time, making it easier for households to budget for healthcare. This contrasts with the financial burden of paying large sums for healthcare services all at once, which can be prohibitive for low-income families. The study's findings align with these observations, (49,60) as SHG members recognize the economic benefits of paying a fixed annual fee that covers a wide range of services within the government health facilities, thus reducing the likelihood of catastrophic health expenditures.

The widespread acceptance and affordability of iCHF in the region have significant implications for health financing and policy design. Health planners and government officials should consider maintaining or even lowering the iCHF annual fees to ensure continued affordability, especially for low-income populations. Additionally, expanding the coverage of iCHF to include more services or integrating it with private health facilities could further enhance its value and acceptance. Public awareness campaigns emphasizing the cost-saving advantages of enrolling in iCHF could also increase participation, as the long-term financial benefits of the scheme become more widely recognized.

While the affordability and acceptance of iCHF were highlighted in this study, future research could investigate whether similar perceptions exist in other regions or among different population groups. There may be geographic or socioeconomic variations in how the cost of iCHF is perceived, especially in areas where access to healthcare facilities is limited. Moreover, further studies could examine how the referral system under iCHF impacts the quality of care and whether members face any delays or challenges when seeking care at different levels of the healthcare system.

In conclusion, the affordability of the iCHF scheme and its acceptance across all government health facilities in the region have been recognized and appreciated by SHG members. The

cost-effectiveness of paying an annual fee compared to out-of-pocket expenses for healthcare services makes iCHF an attractive option for many, contributing to its growing popularity and acceptance. Ensuring that iCHF remains affordable and accessible will be key to maintaining its role as a sustainable health financing mechanism that provides financial protection and increases healthcare access for vulnerable populations.

CHAPTER SIX:

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

Based on the findings of this study the SHGs have an influence on individual enrollment in iCHF. Because SHGs enable its members to raise household income and prioritization, create opportunities for learning and growth, availability of alternative solutions at times of financial crisis, and pay through loans. The SHGs are viewed as the sustainable way of facilitating members to pay for the iCHF premiums where the use sharing out period is viewed as the right time for enhancing sustainability. Loans taken to repay the annual iCHF fee are not a sustainable mechanism for paying for iCHF to low-income households due to a lack of assurance to pay back the loans. Several perceptions on the iCHF scheme from the supported household view the scheme were presented including increased assurance of health services with limitations, affordable and applied all over the country scheme, and areas for the iCHF scheme improvement to attract and retain more beneficiaries to pay for the scheme.

Hence based on the findings above from this study, ensuring individuals are enrolled in the iCHF, the use of the SHG is the right platform which enable individual enrollment in the iCHF scheme. The emphasis should be made during sharing out process where members whocul be encouraged to pay iCHF fee during this time. This is due to the revealed findings that taking loan from the SHG for the annial iCHF fee payment is not a sustainable way. Moreover, there is positive perception from the members on the use of the iCHF since it provides assurance on access to health services with affordable cost.

6.1.Recommendation

Based on the study findings, the following are recommended

6.1.1 Recommendation of the study

1. The findings sharing out process is a sustainable way of enhancing capacity to pay for iCHF. The iCHF Enrollment Officers and stakeholders supporting those in need should use the SHGs as an entry point to sensitize individual enrollment in the iCHF

scheme through mobilizing the supported individual to join the SHGs and those who are in SHGs should be sensitized to pay for the iCHF annual fee.

2. The findings show that iCHF requires further improvement hence the iCHF coordinators should engage the community in the improvement of the Community-Based Fund package to increase the ownership and commitment of the community in the utilization of the services. This can be achieved using the existing SHGs with members enrolled in iCHF scheme.
3. The findings show that upon seeking health services most of the members fail to access services due to limitation of services in the scheme. To improve this the Enrollement officers should create awareness to the newly registered members on the services covered by the scheme and services not covered. This can be achieved through development of the fliers' mentioning services covered by the scheme to avoid over-expectations.
4. Given the different level of economy among community members and ability top pay for the iCHF, the policy makers should introduce tiered premium systems based on income levels, where wealthier members contribute more while ensuring subsidies for the most vulnerable**.**

6.1.2 Recommendation for future research

The study was conducted in a small geographical area in an urban setting. A future similar study can be conducted in other regions of the country covering the rural areas covering the supported individual with iCHF and linked to the SHGs.

References

1. Justice S. Self Help Groups (SHGs) What are SHGs ? Need for SHGs. 2021;(April):1–7.
2. Atieno P. Self Help Groups and Household Asset Acquisition and Income among Women Group Members in Kisumu East Sub County, Kenya. J Educ Pract [Internet]. 2017;8(3):21–7. Available from: https://eric.ed.gov/?id=EJ1131531
3. Schieber G, Baeza C, Kress D, Maier M. Chapter 12. Financing Health Systems in the 21st Century. Dis Control Priorities Dev Ctries (2nd Ed. 2006;225–42.
4. Tanzania Health Financing Policy Notes _ The Role of Complementary Financing Mechanisms in Tanzania's Health Finance Architecture.
5. Preker A, Carrin G. Health Financing for Poor People - Resource Mobilisation and Risk Sharing. Health Financing for Poor People. 2004.
6. Bantie GM, Woya AA, Zewdie BM. Community-Based Health Insurance and Associated Factors in North-Western Ethiopia. The Case of Bahir Dar City. Int J Gen Med [Internet]. 2020 Nov;Volume 13:1207–17. Available from: https://www.dovepress.com/community-based-health-insurance-and-associated-factors-in-north-weste-peer-reviewed-article-IJGM
7. Ekman B. Community-based health insurance in low-income countries: A systematic review of the evidence. Vol. 19, Health Policy and Planning. 2004.
8. Ekman B. Community-based health insurance in low-income countries: A systematic review of the evidence. Health Policy Plan. 2004;19(5):249–70.
9. Donfouet HPP, Makaudze E, Mahieu PA, Malin E. The determinants of the willingness-to-pay for community-based prepayment scheme in rural Cameroon. Int J Health Care Finance Econ [Internet]. 2011 Sep 28;11(3):209–20. Available from: http://link.springer.com/10.1007/s10754-011-9097-3

10. United Republic of Tanzania Ministry of Health, Community Development, Gender, Elderly and Children Health Sector Strategic Plan Leaving No One Behind. 2021.

11. COMMUNITY PERCEPTIONS ON THE USE OF TRADITIONAL MEDICINES FOR MANAGEMENT OF COVID-19 IN ILALA , DAR ES SALAAM , TANZANIA GETRUDE FRANK MWANGAMILO (BSc ESM) Master of Public Health of Muhimbili University of Health and Allied Sciences October , 2021. 2021;

12. Piatti-Fünfkirchen M, Ally M. Tanzania Health Sector Public Expenditure Review 2020. Tanzania Health Sector Public Expenditure Review 2020. 2020.

13. Ngowi AF, Nuru S. Determinants of enrollment in the Improved Community Health Fund among household members in Manyara Region, Tanzania. Tanzan J Health Res. 2023;24(2):97–106.

14. Kagaigai A, Anaeli A, Mori AT, Grepperud S. Do household perceptions influence enrolment decisions into community-based health insurance schemes in Tanzania? BMC Health Serv Res. 2021 Dec 1;21(1).

15. Demissie B, Gutema Negeri K. Effect of Community-Based Health Insurance on Utilization of Outpatient Health Care Services in Southern Ethiopia: A Comparative Cross-Sectional Study . Risk Manag Healthc Policy [Internet]. 2020 Feb;Volume 13:141–53. Available from: https://www.dovepress.com/effect-of-community-based-health-insurance-on-utilization-of-outpatien-peer-reviewed-article-RMHP

16. Los UMDECDE, Amani PJ, Hurtig AK, Frumence G, Kiwara AD, Goicolea I, et al. Tanzania Health Care System. Science (80-) [Internet]. 2021;2(1):31–6. Available from: http://search.ebscohost.com/login.aspx?direct=true&db=lah&AN=20043123361&site=ehost-live%5Cnemail: j_msuya@yahoo.com%5CJohannes.Jutting@oecd.org%5Ca.asfaw@uni-bonn.de

17. Johansen AS, Vracko P, West R. The evolution of community-based primary health

care, Slovenia. Vol. 98, Bulletin of the World Health Organization. World Health Organization; 2020. p. 353–9.

18. Mirach TH, Demissie GD, Biks GA. Determinants of community-based health insurance implementation in west Gojjam zone, Northwest Ethiopia: A community based cross sectional study design. BMC Health Serv Res. 2019;19(1).

19. Chanie MG, Ewunetie GE. Determinants of enrollment in community based health insurance among Households in Tach-Armachiho Woreda, North Gondar, Ethiopia, 2019. Ehtesham HS, editor. PLoS One [Internet]. 2020 Aug 31;15(8):e0236027. Available from: https://dx.plos.org/10.1371/journal.pone.0236027

20. Minyihun A, Gebregziabher MG, Gelaw YA. Willingness to pay for community-based health insurance and associated factors among rural households of Bugna District, Northeast Ethiopia. BMC Res Notes. 2019;12(1).

21. Zeller M, Meyer RL. The Triangle of Microfinance: Financial Sustainability, Outreach, and Impact. Vol. 30, European Review of Agriculture Economics. 2002.

22. Kasonso AD, Chingonikaya EE, Sikira AN. Community attitude towards Community Health Fund on Health Security in Kalambo District, Rukwa Region, Tanzania. J Public Adm Gov. 2020 Jun 18;10(2):311.

23. Ndomba T, Maluka S. Uptake of community health fund: why is Mtwara District lagging behind? J Glob Heal Sci. 2019;1(2).

24. Kwezi HA, Mselle LT, Leshabari S, Hanson C, Pembe AB. How communication can help women who experience a maternal near-miss: A qualitative study from Tanzania. BMJ Open. 2021;11(11):1–7.

25. Lee HE, Veliz PT, Maffioli EM, Munro-Kramer ML, Sakala I, Chiboola NM, et al. The role of Savings and Internal Lending Communities (SILCs) in improving community-level household wealth, financial preparedness for birth, and utilization of reproductive health services in rural Zambia: a secondary analysis. BMC Public

Health. 2022 Dec 1;22(1).

26. Kakiziba DM. USAID Kizazi Kipya Project Final Programmatic Report. 2021; Available from: https://pdf.usaid.gov/pdf_docs/PA00Z3PX.pdf

27. Raza WA, Van de Poel E, Panda P, Dror D, Bedi A. Healthcare seeking behaviour among self-help group households in Rural Bihar and Uttar Pradesh, India. BMC Health Serv Res [Internet]. 2015 Dec 4;16(1):1. Available from: http://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-015-1254-9

28. Subedi KR. Determining the Sample in Qualitative Research. Sch J. 2021;4(December):1–13.

29. Guimarães L, Navarro S, Lievens T. Trends in Sub-Saharan Africa. 2012;(June).

30. World Health Organization. Strategy of Health Care Financing - Asia. 2012;

31. Kakama AA, Namyalo PK, Basaza RK. Feasibility and desirability of scaling up Community-based Health Insurance (CBHI) in rural communities in Uganda: lessons from Kisiizi Hospital CBHI scheme. BMC Health Serv Res. 2020 Jul 17;20(1).

32. Demissie GD, Atnafu A. Barriers and facilitators of community-based health insurance membership in rural amhara region, northwest ethiopia: A qualitative study. Clin Outcomes Res. 2021;13:343–8.

33. Komba F, Gasto F. … and Patient Factors Facilitating the Implementation of Isoniazid Preventive Therapy for People living with HIV attending Care and Treatment Centres in Songea …. Tanzania J Dev Stud [Internet]. 2021; Available from: https://journals.udsm.ac.tz/index.php/tjds/article/view/3921%0Ahttps://journals.udsm.ac.tz/index.php/tjds/article/download/3921/3576

34. Durizzo K, Harttgen K, Tediosi F, Sahu M, Kuwawenaruwa A, Salari P, et al. Toward mandatory health insurance in low-income countries? An analysis of claims data in Tanzania. Heal Econ (United Kingdom). 2022 Oct 1;31(10):2187–207.

35. Desalegn M. Determinants of Enrolment in Community Based Health Insurance program among households in East Wollega Zone , west Ethiopia : Unmatched Case-Control Study. 2022;

36. Akweongo P, Voetagbe E, Tediosi F, Gadeka DD, Salari P, Aikins M. Community perceptions of enrolment of indigents into the National Health Insurance Scheme in Ghana: a case study of the Livelihood Empowerment against Poverty Programme. Glob Heal Res Policy [Internet]. 2022 Dec 28;7(1):4. Available from: https://ghrp.biomedcentral.com/articles/10.1186/s41256-022-00238-2

37. Yunus NA, olde Hartman T, Lucassen P, Barton C, Russell G, Altun A, et al. Reporting of the Translation Process in Qualitative Health Research: A Neglected Importance. Int J Qual Methods. 2022;21:1–6.

38. Cabot Venton, C., Prillaman, SAH., & Kim J. Building Resilience Through Self Help Groups: Evidence Review. Build Resil Through Self Help Groups Evid Rev [Internet]. 2021;(January):1–42. Available from: https://seepnetwork.org/files/galleries/STC_REAL_BuildingResilienceSelfHelpGroups_final_web_0.pdf

39. Johansen AS, Vracko P, West R. The evolution of community-based primary health care, Slovenia. Vol. 98, Bulletin of the World Health Organization. 2020.

40. Shigute Z, Mebratie AD, Sparrow R, Alemu G, Bedi AS. The effect of ethiopia's community-based health insurance scheme on revenues and quality of care. Int J Environ Res Public Health. 2020;17(22).

41. Nshakira-Rukundo E, Mussa EC, Gerber N, von Braun J. Impact of voluntary community-based health insurance on child stunting: Evidence from rural Uganda. Soc Sci Med. 2020;245.

42. Sheffel A, Heidkamp R, Mpembeni R, Bujari P, Gupta J, Niyeha D, et al. Understanding client and provider perspectives of antenatal care service quality: A

qualitative multi-method study from Tanzania. J Glob Health. 2019;9(1).

43. Chingono R, Mebrahtu H, Mupambireyi Z, Simms V, Weiss HA, Ndlovu P, et al. Evaluating the effectiveness of a multi-component intervention on early childhood development in paediatric HIV care and treatment programmes: A randomised controlled trial. BMC Pediatr. 2018;18(1).

44. Wiljer D, Shi J, Lo B, Sanches M, Hollenberg E, Johnson A, et al. Effects of a Mobile and Web App (Thought Spot) on Mental Health Help-Seeking among College and University Students: Randomized Controlled Trial. J Med Internet Res. 2020;22(10).

45. Elia L. Exploring lived experiences of teenage pregnancy and parenting among school dropouts in Tanganyika district in Katavi. Pap Knowl Towar a Media Hist Doc. 2020;

46. Mselle G, Nsanya P, Konlan KD, Lee Y, Ryu J, Kang S. Factors Associated with the Implementation of an Improved Community Health Fund in the Ubungo Municipality Area, Dar es Salaam Region, Tanzania. Int J Environ Res Public Health. 2022 May 1;19(9).

47. Abraham E, Gray C, Fagbamigbe A, Tediosi F, Otesinky B, Haafkens J, et al. Barriers and facilitators to health insurance enrolment among people working in the informal sector in Morogoro, Tanzania. AAS Open Res [Internet]. 2021 Sep 1;4:45. Available from: https://aasopenresearch.org/articles/4-45/v1

48. Jay S, Winterburn M, Choudhary R, Jha K, Sah AK, O'Connell BH, et al. From social curse to social cure: A self- help group community intervention for people affected by leprosy in Nepal. J Community Appl Soc Psychol [Internet]. 2021 May 22;31(3):276–87. Available from: https://onlinelibrary.wiley.com/doi/10.1002/casp.2510

49. Kigume R, Maluka S. The failure of community-based health insurance schemes in

Tanzania: opening the black box of the implementation process. BMC Health Serv Res. 2021 Jul 3;21(1):646.

50. Tungu M, Amani PJ, Hurtig AK, Dennis Kiwara A, Mwangu M, Lindholm L, et al. Does health insurance contribute to improved utilization of health care services for the elderly in rural Tanzania? A cross-sectional study. Glob Health Action. 2020;13(1).

51. The WHO Tanzania Investment Case for 2020-2021.

52. Lyimo MA, Mosha IH. Reasons for delay in seeking treatment among women with obstetric fistula in Tanzania: A qualitative study. BMC Womens Health. 2019;19(1):1–8.

53. Fadlallah R, El-Jardali F, Hemadi N, Morsi RZ, Abou Samra CA, Ahmad A, et al. Barriers and facilitators to implementation, uptake and sustainability of community-based health insurance schemes in low- and middle-income countries: A systematic review. Int J Equity Health. 2018 Jan 29;17(1).

54. Ahishakiye J, Bouwman L, Brouwer I, Matsiko E, Koelen M. Stressors and coping strategies of infant and young child feeding practices in Rwanda: Perceptions of mothers, fathers, grandmothers and community health workers. Ann Nutr Metab. 2017;71.

55. Van Minh H, Pocock NS, Chaiyakunapruk N, Chhorvann C, Duc HA, Hanvoravongchai P, et al. Progress toward universal health coverage in ASEAN. Glob Health Action. 2014;7(1).

56. Ahishakiye J, Bouwman L, Brouwer ID, Matsiko E, Armar-Klemesu M, Koelen M. Challenges and responses to infant and young child feeding in rural Rwanda: A qualitative study. J Heal Popul Nutr. 2019;38(1).

57. Osei Afriyie D, Hooley B, Mhalu G, Tediosi F, Mtenga SM. Governance factors that affect the implementation of health financing reforms in Tanzania: an exploratory

study of stakeholders' perspectives. BMJ Glob Heal [Internet]. 2021 Aug 19;6(8):e005964. Available from: https://gh.bmj.com/lookup/doi/10.1136/bmjgh-2021-005964

58. Nshakira-Rukundo E, Mussa EC, Nshakira N, Gerber N, Von Braun J. Determinants of enrolment and renewing of community-based health insurance in households with under-5 children in rural South-Western Uganda. Int J Heal Policy Manag. 2019;8(10).

59. Modest AR, Ngowi AF, Katalambula L. Enrollment Status and Determinants of Improved Community Health Fund Among Households in Dodoma Tanzania [Internet]. Vol. 6, International Journal of Innovative Science and Research Technology. 2021. Available from: www.ijisrt.com807

60. Tiwari R, Online HKEE, 2020 undefined. the Study of the Contribution of Self-Help Groups in Women Empowerment. Ilkogretim-OnlineOrg [Internet]. 2020;19(4):3913–7. Available from: https://ilkogretim-online.org/index.php?mno=81286

61. Ajuaye A, Verbrugge B, Van Ongevalle J, Develtere P. Understanding the limitations of "quasi- mandatory" approaches to enrolment in community- based health insurance: Empirical evidence from Tanzania. Int J Health Plann Manage [Internet]. 2019 Oct 26;34(4):1304–18. Available from: https://onlinelibrary.wiley.com/doi/10.1002/hpm.2795

62. Carlén K, Kylberg E. An intervention of sustainable weight change: Influence of self-help group and expectations. Heal Expect. 2021;24(4).

63. Clarke J, Ho E, Javaid K, Biscaye P, Reynolds T, Anderson CL. Evans School Policy Analysis and Research (EPAR). 2015;(309):1–95.

64. Panda P, Chakraborty A, Dror DM, Bedi AS. Enrolment in community-based health insurance schemes in rural Bihar and Uttar Pradesh, India. Health Policy Plan

[Internet]. 2014 Dec;29(8):960–74. Available from: https://academic.oup.com/heapol/article-lookup/doi/10.1093/heapol/czt077

65. Dror DM, Majumdar A, Chakraborty A. The effect of consensus on demand for voluntary micro health insurance in rural India. Risk Manag Healthc Policy. 2018;11.

66. Eneh AO. Access to Primary Care in Pennsylvanian Rural Townships. ProQuest Dissertations and Theses. 2018.

67. Taddesse G, Atnafu DD, Ketemaw A, Alemu Y. Determinants of enrollment decision in the community-based health insurance , North West Ethiopia : a case-control study. 2020;1:1–9.

68. Ban R, Gilligan MJ, Rieger M. Self-help groups, savings and social capital: Evidence from a field experiment in Cambodia. J Econ Behav Organ. 2020;180.

69. Rashid I. User Fee Incarease in Improved Community Health Fund. 2017;

70. Abraham E, Gray C, Fagbamigbe A, Tediosi F, Otesinky B, Haafkens J, et al. Barriers and facilitators to health insurance enrolment among people working in the informal sector in Morogoro, Tanzania. AAS Open Res. 2021;4:45.

71. Kabonga I, Zvokuomba K. Household Participation in Internal Saving and Lending Schemes: Impact on Orphans and Vulnerable Children in Chegutu, Zimbabwe. Commonw Youth Dev [Internet]. 2021 Jul 27;18(1). Available from: https://unisapressjournals.co.za/index.php/CYD/article/view/8668

72. AN EXPLORATION OF THE FACTORS INFLUENCING ENROLMENT INTO COMMUNITY HEALTH FUND: A CASE OF SONGEA MUNICIPALITY (TANZANIA). 2017.

73. Qualitative C. Qualitative Research Designs. :171–84.

74. the United Republic of Tanzania Prime Minister ’ S Office Regional Administration

and Local Government Dodoma Municipal Council Strategic. 2021;

75. Majumdar A. Thematic Analysis in Qualitative Research. In: Research Anthology on Innovative Research Methodologies and Utilization Across Multiple Disciplines [Internet]. IGI Global; 2022. p. 604–22. Available from: http://services.igi-global.com/resolvedoi/resolve.aspx?doi=10.4018/978-1-6684-3881-7.ch031

76. Nowell LS, Norris JM, White DE, Moules NJ. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. Int J Qual Methods. 2017 Sep 28;16(1).

77. Ibrahim M. THEMATIC ANALYSIS: A CRITICAL REVIEW OF ITS PROCESS AND EVALUATION. Vol. 1, West East Journal of Social Sciences-December. 2012.

78. Belotto M. Data Analysis Methods for Qualitative Research: Managing the Challenges of Coding, Interrater Reliability, and Thematic Analysis. Qual Rep [Internet]. 2018 Nov 4;23(11). Available from: https://nsuworks.nova.edu/tqr/vol23/iss11/2/

79. Obrist B, Dillip A, Kalolo A, Mayumana IM, Rutishauser M, Simon VT. Savings Groups for Social Health Protection: A Social Resilience Study in Rural Tanzania. Diseases. 2022 Sep 9;10(3):63.

80. Hyunanda VF, Ramírez JP, López-Martínez G, Meseguer-Sánchez V. State ibuism and women's empowerment in indonesia: Governmentality and political subjectification of chinese benteng women. Sustain. 2021;13(6).

81. Kalolo A, Gautier L, Radermacher R, Srivastava S, Meshack M, De Allegri M. Factors influencing variation in implementation outcomes of the redesigned community health fund in the Dodoma region of Tanzania: a mixed-methods study. BMC Public Health [Internet]. 2021 Dec 2;21(1):1. Available from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-10013-y

82. Adeneye A, Musa A, Afocha E, Adewale B, Ezeugwu S, Yisau J, et al. Perception of

community-based health insurance scheme in Ogun State, Nigeria. Glob J Infect Dis Clin Res [Internet]. 2021 Feb 4;001–12. Available from: https://www.peertechzpublications.com/articles/GJIDCR-7-139.php

APPENDICES

Appendix A: INFORMED CONSENT (ENGLISH VERSION).

ID Number_____

Introduction

Hello! My name is **Lazaro Ernest**, a student of Master of Public Health at Muhimbili University of Health and Allied Sciences (MUHAS). On behalf of Muhimbili University of Health and Allied Sciences (MUHAS), I am conducting research on **Role of the SHGs in supporting individual enrollment on iCHF in Tanzania – Case Study of Dodoma City Council.**

Purpose of the study

SHGs have a good platform for community mobilization and sensitization toward access to quality services, Tanzania has got a high formation of SHGs yet with low enrollment in iCHF which increases the risk of the community from accessing health services.

Participation

I would like you to participate in this study. You have been chosen to participate because I think you can provide valuable information related to role of the SHGs in supporting individual enrollment in to iCHF in Dodoma City Council. If you consent to participate in this study, you will be personally interviewed by a researcher or participate in an In-depth interview for about 45-60 minutes.

Benefits

If you agree to participate, it will be for the benefits of the wider community including yourself because the findings generated from the study can be used to make changes that foster more accessibility to health services by the poor part of the community.

Risks

I do not anticipate that any harm will occur to you because of your participation in this study. The information requested is by no means going to affect any human being or generate interest with negative consequences.

Confidentiality

All responses will be kept confidential and will be used only for the purpose of this study and will be private. No identification information will be collected from you during the interview, except your age, sex and education level.

Right to refuse or withdraw

Participation to this study is voluntary. You may decide to participate or not to. No measure will be taken upon your refusal to participate if you decided not to. You are free not to answer any question or any part of the discussion.

Whom to Contact

In case of any question or query concerning this study, please contact the Principal Researcher Lazaro Ernest - 0763436702 If you have any question about your rights as a participant you may contact Dr. Nahya Masoud, Acting **Director of Research Publications, and Innovation (DRPI)** MUHAS. P.O. Box 65001, Dar es Salaam-Tanzania, Tel +2552150302-6)

I ……... have read the contents of this form and understand and my questions have been adequately answered. I agree to participate in this study.

Signature of participant…… Date…….

Signature of research assistant…… …. Date……..

Appendix B; FOMU YA RIDHAA YA KUSHIRIKI KATIKA UTAFITI

(KISWAHILI)

Namba ya Utambulisho_____

Utambulisho

Habari, naitwa Lazaro Ernest ni mwanafunzi wa shahada ya uzamili ya Afya ya Jamii katika chuo Kikuu cha Afya na Sayansi ya Jamii Muhimbili. Katika sehemu ya mafunzo yangu ninafanya utafiti wenye kichwa cha habari '' ***Mchango wa vikundi vya kusaidiana kwenye Jamii katika kusaidia mtu kujiunga na bima ya afya iliyoboreshwa***

Vikundi vya kusaidia kwenye jamii vimeonesha kufanikiwa sana kuhamasisha jamii katika shughuli mbali mbali za maendeleo. Watu wengi wamekuwa wakipewa msaada wa bima za afya na kuhamasishwa kujiunga na vikudi vya kuweka na kuypoka ili wawe na uhakika wa kulipia tena bima zao baada ya mwaka kwisha. Utafiti huu unalenga kuangalia kama vikundi hivi vina mchango wowote kuhamisha watu kujiunga na bima ya afya.

Matokeo ya utafiti huu wa jukumu la vikundi vya kusaidiana vinasaidia watu kujiunga na mfuko wa bima ya afya ni muhimu kwa watunga sera na watoa maamuzi yanayotokana na uthibitisho wa kitafiti. Hivyo matokeo ya utafiti huu yanaweza kutumika kuimarisha mifumo hii au kufuta sera hii ya ongezeko la gharama za papo kwa papo.

Ushiriki

Ningependa ushiriki katika utafiti huu kwa kuwa ninahisi unaweza kutoa taarifa zitakazoweza kufanikisha utafiti huu juu ya ushirikishwaji wa jamii kwenye maamuzi ya ongezeko la gharama za matibabu za '*'papo kwa papo''* ulifanywa kwa lengo la kusukuma watu kujiunga na Mfuko wa Afya ya Jamii (CHF) na mbinu zinazotumiwa na jamii kumudu ongezeko hilo. Endapo utaridhia kushiriki utahojiwa/ au kupewa dodoso ujaze kwa muda wa dakika zisizozidi 15-20. Endapo unaridhia kushiriki katika utafiti huu, utafanya mjadala na mtafiti au pamoja na wenzako katika kundi la watu 8 hadi 10 kwa takriban dakika 45 hadi

60. Utaulizwa maswali juu ya ufahamu wako kuhusu ushirikishwaji wa jamii kwenye maamuzi ya ongezeko la gharama za matibabu za ‘*’papo kwa papo’’* ulifanywa kwa lengo la kusukuma watu kujiunga na Mfuko wa Afya ya Jamii (CHF) na mbinu zinazotumiwa na jamii kumudu ongezeko hilo.

Faida

Endapo utaridhia kushiriki katika utafiti huu itakuwa ni kwa manufaa ya jamii nzima ikijumuisha na wewe mwenyewe kwasababu matokeo yake yanaweza kutumika kufanya mabadiliko yatakayoweza kuongeza uwezo wa kaya maskini kutumia/kupata huduma za afya.

Athari

Sitarajii mshiriki kupata madhara ya aina yeyote kwa kuamua kushiriki kwake. Ingawa baadhi ya maswali ni binafsi, lakini matokeo ya utafiri huu yatakuwa ya jumla kwa washiriki wote wa wilaya Kondoa. Taarifa utakazotoa kwa namna yoyote ile haziwezi kuathiri mtu yeyote.

Usiri

Taarifa zitakazokusanywa ni siri na hakuna mtu yeyote atakayeambiwa ulichosema bali zitatumika kwa madhumuni ya utafiti huu tu. Hapatakuwa na utambulisho wa mshiriki kwenye dodoso, isipokuwa mwaka wa kuzaliwa, jinsi na kiwango cha elimu tu.

Haki ya kukubali au kukataa kushiriki

Ushiriki katika utafiti huu ni wa hiari. Unaweza kukubali kushiriki au kukataa. Hapatakuwa na adhabu yeyote itakayochukuliwa dhidi yako kama utaamua kukataa kushiriki. Pia jisikie huru kutokujibu swali ambalo hutapenda kulijibu

Mawasiliano

Kama uatahitaji ufafanuzi zaidi juu ya utafiti huu, usisite kuwasiliana na Mtafiti Mkuu ***Lazaro Ernest*** mwanafunzi wa shahada ya Uzamili ya Afya ya Jamii katika chuo cha Afya

na Sayansi ya Jamii, S. L. P 65001, Chuo kikuu cha Afya na Sayansi ya Jamii Mhimbili, Dar es Salaam au namba ya mkononi 0763436702 . Kama una swali juu ya stahili zako unaweza kuwasiliana na Dr. Nahya Masoud, ambaye ni **Kaimu Mkurugenzi Utafiti, Uchapaji na Ubunifu,** S. L. P 65001, Chuo kikuu cha Afya na Sayansi ya Jamii Mhimbili, Dar es Salaam au simu namba +2552150302-6.

Appendix C: IN-DEPTH INTERVIEW GUIDE FOR ICHF SUPPORTED SHG MEMBERS (ENGLISH VERSION)

This is an in-depth interview guide for exploring the contribution of Self-help groups (SHGs) on household enrolment in the iCHF.

Preamble information.

i. When going to the data collection site ensure the availability of at least two pens, an audio recorder, a notebook, and an interview guide.
ii. When meeting with a participant, great the participant and get introduced to the participant clearly.
iii. Tell the participant the purpose of your visit including detailing the purpose of the research time to be consumed and means of recordings that will be used and ask for his/her time.
iv. Once has agreed, provide, or read a consent form to the participant and let the participant sign.

DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS.

Participant's number.	Key activity engaged with;
Age	Marital status
Sex	
Level of Education	Family size (number of adult and children)

A. Supported individuals with annual iCHF subscription.

1. What is your enrollment status in iCHF?

Probes.

i. If the participant is active; how did you manage to repay your iCHF card?
ii. If not active; why didn't you pay for your card?

2. What happened you to being supported with iCHF annual subscription payment?

   Probes.

   i. Why did you accept to be supported with iCHF annual payment?
   ii. How was the process of getting the card?
   iii. How did you perceive the support provided to you?
   iv. How did the household members perceive the support provided?

3. What benefit have you gotten since you have been enrolled in iCHF?

   Probes.

   i. What has changed before having iCHF and after having iCHF?
   ii. What are the learnings acquired since you have been enrolled in the iCHF?
   iii. How was your experience being served through iCHF?

4. Why did you get enrolled in a Self-help group taking in to consideration the access to iCHF scheme?

   Probes.

   i. What influenced you to be in the self-help group while have the iCHF card?
   ii. How your enrollment into a Self-help group changed your life on accessing iCHF scheme?
   iii. How does your presence in the self-help group affect your access to health services?

B. Access to loans.

   1. What factors push/influence you to take a loan?

   Probes.

   i. Among the mentioned factors which will you give high priority and why?

ii. How do you consider iCHF payment while taking a loan?

2. How has loan facilitated you or your family members in accessing health services?

Probes:

i. How was loan used to pay for iCHF scheme?

ii. At what time/situation did you take loan to pay for iCHF?

iii. How is loan used to pay for health services?

3. What are your views considering taking loan to pay for iCHF is a sustainable way of ensuring people are covered with CHF scheme?

Probes.

i. Why do you think loans can be used/not used as a sustainable way of ensuring people are covered by iCHF?

ii. How is loans taking sustainable and how is not in ensuring people are covered by iCHF?

iii. What can be done more to increase sustainability of iCHF enrollment?

C. Contribution during sharing-out process

1. What are your key priorities while sharing out in your group?

Probes:

i. Why do you/don't you prioritize health services during sharing out process?

ii. Why do you/don't you consider paying for iCHF card?

2. What are your views on the use of the sharing-out process as a means of paying annual iCHF fee?

Probes:

i. How can/cannot be used as a means of paying iCHF annual fee?

ii. What ways can be used to ensure sharing out process is used for paying iCHF scheme?

iii. Why do you think the sharing out process can facilitate iCHF enrollment?

D. Perceptions of the supported individuals

1. What is your perception on the iCHF services since you have been supported with annual fee payment?

Probes.

i. What relief have you got since you have been enrolled in to the iCHF scheme?

ii. What can be done to make iCHF better scheme?

2. How would you describe iCHF scheme services?

Probes.

i. How do you ensure your membership in iCHF?

ii. How can you encourage others to join iCHF?

3. What is your perception on the linking of supported individuals in groups to support/influence enrollment in iCHF?

Probes.

i. Why do you think groups can be/cannot be supportive on individual enrollement?

ii. How can the proposed actions be implemented?

4. What are the opportunities or obstacles on your enrollment in iCHF

Probes.

i. Why do you think the mentioned are opportunities or obstacles?

ii. How can they be used to increase enrolment and who is responsible?

iii. How can SHG help to solve the challenges?

iv. What action can be used to solve and addressed the shared challenges?

KIAMBATISHO D: MWONGOZO WA MAJADILIANO NA WANANIKUNDI WALIOWEZESHWA KUJIUNGA NA MFUKO WA BIMA WA ICHF (KWA KISWAHILI)

Huu ni mwongo wa majalidiano wenye lengo la kuangalia mchango wa vikundi vya kusaidiana katika kuwezesha kaya zilizolipiwa bima ya afya (iCHF) kuendelea kulipa ada ya kila mwaka.

Maelezo ya utangulizi;

i. Hakikisha wakati wa kwenda kukusanya taarifa unavitendea kazi vya kutasha ambavyo ni kalamu zisizopungua mbili, kinasa sauti, dafatari/notebook, mwongozo wa majadiliano.
ii. Unapokutana na walengwa, wasalimie na jitambulishe kwa ufasaha wakufahamu,
iii. Waeleze walengwa dhumuni la kuwatembelea, malengo ya utafiti unaofanya ni nini, muda utakao tumika kwenye mahojiano, na njia ziatakazotumika kuchukua taarifa hizo na uombe wakupe muda.
iv. Baada ya kukusikiliza na kukubali kukupa muda wa mahojiano, wape na uwasomee fomu ya ridhaa na mwombe mlengwa aweke sahihi yake kwenye fomu hiyo.

DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS.

Namba ya Mhojiwa;	Shughuli ya uzalishaji mali;
Umri;	Hali ya ndoa
Jinsi;	Ukubwa wa Familia (idadi ya watu na watoto)
Kiwango cha Elimu	

A. Watu waliopewa mdaada wa kulipiwa bima ya afy aliyoboreshwa kwa mwaka mmoja

1. Hali yako ya usajili kwenye bima ya afya iliyoboreshwa ikoje?

   Chunguza;

   iii. Kama mhojiwa na mwanachama hai wa bima ya afya iliyoboresha, ni kwa jinsi gani aliweza kulipia ada yam waka ya bima ya afya?
   iv. Kama mhojiwa si mwanachama hai wa bima ya afya iliyoborehswa, kwanini hukulipia teana bima ya afya iliyoboreshwa?

2. Nini kilisababisha ukapewa msaada wa malipo ya mwaka ya bima ya afya iliyoboreshwa?

Chunguza;

v. Kwanini ulikubali kulipiwa malipo yam waka ya bima ya afya iliyoboreshwa?

vi. Mchakato wa kupata bima ya afaya iliyoboreshwa ulikuwaje?

vii. Ni nini maoni yako kuhusu msaada wa malipo wa bima ya afya iliyoboreshwa uliopewa?

viii. Wana kwaya wengina wanamaoni gani kuhusu malipo ya mwaka ya bima ya afya iliyoboreshwa?

3. Ni faida gani umeipata tangu uliposajiliwa kwenye bima ya afaya iliyoboreshwa?

Chunguza;

iv. Ni nini kimebadilika ukilinganisha kabla ya kuwa na bima ya afya iliyoboreshwa na baada ya kuwa na bima?

v. Ni mafunzo gani uliyo yapata tangu ulipojiunga na bima ya afaya iliyoboreshwa?

vi. Ni nini maoni yako kupata hudema ya afaya kupitia bima ya afya iliyoboreshwa?

4. Kwanini ulijiung na vikundi vya kusaidiana vya kijamii?

Chunguza;

iv. Ni nini kilikuhamasisha kuwa mwanachama wa vikundi vya kusaidiana vya kijamii?

v. Ni kwa jinsi gani kujiunga na vikundi vya kusaidiana kumebadilisha maisha yako?

vi. Ni kwajinsi gani uwepo wako kwenye vikundi vya kusaidiana kumeathiri upataji wa huduma za afya?

B. Upatikanaji wa mikopo;

1. Ni sababu gani huwa inakusukuma kupata/kuchukua mkopo?

Chunguza;

iii. Ni sababu ipi huwa unaipa kipaumbele zaidi katika sababu ulizozitaja na kwanini?

iv. Huwa unawaza nini kuhusu kulipia biama ya afaya iliyoboreshwa wakati wa kuchukua mkopo?

2. Ni kwajinsi gani mkopo umewezesha wewe au familia yako kupata huduma ya afya?

Chunguza:

iv. Ni kwajisi gani mkopo ulitumika kulipia bima ya afya iliyoboreshwa?

v. Ni wakati gani/katika hali gani ulichukua mkopo kulipia bima ya afya iliyoborehswa?

vi. Ni kwa jinsi gani unatumia bima ya afya iliyoboreshwa kulipia huduma za afya?

3. Ni nini maoni yako kuhusu kuchukua mkopo kwajili ya kulipia bima ya afya iliyoboreshwa kama njia endelevu ya ulipiaji wa bima ya afya

Chunguza:

iv. Kwanini unawaza kuwa kuchukua mkopo ni njia endelevu ya kulipia bima ya afya?

v. Kama siyo kwani siyo njia endelevu ya kulipia bima ya faya iliyoboreshwa?

vi. Ni nini kinaweza kufanyika zaidi kuweka uendelevu katika kulipia bima ya afya iliyoboreshwa?

C. Mchango wa kipindi cha kugawana katika upatikanaji wa bima ya afya.

1. Ni nini vipaumbele vyako wakati wa kugawana kwenye kikundi chenu cha kusaidiana?

Chunguza:

iii. Kwanini unaweka/hauweki kipaumbele masuala ya kupata huduma za afaya wakati wa kugawana kwenye Kikundi?

iv. Kwanini unafikiria/haufikirii kulipia bima ya afya iliyoboreshwa?

2. Ni nini maoni yako kutumia kipindi cha kuganwana kwenye kikundi kuwa njia endelevu ya kulipia bima ya afya iliyoboreshwa?

Chunguza:

iv. Ni kwajili gani hili linawezekana/ haliwezekani?

D. Mtazamo wa watu waliolipiwa bima ya afya iliyoboreshwa.

1. Ni nini uzoefu wako katika upatikanaji wa huduma za afya kwa njia ya bima ya afaya iliyoboreshwa tangu iliposaidiwa kulipia ada ya mwaka ya bima ya afya?

   Chunguza:

   iii. Ni unafuu gani ulioupata tangu ulipojiunga na bima ya afaya iliyoboreshwa?

   iv. Kwa uzoefu wako ni kitu gani kinaweza kuboreshwa zaidi kuvutia watu wengi zaidi kujiunga?

2. Unaweza kuielezea vipi bima ya afya iliyoboreshwa?

   Chunguza:

   iii. Ni kwa jinsi gani unahakisha unaendelea kuwa mwanachama wa bima ya afya iliyoboreshwa?

   iv. Je unaweza kuwashawishi wengine kujiunga na mfuko wa bima iliyoboreshwa?

   v. Ni kwajinsi gani unaweza kuwashawishi?

Appendix E: IN-DEPTH INTERVIEW GUIDE FOR SHG LEADERS (ENGLISH VERSION)

This is an in-depth interview guide for exploring the contribution of Self-help groups (SHGs) on household enrolment in the iCHF.

Preamble information.

i. When going to the data collection site ensure the availability of at least two pens, an audio recorder, a notebook, and an interview guide.
ii. When meeting with a participant, greet the participant and get introduced to the participant clearly.
iii. Tell the participant the purpose of your visit including detailing the purpose of the research time to be consumed and means of recordings that will be used and ask for his/her time.
iv. Once agreed, provide, or read a consent form to the participant and let the participant sign.

DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS.

Participant's number.	Key activity engaged with;
Age	Marital status
Sex	Family size (number of adult and children)
Level of Education	

A. Supported individuals with annual iCHF subscription.
   1. What is the status of individuals who were supported with iCHF annual enrollment?
      Probes.
      i. How do these SHGs facilitate/support issues related to access to health services?
   2. What are the key aspects/services that social fund does support to its members?
      Probes:
      i. How this social fund support individuals on the access to health services
      ii. At what situation this fund can support the individuals?
      iii. How does the fund support iCHF enrollment?

B. Access to loans.

1. What factors push/influence most of your group members to take a loan?

   Probes.

   i. Among the mentioned factors which is most common to most loan takers?

   ii. How do your group members consider iCHF payment while taking a loan?

2. How has loan facilitated the group members or their relatives in accessing health services?

   Probes:

   i. How was loan used to pay for iCHF scheme?

   iii. At what time/situation did members took loan to pay for iCHF?

3. What are your views considering taking loan to pay for iCHF as way of ensuring people are covered with CHF scheme?

   Probes:

   i. How can/cannot be used as a means of paying iCHF annual fee?

   ii. What ways can be used to ensure sharing out process is used for paying iCHF scheme?

   iii. Why do you think the sharing out process can facilitate iCHF enrollment?

C. Contribution during sharing-out process

1. What are the members' key priorities while sharing out in your group?

   Probes:

   i. Why do you/don't you prioritize health services during sharing out process?

   ii. Why do you/don't you consider paying for iCHF card?

2. What are your views on the use of the sharing-out process as a means of paying annual iCHF fee?

   Probes:

i. How can/cannot be used as a means of paying iCHF annual fee?

ii. What ways can be used to ensure sharing out process is used for paying iCHF scheme?

iii. Why do you think the sharing out process can facilitate iCHF enrollment?

D. Perceptions of the supported individuals

1. What are your views on the people has been supported with annual iCHF fee payment joining the SHGs?

Probes:

i. What values do SHGs can add to the supported individual on annual iCHF payment?

ii. How to make SHGs more supportive to the enrolled iCHF members?

2. How would you describe iCHF scheme?

Probes:

i. How do you ensure your membership in iCHF?

ii. How can you encourage others to join iCHF?

3. How to make groups more supportive in influencing enrollment in iCHF?

Probes:

i. Why do your thung groups can be/cannot be supportive on individual enrollment?

ii. How can the proposed actions be implemented?

4. What are the opportunities or obstacles on your enrollment in iCHF

Probes.

i. Why do you think the mentioned are opportunities or obstacles?

ii. How can they be used to increase enrolment and who is responsible?

KIAMBATISHO F: MWONGOZO WA MAJADILIANO VIONGOZI WA VIKUNDI VYA KUSAIDIANA (KWA KISWAHILI)

Huu ni mwongo wa majalidiano wenye lengo la kuangalia mchango wa vikundi vya kusaidiana katika kuwezesha kaya zilizolipiwa bima ya afya (iCHF) kuendelea kulipa ada ya kila mwaka.

Maelezo ya utangulizi;

i. Hakikisha wakati wa kwenda kukusanya taarifa unavitendea kazi vya kutasha ambavyo ni kalamu zisizopungua mbili, kinasa sauti, dafatari/notebook, mwongozo wa majadiliano.
ii. Unapokutana na walengwa, wasalimie na jitambulishe kwa ufasaha wakufahamu,
iii. Waeleze walengwa dhumuni la kuwatembelea, malengo ya utafiti unaofanya ni nini, muda utakao tumika kwenye mahojiano, na njia ziatakazotumika kuchukua taarifa hizo na uombe wakupe muda.
iv. Baada ya kukusikiliza na kukubali kukupa muda wa mahojiano, wape na uwasomee fomu ya ridhaa na mwombe mlengwa aweke sahihi yake kwenye fomu hiyo.

MAELEZO YA SIFA ZA ANAYEHOJIWA

Namba ya Mhojiwa;	Shughuli ya uzalishaji mali;
Umri;	Hali ya ndoa
Jinsi;	Ukubwa wa Familia (idadi ya watu na watoto)
Kiwango cha Elimu	

A. Watu waliopewa mdaada wa kulipiwa bima ya afy aliyoboreshwa kwa mwaka mmoja
   1. Hali ya watu waliopewa msaada wa kujiunga na bima ya afya iliyoboreshwa ikoje kwasasa ukulinganisha na wakati wanajiunga na vikundi vya kusaidiana?
      Chunguza;
      ii. Ni kwa jinsi gani vikundi vya kusaidiana ninawezesha/kusaidia masuala yahusuyo upatikanaji wa huduma za afya?
   2. Ni kipengele/huduma gani ambazo mfuko wa Jamii kwenye kikundi huwa unasaia na kwajinsi gani?

Chunguza:

iv. Ni kwa jinsi gani mfuko wa Jamii unawezesha wanachama kupata huduma za afya?

v. Katika hali gani mfuko huu wa Jamii huwa unasaidia watu?

vi. Ni kwajinsi gani mfuko wa Jamii unasaidia kusajili watu katika mfuko wa bima ya afya iliyoboreshwa?

B. Upatikanaji wa Mkopo;

1. Ni sababu zipi zinazosukuma/kuhamasishwa wanachama wengi wa kikundi chako kuchukua mkopo?

   Chunguza;

   iv. Katika sababu ulizotaja, ni sababu ipi ya kawaida kwa waanachama wengi wanaochukua mkopo?

   v. Ni kwa jinsi gani wanachama wako wanafikiria suala la kulipia bima ya afya uliyoboreshwa wakati wa kuchukua mkopo?

2. Kwa uelewa wako, ni kwa jinsi gani mkopo unawezesha wanakikundi au wanafamilia wao kupata huduma za afya?

   Chunguza:

   ii. Ni kwa jinsi gani mkopo huwa unatumika kulipia bima ya afya?

   vi. Ni wakati gani/katika gani wanachama wanachukua mkopo kwajili ya bima ya afya iliyoboreshwa?

3. Ni nini maoni yako kuhusu kufanya uchukuaji wa mkopo kama njia endelevu ya kuwezeshwa watu kulipia bima ya afya iliyoboreshwa?

   Chunguza:

   i. Kwani unafikiria inawezekana au haiwezekani kuwa njia ya endelevu ya kujiunga na bima ya afaya iliyoboreshwa?

   ii. Kwanini unafikiria kuwa ni njia endelevu au siyo njia endelevu ya kujiung na mfuko wa bima ya afya iliyoboreshwa?

   iii. Ni nini kinaweza kufanyika kufanya suala la kujiung na mfuko wa bima ya afya iliyoboreshwa kuwa endelevu?

C. Mchango wa kipindi cha kugawana katika upatikanaji wa bima ya afya.

1. Ni nini vipaumbele vyako wakati wa kugawana kwenye kikundi chenu cha kusaidiana?

   Chunguza:

   v. Kwanini unaweka/hauweki kipaumbele masuala ya kupata huduma za afaya wakati wa kugawana kwenye Kikundi?

   vi. Kwanini unafikiria/haufikirii kulipia bima ya afya iliyoboreshwa?

2. Ni nini maoni yako kutumia kipindi cha kuganwana kwenye kikundi kuwa njia endelevu ya kulipia bima ya afya iliyoboreshwa?

   Chunguza:

   iv. Ni kwajili gani hili linawezekana/ haliwezekani?

D. Mtazamo wa watu waliolipiwa bima ya afya iliyoboreshwa.

1. Ni nini maoni yako kuhusu watu wanaopewa msaada wa kulipia ada ya mwaka ya bima ya afya iliyoboreshwa kujiunga na vikundi vya kusaidiana?

   Chunguza:

   iii. Vikindi vya kusaidiana vinaongeza thamani gani kwa watu walipewa msaada wa kulipia ada yam waka ya bima iliyoboreshwa?

   iv. Ni jinsi gani tunweza kufanya vikundi vya kusaidiana kuwa wezeshi wa wanachama waliojiunga na bima ya afya iliyoboreshwa?

2. Unweza kuilezea vipi bima ya afya iliyoboreshwa?

   Chunguza:

   i. Ni kwa jinsi gani unahakisha unaendelea kuwa mwanachama wa bima ya afya iliyoboreshwa?

   v. Ni kwajinsi gani unaweza kuwashawishi wengine kujiunga na mfuko wa bima iliyoboreshwa?

   vi. Ni kwajinsi gani unaweza kuwashawishi?

3. Ni kwa jinsi gani tunaweza kufanya vikundi vya kusaidiana kuwa wezeshi zaidi katika kujiunga na bima ya afaya iliyoboreshwa?

   Chunguza:

iii. Ni kwajinsi gani mapednekezo/maoni yako yanaweza kufanyiwa kazi au kwajinzi gani haiwezekani?

iv. Ni nani mhusika mkuu zaidi katika hili na kwa jinsi gani?

4. Ni vishawishi/vizuizi vilivyopo kwenye utaratibu wa kujiunga na bima ya afya iliyoboreshwa?

   Chunguza;

   i. Ni jinsi gani vinaweza kutumika kama fursa kuboreshwa zaidi?

   ii. Kwanini unadhani ni fursa/vikwazo kwenye kujiunga bima ya afaya iliyoboreshwa?

Appendix G: IN-DEPTH INTERVIEW GUIDE FOR ENROLLEMENT OFFICERS (ENGLISH VERSION)

1. How do you enroll the supported households with annual CHF fee?

   Probes:

   i. What is a different mechanism used to enroll the supported household?

2. How do you ensure they are able to renew their cards?

   Probes:

   i. What support is provided to these individuals to ensure that are paying for annual fee?

   ii. What linkage do you have with those who support them?

3. What are the challenges on the renewal of iCHF cards in most of the individuals?

   Probes

   i. What are the common challenges pronounced by the members?

   ii.

4. What feedback do you get from the iCHF supported household with annual fee payment?

   Probes:

   i. How supported individuals satisfied with the services they get?

5. What are your views on linking the supported households to a SHGs as a mechanism of ensuring they have capacity to renew their cards?

   Probes:

   i. How does the supported individuals managed to repay for iCHF?

   ii. What is the key support for their enrollment in iCHF?

6. In your views what mechanism can be used to influence household enrollment in iCHF?

   Probes:

   i. How the mentioned mechanism can be implemented?

   ii. How effective is the proposed mechanism?

KIAMBATISHO H: MWONGOZO WA MAJADILIANO VIONGOZI WA VIKUNDI VYA KUSAIDIANA (KWA KISWAHILI)

Huu ni mwongo wa majalidiano wenye lengo la kuangalia mchango wa vikundi vya kusaidiana katika kuwezesha kaya zilizolipiwa bima ya afya (iCHF) kuendelea kulipa ada ya kila mwaka.

Maelezo ya utangulizi;

i. Hakikisha wakati wa kwenda kukusanya taarifa unavitendea kazi vya kutasha ambavyo ni kalamu zisizopungua mbili, kinasa sauti, dafatari/notebook, mwongozo wa majadiliano.
ii. Unapokutana na walengwa, wasalimie na jitambulishe kwa ufasaha wakufahamu,
iii. Waeleze walengwa dhumuni la kuwatembelea, malengo ya utafiti unaofanya ni nini, muda utakao tumika kwenye mahojiano, na njia ziatakazotumika kuchukua taarifa hizo na uombe wakupe muda.
iv. Baada ya kukusikiliza na kukubali kukupa muda wa mahojiano, wape na uwasomee fomu ya ridhaa na mwombe mlengwa aweke sahihi yake kwenye fomu hiyo.

MAELEZO YA SIFA ZA ANAYEHOJIWA

Namba ya Mhojiwa;	Shughuli ya uzalishaji mali;
Umri;	Hali ya ndoa
Jinsi;	Ukubwa wa Familia (idadi ya watu na watoto)
Kiwango cha Elimu	

7. Ni kwa jinsi gani huwa mnasajili wanachama waliopewa msaada wa kulipia ada yam waka ya bima ya afya iliyoboreshwa?
   Chunguza:
   ii. Kuna utofauti unaotumika kuwasajili wanachama?
   iii. Kwanini kuna huo/hakuna huo utofauti?
8. Ni kwa jinsi gani mnahakikisha wanaweza kulipia bima zao baada yam waka mmoja kwisha?
   Chunguza:
   iii. Ni msaada gani mnatoa kwa wanachama kuweza kujiung na bima ya faya iliyoboreshwa ili waweze kulipia tena?
   iv. Kuna uhusiano wowote kati yenu na wale waowalipia na kwaajili ya mwendelezo wa kujiunga na bima ya afya?

9. Ni changamoto gani kuu zianawakabili wanachama wakati wa kulipia bima za afya zinazowafanya wakubalia au wakatae kulipia bima ya afya?
   Chunguza;
   iii. Ni changamoto gani zinazotajwa zaidi?
   iv. Kwanini unadhani changoto hizo zinatajwa zaidi?
10. Ni mrejesho gani mnaopata kutoka kwa wanachama waliolipiwa ada ya mwaka kuhusu huduma za bima ya afya iliyoboreshwa?
    Chunguza:
    ii. Ni kwa jinsi gani unadhani wanachama wanarishwa/hawaridhishwi na huduma za bima ya afaya iliyoboreshwa?
    iii. Nini kinaweza kufanyika ilikuboreshwa hili zaidi?
11. Nini maoni yako kuhsu kuwaunganisha wanachama na vikundi vya kusaidiana kama njia ya kuwawezesha kujiunga na bima ya afya?
    Chunguza:
    iii. Ni kwa jinsi gani vikundi vinaweza kuchangia wanachama kujiunga na bima ya afaya iliyoboreshwa?
    iv. Ni kitu gani kinaweza kuhamasisha wanachama waliopo kwenye vikundi kujiunga na bima ya afya iliyoboreshwa?
12. Kwa maoni yako ni kitu gani kinaweza kushawishi watu wengi zaidi kujiunga na bima ya afya iliyoboreshwa?
    Chunguza:
    iii. Ni kwajinsi gani njia uliyotaja inaweza kutekelezwa?
    iv. Njia hiyo ni kwa jinsi gani inaweza kuwa na ufanisi mkubwa zaidi?

Appendix I: FOCUSED GROUP DISCUSSIONS (FGDs) GUIDE (ENGLISH VERSION)

INTRODUCTION.

My name is Lazaro Ernest we are doing research that aim to explore the contribution of SHGs on the individual enrollment in to iCHF scheme in Dodoma City Council. The information will give light as to the extent of SHGs influences individual enrollment in to the iCHF scheme which can be used as a way of promoting individual enrollment in to the iCHF.

In a group of 5-8 people we will discuss issues related to how the SHG influences individual enrollment in to iCHF scheme by creating financial assurance of the individuals. Further, we will discuss the implications of linking individuals in to the SHGs in assuring access to health services to individuals.

The information you give us is completely confidential, and we will not associate your name with anything you say in this focus group discussion.

We would like to tape the discussions to make sure we capture the thoughts, opinions, and ideas we hear from you. No names will be attached to the focus groups and the tapes will be destroyed as soon as they are transcribed.

Here are some norms that we can agree together to make our discussion as smooth as possible.

 Everyone should participate.

 Switch off your phones.

 Information coming out of this discussion must not be shared with any third party. It is confidential.

 No side conversations, stay in the group.

 We are not seeking a common view, so be free no one is wrong.

 Have fun.

1. How can groups influence individual enrollment in to iCHF?
2. How do SHGs support/influence assurance to health services to its members?
3. How is sharing out process support individual enrollment in to the iCHF scheme?
4. What are the key priorities during the sharing out process?
5. How loans can be used to support individual enrollment in iCHF
6. What can influence you to take loan from the group?
7. How iCHF support access to health services?
8. What are your views on ensuring individuals who are supported with iCHF linked to SHGs?
9. Based on your views and experience what mechanism can be used to ensure individuals are able to pay for annual iCHF payment?
10. In your opinion what action can be taken to ensure all individuals who are supported with iCHF annual fee payment have capacity to repay?

Appendix J: MWONGOZO WA MAJADILIANO KWENYE MAKUNDI LENGWA (KWA KISWAHILI)

UTANGULIZI.

Jina langu ni Lazaro Ernest mwanafunzi wa mwaka wa pili Chuo Cha Afya Muhimbili ninafanya utafiti kuangalia mchango wa vikundi vya kusaidiana katika kusaidia watu kujiunga na bima ya afya iliyoboreshwa kwenye Jiji la Dodoma. Taarifa hizi zitatoa mwangaza nik kwa jinisi gani vikundi vy kusaidiana vinaweza kutumika kuongeza wanachama wengi zaidi kujiunga kwenye mfuko wa bima ya afaya iliyoboreshwa.

Majadiliano haya yatafanyika katika vikundi vya watu 5-8 na kujadilia masuala yanayohusu kujiunga na vikundi vya kusaidiana kuwezesha watu wengi zaidi kujiunga na bima ya afya iliyoboreshwa. Pia tutajadili uhusiano/matokeo ya kuwaunganisha watu waliopewa msaada wa bima ya afya iliyoboreshwa kwenye vikundi vya kusaidiana.

Taarifa mtatkazozitoa ni za siri na hazitahusianishwa na majina yenu au kitu chochote kinachomhusu mtu binafsi katika kundi hili mahususi.

Tutapenda kurekodi majadiliano haya kuhakikisha kuwa tunachukua taarifa zote muhimu na kuyapata mawazo, maoni, na mitazamo yenu katika majadiliano haya. Hakuna jina lolote liatakalo ambatanishwa na majadiliano haya na mazungumzo yaliyorekodiwa yatafutwa kabisa mara tu baada ya mahojiano kunukuliwa.

Haya ni baadhi ya mambo tuyoweza kukubaliana kufanya majadiliano yetu kuwa mazuri zaidi kadri iwezekanavyo.

 Kila mmoja ashiriki kikamilifu.

 Simu zizimwe au kuwa katika hali ya ukimya

 Taarifa zote zitokanazo na majadiliano haya zisishirikishwe mtu wa tatu ni taarifa za siri

 Hakutakuwa na majadiliano mengine nje ya kundi hili

 Hatu tafuti mawazo ya pamoja, hivyo muwe huru kujieleza hakuna anayekosea kila mmoja yupo sahihi

 Kufurahi

1. Ni kwa jinsi gani vikundi vinaweza kushawishi/kusaidia watu kujiunnga na mfuko wa bima ya afya iliyoboreshwa?
2. Ni kwa jinsi gani vikundi vya kusaidiana vinawapa uhakika wa kupata huduma za afya wanachama wake?
3. Ni kwa jinsi gani mchakato wa kugawana unaweza kutumika kuhakikisha watu wanasajiliwa kwenye bima ya afya iliyoboreshwa?
4. Ni vipaumbele gani watu wanakuwa navyo wakati wa kugawana fedha kwenye kikundi?
5. Ni kwa jinsi gani mikopo inaweza kutumika kuwezesha watu kujiunga na bima ya faya iliyoboreshwa?
6. Ni mambo gani yanayohamasisha/yanayochangia watu kuchukua mikopi kwa wingi kwenye kikundi chenu?
7. NI kwajinsi gani Mfuko wa biama ya afya iliyoboreshwa inawezesha upatikanaji wa huduma za afya?
8. Ni yapi maoni yenu kuhusu kuwaunganisha watu waliopewa msaada wa bima ya afya iliyoboreshwa kwenye vikundi vya kusaidiana?
9. Kwa mtazamo wenu na uzoefu mlionao, ni mbinu gani zianweza kutumika kuhakikisha watu wengiu wanajiunga na bima ya afya iliyoborehswa na kulipia kila mwaka?
10. Kwa maoni yenu, ni kwajisi gani vikundi vinaweza kusaidi watu wengi kulipia bima ya afya kila mwaka**?**

Appendix K: Ethical clearance letters

UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR – RESEARCH, PUBLICATIONS AND INNOVATION

Ref. No.DA.282/298/01.C/1873 Date: 20/08/2023

MUHAS-REC-08-2023-1873
LAZARO ERNEST
SHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES
MUHAS

RE: APPROVAL FOR ETHICAL CLEARANCE FOR A STUDY TITLED: CONTRIBUTION OF SELF-HELP GROUPS TO ENROLLMENT IN IMPROVED COMMUNITY HEALTH FUND IN TANZANIA: A CASE OF DODOMA CITY COUNCIL

Reference is made to the above heading.

I am pleased to inform you that the Chairman has on behalf of the University Senate, approved ethical clearance of the above-mentioned study, on recommendations of the Senate Research and Publications Committee meeting accordance with MUHAS research policy and Tanzania regulations governing human and animal subjects research.

APPROVAL DATE: 20/08/2023
EXPIRATION DATE OF APPROVAL: 20/08/2024

STUDY DESCRIPTION:
Purpose:
The purpose of this observational case study design is to explore the contribution of the self-help groups in the community on the individual's enrollment in the improved community health fund with a specific focus on the individuals who were supported by different stakeholders on annual enrollment fee payment and linked to self help-grpups.

The approved protocol and procedures for this study is attached and stamped with this letter, and can be found in the link provided: https://irb.muhas.ac.tz/storage/Certificates/Certificate%20-%2014844.pdf and in the MUHAS archives.

UNITED REPUBLIC OF TANZANIA
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR – POSTGRADUATE STUDIES

In reply quote;
Ref. No. HD/MUH/T.468/2021

18th September, 2023

Regional Administrative Secretary,
P.O. Box 914,
DODOMA

Re: INTRODUCTION LETTER

We would like to inform you that the bearer of this letter is **Lazaro Ernest** with Reg. No. HD/MUH/T.468/2021 is a student at Muhimbili University of Health and Allied Sciences (MUHAS) *pursuing MPH-Distance Learning.

As part of his studies, he will be doing an elective research titled: **"Contribution of Self-Help Groups to Enrollment in Improved Community Health Fund in Tanzania: A Case of Dodoma City Council."**

The research has been approved by the Chairman of University Senate.

Kindly provide him the necessary assistance to facilitate the conduct of his research.

We thank you for your cooperation.

Victoria Mwanilwa
For: DIRECTOR, POSTGRADUATE STUDIES

c.c **Lazaro Ernest**

9 United Nations Road; Upanga West; P.O. Box 65001, Dar Es Salaam; Tel. G/Line: +255-22-2150302/6; Ext. 1015; Direct Line:+255-22-2151378;Telefax:+255-22-2150465;E-mail:dpgs@muhas.ac.tz;Web:https://www.muhas.ac.tz

The PI is required to:

1. Submit bi-annual progress reports and final report upon completion of the study.
2. Report to the IRB any unanticipated problem involving risks to subjects or others including adverse events where applicable.
3. Apply for renewal of approval of ethical clearance one (1) month prior its expiration if the study is not completed at the end of this ethical approval. You may not continue with any research activity beyond the expiration date without the approval of the IRB. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.
4. Obtain IRB amendment (s) approval for any changes to any aspect of this study before they can be implemented.
5. Data security is ultimately the responsibility of the investigator.
6. Apply for and obtain data transfer agreement (DTA) from NIMR if data will be transferred to a foreign country.
7. Apply for and obtain material transfer agreement (MTA) from NIMR, if research materials (samples) will be shipped to a foreign country.
8. Any researcher, who contravenes or fail to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine as per NIMR Act No. 23 of 1979, PART III section 10 (2)
9. The PI is required to ensure that the findings of the study are disseminated to relevant stake holders.
10. PI is required to be versed with necessary laws and regulatory policies that govern research in Tanzania. Some guidance is available on our website https://irb.muhas.ac.tz/

Dr. Nahya Salim Mabrouk,
Chairperson, MUHAS Research and Ethics Committee



THE UNITED REPUBLIC OF TANZANIA
PRESIDENT OFFICE
EGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

Dodoma Region
Address REGCOM
Tel No: 2324343/2324384
E-Mail No.
Fax No. 255 026 2320046
In reply please quote:



Regional Commessioner's Office,
Mkapa House,
2 Hospital Road,
P.O. Box 914,
41103 DODOMA.

Ref. No. HA. 107/249/017/31

25 October, 2023

The Director,
Dodoma City Council,
P. O. BOX 1249,
DODOMA.

RE: RESEARCH PERMIT

Please refer to the above subject.

This is to introduce to you Mr. Lazaro Ernest who is a student at Muhimbili University of Health and Allied Sciences (MUHAS) pursuing MPH-Distance Learning. The research will be conducted from 20th August, 2023 to 20 August, 2024.

The research title is ***"Contribution of Self-Help Groups to Enrollment in Improved Community Health Fund in Tanzania: A case of Dodoma City Council"***.

Please accord her with all necessary assistance to achieve research objectives.

Thank you for your cooperation.

Prisca Lusoli
For: **REGIONAL ADMNISTRATIVE SECRETARY**
DODOMA

Copy to: Chairperson,
MUHAS.

Mr. Lazaro Ernest
MUHAS

JAMHURI YA MUUNGANO WA TANZANIA
OFISI YA RAIS
TAWALA ZA MIKOA NA SERIKALI ZA MITAA
HALMASHAURI YA JIJI LA DODOMA

Unapojibu tafadhali taja:

Kumb.Na.HJD/E.10/4/172 **Tarehe:** 08/11/2023

Afisa Mtendaji Kata,
Kata ya Chang,ombe na Ipagala,
S.L.P 1249,
DODOMA.

YAH: KUMTAMBULISHA BW. LAZARO ERNEST MWANAFUNZI WA CHUO KIKUU CHA MUHIMBILI (MUHAS) KWA AJILI YA KUFANYA UTAFITI

Husika na kichwa cha habari hapo juu.

2. Bw. Lazaro Ernest ni Mwanafunzi katika Chuo Kikuu cha Muhimbili (MUHAS). Kwa sasa anafanya utafiti kuhusu **"CONTRIBUTION OF SELF- HELP GROUPS TO ENROLLMENT IN IMPROVED COMMUNITY HEALTH FUND IN TANZANIA: A CASE OF DODOMA CITY COUNCIL"**. Utafiti huu ni Muhimu kwa ajili ya Masomo yake lakini pia kwaajili ya Halmashauri ya Jiji.

3. Kwa barua hii tafadhali mpe ushirikiano utakaohitajika ili aweze kufikia malengo yake. Aidha Halmashauri haitahusika na gharama zozote zitakazojitokeza awapo katika utafiti. Kibali hiki ni kuanzia tarehe **09 Novemba 2023 mpaka 30 Machii 2024.** Pia atatakiwa kufuata Kanuni na taratibu za Utumishi wa Umma.

4. Nakutakia kazi njema.

Charity E. Sichona
Kny: MKURUGENZI WA JIJI
DODOMA.

Kny: MKURUGENZI WA JIJI
HALMASHAURI YA JIJI LA DODOMA
S.L.P 1249,
DODOMA

Nakala:- Afisa Maendeleo Kata ya Chang,ombe na Ipagala. - Kwa taarifa na ushirikiano.

" MWANAFUNZI – Ripoti Ofisi ya Mtendaji Kata – Chang,ombe na Ipagala.

Mtaa wa CDA, S.L.P. 1249, 41183 Dodoma, Simu: +255262354817, Nukushi: +255262321550, Barua Pepe: cd@dodomacc.go.tz, Tovuti: www.dodomacc.go.tz