HOUSEHOLD AND HEALTH FACILITY RELATED FACTORS CONTRIBUTING TO LOW ENROLMENT TO COMMUNITY HEALTH FUND IN ROMBO DISTRICT

By

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Dissertation submitted in partial fulfilment of the Degree of Masters of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences

Muhimbili University of Health and Allied Sciences

October, 2010

CERTIFICATION

The undersigned certify that has read and hereby recommend for acceptance by Muhimbili University of Health and Alied Sciences a dissertation entitled *Household and Health Facility Related Factors Contributing to Low Enrolment to Community Health Fund in Rombo District*, in partial fulfilment of the requirements for the degree of Master of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences.

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Date: 05/11/2010

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ACKNOWLEDGEMENT

I am indebted to extend my sincere thanks to the following individuals and Institutions for their tireless efforts in facilitating this dissertation for the MA HPM degree.

The Norwegian Masters (NOMA) program; for sponsoring me to pursue the master degree programme.

My Supervisors: Dr. Siri Lange and Prof. Phares Mujinja for their supervisory work during the whole period from proposal to dissertation writing. Their positive remarks were the major motive behind my tireless efforts in developing and writing this dissertation.

The District Medical Officer and the Council Director of Rombo District: for allowing this study to be carried out.

All the study participants: who willingly used their precious time to participate in the study.

My class mates, with whom I interacted on daily basis during the entire study period.

DEDICATION

This work is dedicated to my Lovely Sister Claudia, who tirelessly gave me encouragement and necessary support throughout the whole process of proposal writing, data collection and developing this dissertation.

ABSTRACT

Background: Tanzania like many other developing countries is facing challenges in finding proper mechanism of health care financing that would ensure equitable access to health care for all her citizens especially those employed in non-formal sector. The government of Tanzania has initiated a number of prepayment schemes as an effort to provide health care financial protection for its citizen. Community Health Fund (CHF) is one of the schemes aimed for rural population. CHF have proved to provide well functioning health care financial protection to its members. However, its enrolment level in all districts has remained unexpectedly very low.

Objectives: The main objective of this study was to identify household and health facility related factors that contribute to low enrolment to CHF scheme in Rombo District.

Methods: It was a cross-sectional study which employed mixed methods of data collection. Both qualitative and quantitative data were concurrently collected. The study involved four samples: 144 household heads; 150 exit patients; 36 health staff and 3 CHF district officials. The four samples were included in order to obtain enough triangulation of information. Data from each method were analysed separately; Quantitative data ware entered and analysed in the SPSS computer program where descriptive statistics were derived; Qualitative data were analysed by generating themes according to the study objectives with the aid of ATLAS.ti 6 computer program. The generated themes were embedded in to the quantitative results to enrich where it fits.

Results: Health staffs' practices were highly accepted by exit patients; also health staff had positive opinions on CHF usefulness. These were potential optimistic findings that were expected to attract more community members to join the scheme. However, lack of knowledge about CHF operations and use of private health facilities among household heads had significant negative effect in CHF enrolment.

In addition, lack of fixed time for registration of CHF members was identified to create a loophole for drop out and non-enrolment.

Conclusion and Recommendation

Based on the results of this study it is therefore recommended that District CHF Management should strengthen community sensitization and education about CHF scheme. Additionally, revisiting the rules that guide implementation of CHF in Rombo district is necessary in order to remove the loopholes that contribute to non-enrolment and drop out of the scheme.

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ACRONYMS

AAR	American Air Rescue
CHF	Community Health Fund
CBHF	Community Based Health Funds
DDH	Designated District Hospital
DHB	District Health Board
MOH	Ministry of Health
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
TIKA	Tiba Kwa Kadi (Health services through a prepay card)
URT	United Republic of Tanzania
VC	Village council
WHC	Ward Health Committee

DEFINITION OF TERMS

Community Health Fund (CHF) – Is a form of pre-payment scheme regarded as a strategy of providing additional funds for financing health services to rural population in Tanzania. It is expected to serve as a means of ensuring greater security of access to health care, empowering households and communities in health care decision and promoting cost sharing with strong local participation.

Health risk – A probability /chance of falling sick. In this study it reffered to perceived probability of falling sick among individual household heads and their household members.

Non-formal economies – In this study refers to financial system on which people work outside the formal sector including self employments, small scale business and small-scale agricultural activities.

Policy actors- In this study it imply those who implement policy i.e. profssionals (health staff) and those who receive end of the policy i.e. patients and other citizens. They both have influence on policy performance.

Practices- In this study practices refers to the actions or deeds. Health staffs' practices here mean those actions they do in their day-to-day interaction with CHF members as well as other patients. Health staff practices towards CHF and its members can be associated with their knowledge and opinion on the usefulness of the scheme.

Risk pooling – In this study it refers to ccumulation of funds from a group of people with diverse health risks and income levels with the aim of covering costs of health care for members once they fall sick.

Universal coverage – In this study it refers to the situation where there is physical and financial access to necessary health care of good quality for every one in the society. It implies protection against the risk that if expensive health care services are needed, the costs of these services will not prevent persons from using them or impoverish their families.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Lack of access to quality health services is a widely known problem that affects the poor more due to their economic disadvantage. Equity problems become more prominent in low-income countries where there are no effective mechanisms to provide financial protection for health care to all [1]. In these poor countries social health insurance mostly cover the minority because the large proportion of population are employed in non-formal sectors or not employed at all. It is difficult to collect funds as this group of population have irregular incomes which can not be deducted for membership fee. This has resulted into the increasing advocacy for Community-Based Health Insurance (CBHI) schemes to provide protection to people in informal sectors to protect them from financial risks [2].

From independence in 1961 up to the early 1990s, Tanzania was providing free social services to all its citizens including health care. Health care was financed through general taxation, donors funding and local and foreign aids. However, tax-funded health system did not become sustainable due to the lack of a strong tax base and low institutional capacity to effectively collect taxes [3]. Aids and donor funds that could be used to finance health services also have setbacks such as delay in disbursing, and furthermore are not reliable as they depend on donors' ability and willingness to provide the funds. During 1980s changes in economic performance due to external and internal macroeconomic shocks required economic and social sector reforms, including the health sector. The health sector reforms in Tanzania were therefore initiated and implemented in four aspects namely; ideological reforms, organizational reforms, managerial reforms and financial reforms [4, 5].

Cost sharing in health services was introduced in 1993 as one aspect of financial reforms whereby individuals/households have to pay user fees for their health services when they go to the public health facilities. This was necessary because the government could not afford to provide free services through tax financing due to increase in costs of treatment, increased burden of disease, and poor performance of

the country's economy [6]. Since then the main mode of payment for health care was out of pocket at the health facility.

Cost of health care is always greater than the financial ability among poor individuals or households, especially those involved in non-formal economies or un-employed in developing countries [7]. Sickness is erratic and out of pocket payment in an event of sickness can be catastrophic where a person can be forced to sell economic assets in order to pay for health care [1, 8]. In relation to this, the government of Tanzania has established a number of prepayment schemes to surrogate "out of pocket" mode of payment as an effort to provide financial protection for health to her citizen.

The Government and some of its institutions initiated prepayment schemes that include: National Health Insurance Fund (NHIF) for Civil Servants; Social Health Benefit Insurance Fund (SHBIF) for National Social Security Fund (NSSF) members; and Community Health Fund (CHF), which was pre-tested in 1996 for people in non-formal sector and rural population and its urban counterpart TIKA [1, 9]. There are also private for profit insurance schemes like AAR.

1.2 Community Health Fund

The Community Health Fund (CHF) was introduced in Tanzania as government's effort to make health care affordable and available to the rural population and those employed in non-formal sector. According to CHF Act no 1 of 2001 it has the following objectives: to mobilize financial resources from the community for provision of health care services to its members; to provide quality and affordable health care services through sustainable financial mechanism; and to improve health care management in the communities through decentralization. Also it was established with the following expected results: a sustainable financial mechanism; adequate medical supplies and equipment at health facilities; improve quality of health care services; adequate, skilled and motivated health providers and improved community participation [10]

CHF schemes have shown some improvement in access to health care among peasants in rural areas, which has also influenced health care seeking behaviours among its member like seeking health care once one is in need [11]. There is

evidence that CHF type schemes can provide protection to their members by significantly reducing the level of out of pocket payments for health care [12]. However since its establishment in Tanzania, the rate of enrolment has remained unexpectedly very low among the targeted population. The following implementation problems are identified by different studies: limited ability to pay a membership fee among poor people; poor quality of care provided in public health facilities; lack of trust in managers of the scheme and limited acceptance of need to insure against health risks among the rural population [13-15]

1.3 Problem statement

The Community Health Fund adds on the government's effort to reduce individual risks of losing income in the event of sickness among the poor population. It is agreed to be a more appropriate health financing mechanism that could improve access to health care among people in the informal sector by pooling risk together. Tanzania government provides a matching grant to CHF that is equal to the amount collected by the respective scheme. The higher the amount of funds collected by CHF the more the matching grants/ government subsidy the scheme receives. Therefore for CHF to benefit from the subsidies and improve quality of health services, high coverage is a necessary condition.

Despite its importance, the enrolment rate of CHF in Tanzania has never reached the expected coverage. Accordingly, Shaw found that enrolment of community members to the scheme in some rural districts like Igunga and Singida was 6 and 4 percent respectively. This was low in comparison to the expectations of 30 percent of the district population [16]. In some schemes, where enrolment was previously relatively high a decline has also been realized. For instance in Hanang district membership was around 3 percent of total households in 2001; however more recent data indicates that enrolment fell to 2.2 per cent in 2003 [17]. Low coverage of CHF is a problem and it denies protection to target population and therefore leave them at risk of economic deprivation at event of sickness. It also deters their access to quality health care [18]. For the CHF to cushion enrolees against financial loss it has to collect sufficient funds to meet the payment obligations (risk distribution).

A number of studies have been done to evaluate factors affecting enrolment to CHF in Tanzania. From the studies it has been found that the schemes in some districts, are facing a number of implementation problems including: inability to pay for membership fees among the poor households; poor quality of care provided in public health facilities; lack of transparency in the use of funds, poor staff attitudes, and limited acceptance of a need to insure against health risks among the rural population [14]. These factors are also associated with both dropping out and not joining the scheme. Literature on process of implementation as a factor affecting the performance of CHF in Tanzania was scanty; only one study was found [14]. This study employed policy analysis approach. It explored the effect of socio-economic status of households and managerial practices to CHF enrolment. However, the influence of other implementation factors such as characteristics and practices of health staffs and household heads' on CHF performance were not explored.

Consequently, little is known on how health staffs' practices and household heads' characteristics affect CHF enrolment. This study is therefore aiming at seeking knowledge on how health staffs and household heads' actions affect enrolment to the CHF scheme in Rombo district.

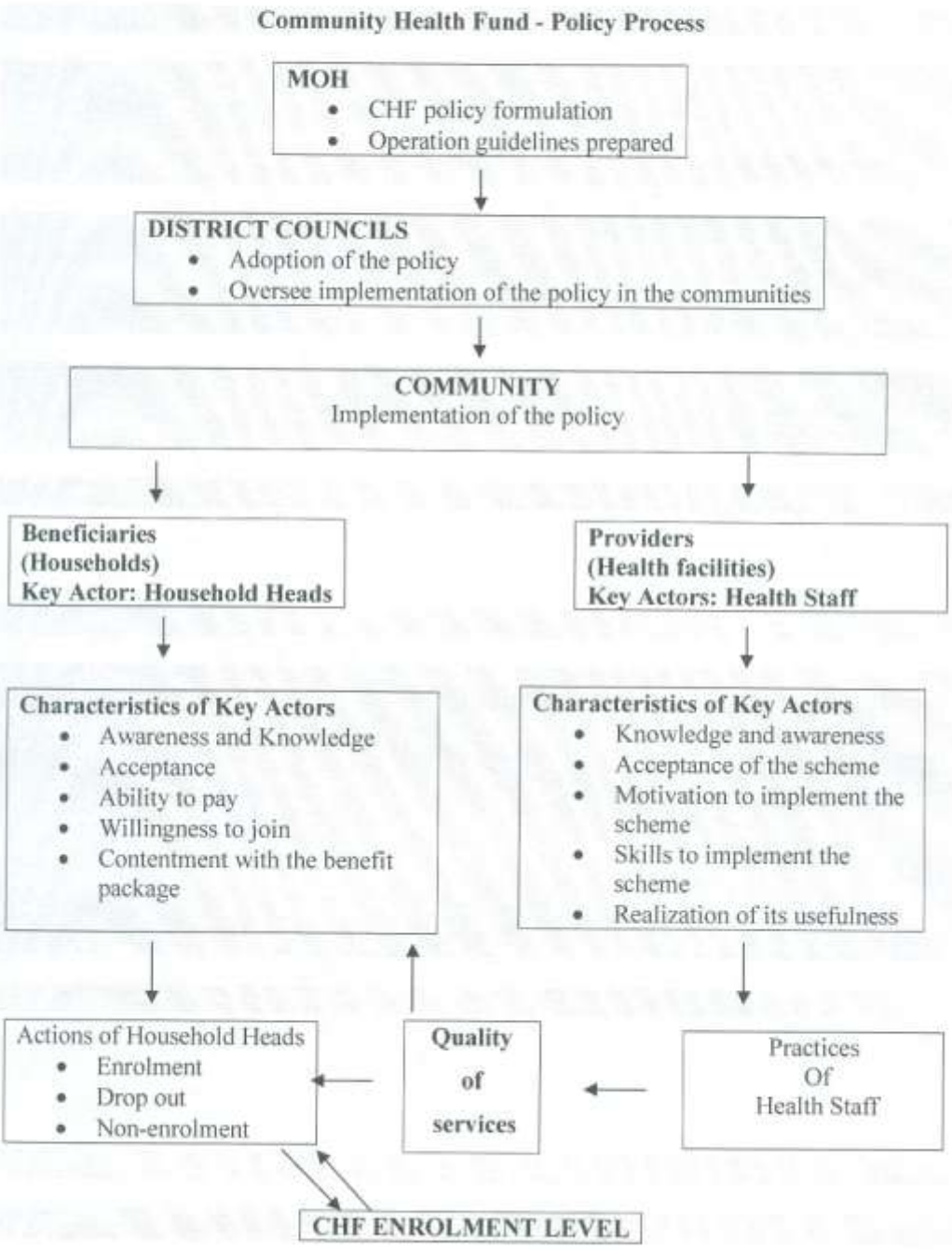
1.4 Conceptual Framework

The CHF scheme was designed and its operational guidelines were prepared by the Ministry of Health and Social Welfare. Thereafter it was passed down to district councils which are assigned to oversee its implementation in their respective communities as shown in Figure 1. Given that CHF process followed top-down implementation approach, it was therefore likely to face implementation challenges or rejection from lower level actors.

At community level both the beneficiaries and providers who are important actors in implementation of CHF plays great role on its performance. On the providers' side there may be lack of required skills, shortage of staff, lack of incentives for additional tasks, which might lead to low motivation in implementing the scheme. Low motivation among the health staffs may lead to poor practices which might contribute to poor quality of the services they provide and hence negatively affect beneficiaries' satisfaction.

On the other hand, household heads' characteristics and opinions on CHF scheme determine their willingness to join. Household heads might reject the scheme just because they would not know its benefit or because the scheme would not satisfy their expectations. For example, lack of referral services to higher level hospitals has been mentioned to be among factors contributing to low enrolment [16,17]. Furthermore, discontent encountered by early adopters because of the poor quality of services may lead to drop out or discourage other household heads from joining the scheme. Both drop out and non- enrolment may contribute to low enrolment rate to CHF in Rambo district. See Figure 1 for illustration.

Figure 1: Conceptual Frame Work



1.5 Research questions

1. How do the health staffs' practices affect enrolment to CHF scheme?
2. How do the household heads' characteristics affect enrolment to CHF in Rombo district?
    - What are household heads' characteristics that contribute to drop out of CHF members from the scheme in Rombo district?
    - What are household heads' characteristics that contribute to non-enrolment to CHF scheme in Rombo district?

1.6 Rationale for the study

The study was aimed at exploring the implementation problems deterring CHF enrolment level in order to ensure its success in Rombo district. Knowing the problems would lead to finding better solution. Increase in CHF enrolment level would improve access to health care among the target population. This is accordance to the goal of the nationl health policy that is universal access to health care [19]. Health care financial protection would as well enhance realization of the National Strategies for Growth and Poverty Reduction (NSGPR) by reducing the chances of losing income due to costs of ill health among its members [20]. In addition findings of this study will provide baseline information for other studies on implementation factors affecting CHF enrolment in Rombo district.

1.7 Objectives

1.7.1 Broad Objective

To investigate the household and health facility related factors that contribute to low enrolment to CHF scheme in Rombo district.

1.7.2 Specific objectives

1. To identify household heads' characteristics which contribute to low enrolment to CHF scheme in Rombo district.
2. To identify household heads' opinions on contributing factors for low enrolment to CHF scheme in Rombo district.
3. To examine the arrangements for CHF members as compared to non-members when seeking services in public health facilities in Rombo district

4. To examine health staffs' practices during their interaction with CHF members when seeking services at public health facilities in Rombo district.
5. To identify health staffs' opinion on usefulness of CHF scheme in Rombo district.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Health Care Financing in General

Tanzania like other developing countries is facing problems in ensuring equitable access of health care to all its citizens. Together with other accessibility problems like long distance from homes to the health facilities and poor quality of available services, problems of financing health care services has remain as an outstanding barrier to universal access to health service. Health care financing problem become worse at household or individual level when there is no well working financial protection. In Tanzania financial protection for health care covers small proportion of the population due to the fact that majority of Tanzanians are employed in informal sector or not employed at all [1]. This makes difficult to establish an efficient mechanism of financial protection for health that covers the whole population due to lack of regular income and hence difficult in collection of funds [2].

2.2 Health care financing in Tanzania

Since Independence, 1961 the government of Tanzania was providing free social services to its citizens including health care. Financing of health care was mainly through general taxation. There after tax financing was not enough due to lack of effective tax collection mechanism, increased donor dependence, majority of the population being employed in informal sector [9]. In 1981 changes in the global economic policy necessitated social sector reform including health sector. Among the reforms held in health sector was financial reform where other sources of funds were implored as the government failed to provide free health services by using general taxation alone. This was caused by reduction of budget for health, increased burden of disease, increased cost of treatment and diagnostics and poor economic performance in the country [6]. Cost sharing was introduced to add to the general taxation in order to raise enough money for provision of quality health services to Tanzanians. Cost sharing have been implemented in several ways like out of pocket payment of user fees at the point of use; prepayment schemes such as the National Health Insurance Fund (NHIF) for civil servants, Social Health Insurance Benefit (SHIB) for National Social Security Fund (NSSF) members who are employees in

the formal private sector. Community Health Fund (CHF) for people in non-formal sector in the rural and its equivalent TIKA in urban areas. Recently also there have been a number of privately owned health insurance schemes like American Air Rescue (AAR)

Out-of-pocket health expenditures are often large compared with the incomes of poor households. This limits their access to services and pushes many of them into abject poverty when health shocks occur [8, 21]. Further more, poor households without reliable sources of income may be forced to use all or significant part of their little savings or even sell their assets in order to pay for the costs of health care for their sick family member [8].Vulnerable population groups like poor women and children are more likely to be affected by out-of-pocket payment as they have no control power over household resources.

2.3 Community Health Fund (CHF)

The community Health Fund (CHF) was initiated as part of the health sector reform with the aim of improving financial sustainability and increase access to health services. Together with CHF there is a compulsory National Health Insurance (NHIF) scheme which covers all the civil servants. Also National Social Security Fund (NSSF) is now offering a benefit package for health care to formal private sector employees (SHIB). However, the NHIF and NSSF cover only a small proportion of Tanzanians as majority of the population are involved in non-formal economies like peasants in rural areas. CHF is a prepayment scheme for people employed in non-formal sector in the rural areas. It is based on the concept of risk pooling where by members pay a small contribution on a regular basis to offset the risk of needing to pay a much larger amount of money for user fees when they fall sick [22]. Community health funds are important steps towards universal coverage following the widely acknowledged difficulties which exist in tax financing and social health insurance, especially in less developed countries [23].

CHF organizational structure is built on the existing structure of the Local Government operations to avoid new and parallel structures. At ministerial level two ministries are involved formulating and overseeing CHF implementation; the Ministry of Health and the Prime Ministrs Office Regional Administration and Local

Governments (PMORALG). At the district level CHF is managed by District Council through District Health Board (DHB). At ward level it is managed by Ward Health Committee (WHC), and at village level it is managed by Village Council (VC) through its village government, which is advised by the village primary health committee [24].

CHF operates in association with the health sector activities within a particular district. The scheme works with the Rural Health Posts, dispensaries, health centres and district hospitals. That means CHF services are confined within a single district and the district council is the highest level of CHF services. Consequently, when CHF members need higher specialized care like a referral to regional or consultant hospitals they have to pay from their pockets. Accordingly, CHF also lack cross subsidization across districts and regions which might have different income levels and health risks due to different geographic and climatic conditions.

The scheme promotes community participation and empowerment through establishment of the facility health committees and council health boards which assist in administering the fund. Community members participate in decisions on how their health facility operates regarding availability and quality of services. It is expected that with CHF communities would realize the value of health and be willing to contribute. It strengthens community participation and ownership of health services in their localities [24]. CHF members pay agreed fee (premiums) once a year and they receive a membership card with which they will receive health services throughout the year. Usually payment is done during the harvest season where by most households have some crops to sell and earn money to pay the premium. To ensure equity in health care accessibility, CHF is accompanied by exemption policy whereby households that are too poor to pay the premiums are provided with free cards after they have been identified by the community to enable them to access health care [24].

A successful CHF could improve equity in health care to Tanzanians as it is argued by Shaw that CHF aims at improving health outcomes through better access to quality services and improved risk protection [16]. It is evidenced that CHF types of

schemes reach a large number of low-income populations who would otherwise have no financial protection against the cost of illness [25]. CHF schemes have great potential to improve access of health care to poor people. It removes payments at the point of use and allow members to pay when they can afford. Howerver low enrolment to the schemes in many districts of Tanzaania including Rombo reverses its positive effect because only small proportion of the target population would be protected. In addition fewer members in the scheme would render it to have an incorrect mix of members and thereafter interfere with the vital goal of cross subsidization and risk pooling.

2.4 Low enrolment to CHF scheme

Low enrolment in CHF scheme interferes with the realization of the important goal of cross subsidization as poor and sickly households are more likely to join the scheme as compared to the wealthier and healthy ones (adverse selection). At community level there should be cross-subsidization between the poor and the rich and between ill and healthy individuals or households [1]. CHF is expected to raise enough funds to subsidize the poor who cannot pay for their health care. Thus in order to have the correct mix in the composition of members in a scheme high enrolment is a necessary factor as it was argued by Msuya and latter by McIntyre that a well functioning risk pool capable of insuring its members adequately should consist of a sufficient number of members among which a mixture of high risk and low risk as well as wealthier and poor households will be aggregated [1,11]

Despite the CHF benefits and effectiveness in improving equity in health care accessibility, its uptake has remained low in many districts including Rombo district. Many reasons have been mentioned by other studies as the causes for low up take: perceived low quality of services in the public health facilities, lack of transparency in expenditure of collected funds, low community voice in decision making on how health services should be managed, government bureaucracy in CHF implementation; poor staff attitude and high membership fees [9, 11, 14, 17, 24]. Even though there are many problems encountered in CHF implementation, deliberate effort to make it a sustainable method for health financing is still needed to reduce the high amount of out-of-pocket payments and the incidence of catastrophic health shocks among people in informal sector [8, 12, and 21].

2.5 Policy implication for low enrolment to CHF

The factors for low enrolment to CHF scheme mostly resemble implementation problems of equity related policies [22]. CHF may be rejected by the implementers due to the fact that it was planned and formulated at the central level by the Ministry of health in collaboration with the World Bank then sent to the district councils to be implemented. Implementers may have many problems in implementation as they might not be prepared to perform some new tasks. Among the implementation problems might include lack of additional skills to run a finance scheme, increased work load without any incentive, or just inability to accept the scheme as important means to enhance health care accessibility to the poor, a problem to many equity related policies. Problems like poor staff attitude, lack of transparency in management of funds, long bureaucracy in the use of fund in the facilities might be brought about by implementers during the implementation process and it may imply lack of motivation and commitment in running the scheme.

A particular policiy would require particular skills for its effective implementation. A new scheme will require additional administrative and managerial skills that mean CHF implementers who are mainly health staffs and elected ward health committees to mention a few, may require additional skills in administration of the scheme including financial and information management [13]. Or it may be necessary to hire other professional cadres special to operate the scheme. If the formulation of CHF was not accompanied with creation of additional skills then there may be a mismatch between the scheme capacity requirement and availability of necessary skills. Lack of appropriate skills and limited acceptability among policy implementers may have greater influence in their actions. One can see clearly that implementers are important actors in the policy process [13]. Policy implementers includes: bureaucrats, Professionals and Street level bureaucrats [14]. Street level bureaucrats are: service providers, 'semi professionals and professionals working in the bureaucracies (like hospitals, health centers and dispensaries). They make many day-to-day decisions throughout their interaction with policy users; hence they have influence on how policy is experienced by users [26]. Policy implementers occasionally create bureaucratic environment i.e. arrangements, routines, rules and

rigid practices as coping strategies, for example when client needs typically surpass the available resources [26,27]. Sutton argues that policies often change as they move through bureaucracies to the local level where they are implemented [28]. As a result of some practical consideration, as well as political opinion of those who work in these bureaucracies, influence the policy practice to produce an outcome which may be significantly different from the original intention of a policy [28]. Likewise, the CHF policy might have been altered in one way or another by its implementers and hence to affect the way it is perceived by the community members and hence their willingness to join or drop out of the scheme.

Policy actors include those involved in policy formulation and all those who are likely to be affected by policy developments, including commercial interests, civil society organizations and beneficiaries. Among the factors that influence policy implementation include: policy characteristics; policy formation; vertical public administration; characteristics of implementation institutions; the behaviour of front-line staff; the impact of responses from those affected by policy; and the surrounding environmental factors [29]. Health staff should not be considered as simply devices in the process of CHF implementation, but to a certain extent, they have substantial ability to mould its outcomes and affect enrolment rate. Similarly, the responses of those beneficiaries who joined the scheme earlier influence the pace of other people in the community to adopt or reject the scheme.

2.6 Policy analysis theories

Policy analysis theories advise that, as actors responsible for implementation apply substantial discretion in their day to day decisions, they may react against efforts to impose policy change [30, 31]. Some theorists suggest that, if planned correctly, implementation can be managed through a top–down process while change is controlled by central actors. However, bottom-up theorists emphasize the difficulties of such control given that the apparently powerless implementers may effectively re-translate and re-create policy through their practices [27, 29, 32, 33]. Also it has been found that policy implementers react negatively to new policies formulated at national-level without their involvement [34, 35]. In addition policies often change as they move through bureaucracies to the local level where they are implemented [28]. Practices of health staffs might have an influence on quality of services provided at

the supply side which in the long-run would affect contentment in the demand side; both the supply and demand side are likely to affect policy success [36, 37]. In this study health staff and household heads are regarded as frontline implementers of CHF policy in both supply and demand side respectively.

2.7 A place for this study

In order to ensure CHF success, there is a need of explore the problems facing CHF implementation which in turn will facilitate the effort of creating correct solutions. Frontline implementers of policy are known to have a significant discretion in determining policy success. The available literature on implementation factors affecting CHF performance mostly report on influence of managerial practices and households' socio-economic status. No study in Tanzania ever analysed the actuality on how practices of health staffs and household heads' characteristics towards CHF can influence enrolment and hence its performance. This knowledge gap offered an opportunity for this study to be conducted.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Description of the study area

The study was carried out in Rombo District. Rombo is among the six districts of Kilimanjaro Region. The climate of the district is tropical type and it is cool most of the time. There are two rain seasons which make it possible for agricultural activities. The main source of income of Rombo people is small scale farming of coffee and banana. Rombo people also cultivate other crops for subsistence like maize, beans, cassava, yams, finger millet, sunflower and variety of fruits and vegetables. Rombo was apropropriate for this study because it is among the ruaral districts and it launched CHF since 2005. Five years of CHF operations in the district was considered enough time for the scheme to be evaluated.

3.1.1 Administrative structure

Rombo district is subdivided into 5 divisions with four wards each and 3 villages for each ward. These make a total of 20 wards and 60 villages. The villages are further subdivided into several hamlets. Each hamlet comprises of 10 -15 households and it is governed by a local government appointee known as ten-cell leader. The total population in Rombo district was estimated to be 255,343 [38].

3.1.2 The structure of health system

Health delivery system in the district follows Central and Local Government structures. Accordingly the policy is formulated by the Ministry of Health; the Region interprets national policies and supervises their implementation; District Authorities oversee health services delivered by dispensaries, health centres and hospitals within the district.

3.1.3 Health facilities and services

Rombo has 2 private hospitals; 4 rural health centres owned publicly; 46 dispensaries among which 26 are owned by private enterprises; and 35 publicly owned Maternal and Child Health Clinics (MCH). In average one hospital in Rombo serves 127,671 people while national average population per hospital is 100,000; population per physician ratio of 42,557:1 which is higher than the national average of 24,930:1;

population per rural health centre is 85,114 which is higher than the national average of 50,000; population per dispensary is 5551 which is close to the national average of 5,000 – 10,000. Hundred percent of Rombo population is within 0-10km distance from a rural health centre and 99.3% are within 0-5km distance from a dispensary while the national average is 0-10km from a rural health centre and 0-5 from a dispensary [38, 39]. The referral system in Rombo District follows the national policy. The dispensary is the lowest level followed by health centre and lastly the District Hospital which in Rombo is a Designated Hospital (privately owned by the Roman Catholic Diocese of Moshi.)

3.2 Study design

A cross-sectional exploratory population survey, using both qualitative and quantitative data collection methods was conducted in March 2010 in Rombo District. Concurrent triangulation technique was employed where both qualitative and quantitative data were collected at the same time (concurrently) which means one method of data collection had no influence over the other [40]. Furthermore data from each method were analysed separately and the results were merged and compared.

3.3 Study population

The study population was composed of household heads, health facilities, health staffs and the district CHF management officials in Rombo District.

3.4 Study sample

The study used Four samples: One-household heads in all the three categories of CHF membership status that means active members, drop outs, and those who had never joined the scheme; Two-Exit Patients of all the three categories of CHF membership status from both in-patient and out-patient health facilities; Three-Health staffs: from both in-patient and out-patient settings and Four-the District CHF management officials

3.4.1 Sample size for households' heads

Sample size for households was calculated by using a formula designed for population survey in cross sectional studies [41]. This formula was used because the

rate of CHF enrolment among community members is almost evenly distributed throughout the divisions and villages of Rombo District. The formula states that;

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

Where:

n=estimated minimum sample size

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

P= proportion of CHF members in Rombo district (currently estimated to be 10%. of all households)

ε=Accepted margin of error 5%

$$n=\frac{2^2 10(100-10)}{5^2}=144$$

A minimum of 144 household heads were required. Due to time and resource constrain the same number of household heads were involved in the study.

3.4.2: Sample size for health facilities

Three health centres and 8 dispensaries and the district hospital were included in the study; where 36 health staffs and 150 patients were obtained as shown in the sampling technique bellow. Rombo district has 4 health centres and 20 dispensaries owned by the government therefore taking 3 health centres and 10 dispensaries makes more than 50% of all public rural health facilities in the district and this will make a representative sample. Designated district hospital was latter involved.

3.4.3 Sampling procedures

3.4.3.1 Selection of household heads

Three divisions were randomly selected from the five divisions of Rombo district. At the division level, a list of all villages in the division was obtained which became a sampling frame whereby 2 villages were purposively selected to make sure that there is a public health facility within each selected village. This procedure was applied to all 3 selected divisions to make a total of 6 villages.

At the village level, the lists of active CHF members and those who dropped out were obtained from the nearby dispensary and/or health centre and non-members were obtained from the community. Stratified random sampling was employed to obtain 24 household heads from each village in the following three strata according to CHF membership status: 8 active CHF members; 8 previous CHF members who dropped out of the scheme; and 8 of those household heads who had never registered with CHF. Sampling between the strata was disproportionate, as the stratum of those who had never enrolled with CHF had many people compared to the other two strata and hence it was under sampled [42].

It was important to have all these categories of household heads in the study so that views from each group could be solicited as reasons for drop out might be different from reasons for not joining. Both drop outs and non-enrolment contributes to low enrolment. Also gender balance was considered, efforts was made to try to include both households with male heads in at least equal numbers as female headed households.

3.4.3.2 Selection of health facilities

Purposeful sampling technique was employed to obtain a total of 12 health facilities: The designated district hospital; 3 rural health centres and 8 rural dispensaries from which the health staffs and exit clients were obtained. Purposeful sampling was necessary so that the selected health facilities are located within the 3 selected divisions. The aim was to allow the same staffs that interact with interviewed household heads to be included in the study in order to get coherent information.

3.4.3.3 Selection of health staff

Thirty six health staffs, 3 from each facility in the following categories: clinician, nurse and technician who were available in the facility on the day of interview were included in the study.

3.4.3.4 Selection of exit patients

Stratified random sampling was employed to select exiting patients from the identified health facilities in two groups: CHF members and non members. At least 12 exiting patients from each facility were included in the study to make a total of

150 clients. However, the sample was also disproportionate because CHF non-members were too few among the exit patients hence they were over sampled in order to avoid sample bias.

3.4.3.5 Selection of District and CHF management officials

The District Medical Officer (DMO), District CHF coordinator and the Medical officer in-Charge of the Designated District Hospital were selected and interviewed as key-informants for in-depth interview by the virtue of their positions. They were regarded to have more information and knowledge about CHF and its implementation process. In-charge of the designated district hospital was involved because the hospital is partially private and it is an important stakeholder in CHF as community members use the hospital as their Referral District Hospital.

3.5 Data collection

3.5.1 Data collection instruments

Three sets of semi-structured questionnaires were used, one for heads of households, one for health staffs and one for exit patients to collect quantitative data. On the other hand interview guides were used to collect qualitative information from health staffs and the key-informants. Both the questionnaires and interview guides were translated into Kiswahili language for easy understanding by the study participants. A digital audio recorder was used to record the in-depth interview information

3.5.2 Data collection procedure

One week before the actual data collection process the questionnaires and interview guides were pre-tested by interviewing 10 household heads 3 health staffs and 10 exit patients in Ikuini village and dispensary respectively. Ikuini village is near by Mkuu town within Rombo District hence it was considered to resemble the selected villages in many aspects. The questionnaires and interview guides were corrected and reprinted for the actual process of data collection. The audio recorder was pre-tested on the day of purchase by recording the conversation between the principal researcher and the seller

Data collection procedure took about 27 days starting from 1st to 27th March. On 1st March the researcher obtained permission form the district council director and the

DMO to collect data in the selected villages and health facilities. From 2nd to 6th both the researcher and the assistant walked to the selected villages for introduction and setting strategies on how they can trace the selected CHF members and drop outs. Afterwards the principal researcher collected data from exit patients, health staffs and key informants while the research assistant collected data from household heads. Every evening the researcher and the assistant were meeting to review the filled questionnaires for correcting any error and entering their data in the SPSS computer program.

3.5.3 Household heads interview

Prior information about the study was sent to all households in the selected villages through the local government authority. Both the principal researcher and the assistant were introduced to ten-cell leader and have little conversation about CHF in his area. The ten-cell leader also helped in locating the household heads whose names were in the list of members and drop outs in his area. Thereafter the research assistant walked household-to-household in the selected village. In the household the research assistant asked for consent from the head of a household or his/her representative to participate in the study. The research assistant interviewed household heads who were willing to participate in the study by using a semi-structured questionnaire.

3.5.4 Exit interview

After obtaining the permission from the health facility in-charge, the researcher stayed at the exiting point of the facility for a whole interview day. The principal researcher explained about the study to the exiting clients and before the interview the researcher asked for consent from the interviewees to be involved in the study. Clients who were willing to be interviewed were provided with a place to sit. Then the researcher interviewed them by using a semi-structured questionnaire. In addition to interview the researcher conducted one focussed group discussion with exit patients aiming at getting more in-depth information about practices of health staffs.

3.5.5 In-depth interviews

The researcher visited the selected health staffs in their respective job stations for quantitative and the in-depth interviews. From health staffs we collected information about their opinions on CHF usefulness and their practices during implementation of

the scheme.The researcher also visited the DMO, CHF Coordinator and the Medical Officer in-charge of the district hospital in their respective offices for the in-depth interviews. From them we collected information about CHF operations, opinion on its usefulness, success and challenges and way forward to improve the scheme.

3.5.6 Measurement criteria

A. Knowledge on CHF among household heads

The interviewer listened carefully to the respondents' explanations and judged it against the given criteria based on the fact about CHF operations in Rombo district. The following were the criteria used to judge the accuracy of knowledge about CHF.

a- CHF is a voluntary health care financing scheme, membership fee is 5000Tshs which have to be paid once a year; maximum of 6 members of a household can be served by one membership card; the card can be used 14 days after registration; CHF pays for all available services from a dispensary to the district hospital and it pays only for 14 days when a member is admitted in the district hospital.

b- Failure to explain the above features of CHF operations or saying the opposite of any of them.

c- They only knew there is CHF and they were required to join but they did not know any thing about its operations.

Key a=correct knowledge; b=not correct knowledge; c=cannot explain.

B. Usefulness of CHF

Health staffs' opinion on CHF usefulness was equated to their realization of CHF benefits, and it was examined through in-depth interview.

3.6 Data management and analysis

During data collection, all filled questionnaires were revisited by the principal researcher. Both the principal researcher and the research assistant checked the questionnaires for any error and then entered them in a computer every day of data collection. Quantitative data from the pre coded questionnaires were entered using SPSS version 13 computer program. In data analysis frequencies and descriptive statistics were generated. Chi-square was used for significance testing of cross tabulated variables.

The recorded qualitative information were transcribed and translated into English language by the Principal researcher. ATLAS.ti 6 computer program was used to create networks, codes and themes for the transcribed qualitative information. The themes from each code were embedded to the results chapter to enrich the quantitative findings in a particular area where it fits the most.

3.7 Study limitation

Although we had the lists of CHF active members and drop outs during data collection, it was difficult to trace them as their households were widely scatterd in the villages.We had to walk long distances to reach all the selected household heads.

3.8 Ethical consideration

Ethical clearance was provided by Muhimbili University of Health and Allied Sciences (MUHAS) Research Committee. Rombo District Council Authority was consulted for permission to conduct a study. During data collection, participants were given a consent form which explains all the information about the aim, benefits, and risks of the study. The form was also explaining the right of the participant to agree refuse or drop out from the study. Then Participants responses are kept with confidential as their names are not appearing on the questionnaire instead questionnaire numbers were used. Each questionnaire was attached with a consent form. The right of the respondents to participate in the study or not was respected. There was no coercion or penalty for those who refused to participate.

CHAPTER FOUR

4.0 RESULTS

4.1 Socio-Demographic characteristics of study participants

4.1.1 Characteristics of Household Heads

Age and Sex Distribution

Both male and female household heads of different age groups were involved in the study. The ages of household heads ranged from 30 to 73 years, with the mean age of 44years and the median age of 42 years. The age group of 30-40 years had the highest proportion 57 (39.6%) of respondents, of which 27 (47.4%) were males and 30 (52.6%) female while the age group of 60 years and above had the lowest proportion 9 (6.2%) of respondents all of them were male. (Table 1)

Marital status of household heads

The highest proportion 123(85.4%) of household heads were married of which 88 (71.5%) were male; separated household heads were 7 (4.9%), of which 5 (71.4%) were male; widowed household heads were 13 (9%), of which 4 (30.8%) were male; only one single male household head was involved in the study (Table 1)

Level of education of household heads

Majority 115 (79.9%) of interviewed household heads had primary education where 36 (31.3%) of them were female; 17 (11.8%) of household heads had secondary education, among them 7 (41.2%) were female; and 12 (8.3%) of household heads had no formal education, of them 3 (25%) were female (Table 1)

Household heads' main source of income

Majority 101 (70.1%) of household heads had small scale farming as their main source of income, of them 73 (72.3%) were male; 43 (29.9%) of household heads were petty traders, of them 25 (58.1%) were male (Tale 1).

Table 1: Characteristics of Household Heads by Sex

Variables	Sex					
	Male		Female		Total	
	Frec	%	Frec	%	Frec	%
Age distribution in years						
30-40 years	27	47.4	30	52.6	57	39.6
40-50 years	38	70.4	16	29.6	54	37.5
50-60 years	24	100	0	0.0	24	16.7
60+ years	9	100	0	0.0	9	6.2
Marital status						
Single	1	100	0	0.0	1	0.07
Married	88	71.5	35	28.5	123	85.4
Separated	5	71.4	2	28.6	7	4.9
Widowed	4	30.8	9	69.2	13	9.0
Education level						
No formal education	9	75	3	25	12	8.3
Primary school	79	68.7	36	31.3	115	79.9
Secondary school	10	58.8	7	41.2	17	11.8
Main source of income						
Small scale farming	73	72.3	28	27.7	101	70.1
Petty trade	25	58.1	18	41.9	43	29.9
Total	**98**	**68.1**	**46**	**31.9**	**144**	**100**

4.1.2 Characteristics of Exit Patients

Among 150 exit patients 40 (26.7%) came from in-patient setting, 22 (55%) of them were male; 110 (73.3%) exit patients were from the out-patient, 28 (25.6%) of them were male. (Table 2)

Duration of hospital stay for in-patients

Among the 40 in-patients, the majority 23 (57.5%) had stayed in the health facility for maximum of 3 days, 11 (47.8%) of them were female; 10 (25%) of in-patients stayed for maximum of 7 days, of them 5 (50%) were female; 3 (7.5%) of in-patients stayed for maximum of 14 days, of them 1 was female; and 4 (10%) of in-patients stayed for 14 days or more, of them 3 (75%) were male (Table 2).

Table 2: Characteristics of Exit patients by Sex

Variable	Sex					
	Male		Female		Total	
	Frec	%	Frec	%	Frec	%
Type of health services						
In-patient	22	55.0	18	45.0	40	26.7
Out patient	28	25.5	82	74.5	110	73.3
Total	50	33.3	100	66.7	150	100
Duration of stay in-patients						
1-3 days	12	52.2	11	47.8	23	57.5
3-7 days	5	50	5	50	10	25.0
7-14 days	2	66.7	1	33.3	3	7.5
14 or more days	3	75	1	25	4	10
Total	22	55	18	45	40	100

4.1.3 Characteristics of Health Staff

Among 36 interviewed health staff, 12 (33.3%) were clinicians of which 6 (50%), of them were female; 23 (63.9%) were nurses, 4 (17.4%) of them were male; and one male technician (Table 3)

Experience of health staff in working with CHF

Majority 15 (41.7%) of interviewed health staff had worked with CHF for 6 years or more, among whom 4 (26.7%) were male; 14 (38.9%) of health staff had worked with CHF for 3 to 6 years, 5 (35.7%) of them were male; and 7 (19.4%) health staff had worked with CHF for a maximum of 3 years, 2 (28.6%) of them were male (Table 3).

Table 3: Characteristics of health staff by Sex

	Sex					
Variable	**Male**		**Female**		**Total**	
	Frec.	**%**	**Frec.**	**%**	**Frec.**	**%**
Cadres						
Clinicians	6	50	6	50	12	33.3
Nurses	4	17.4	19	82.6	23	63.9
Technicians	1	100	0	0.0	1	2.8
Experience in working with CHF						
1-3 years	2	28.6	5	71.4	7	19.4
3-6 years	5	35.7	9	64.3	14	38.9
6 or more years	4	26.7	11	73.3	15	41.7
Total	11	30.6	25	69.4	36	100

4.2 Management and Operations of CHF in Rombo District

The following are explanations on how CHF is implemented in Rombo District as given by the Key- informants. (DMO, CHF Coordinator and Medical Officer in-charge of the District Hospital)

Joining Process

The study found that the process of joining CHF starts by a head of household willingly going to the nearby public health facility for registration. The registration fee was TShs. 5,000 during the study period; it was reduced from Tshs.10, 000 which was the fee when the fund started in Rombo district. Then she/he is given a membership card: on the card a picture (preferably one picture of all six people or a passport size of each person can be used) of six members of a registered household is attached and stamped. This card becomes valid 14 days after the date of issue. There was no fixed time period for registration of members.

Management of finance

The health facility in-charge takes care of collected funds and he/she sends the money together with the general performance report of his/her health facility to the DMO on monthly basis. The DMO conducts a monthly meeting with all public health facility in-charges or their representatives where he receives CHF report and the money collected within the previous month. If a facility collects Tshs 100,000 or more per month then 20% of the money is given back to the respective health facility; Facilities whose monthly collection is less than the mentioned amount all the money would be taken to CHF account. CHF money is managed at council level where the DMO is signatory.

Health Service Package

CHF members were supposed to receive all types of services they need and which are provided by the health facility they visit. The services include referral from a rural dispensary through a health centre up to the district hospital. If a member is admitted in the district hospital CHF pays for him/her for fourteen days only. After the 14th day a patient would start to pay out of pocket for each service provided unless the physician writes a special request to ask CHF to continue paying for the

patient. This was supposed to be provided where the physician has recommended a longer stay of more than 14 days in the district hospital.

Modes of payments

The District Hospital sends the bills for each patient and each service to the DMOs' office on monthly basis. The DMO and the Council Director prepare payments and then write a cheque for the reimbursements to the hospital on monthly basis as well.

4.3 Situation of CHF enrolment

4.3.1Membership status among household heads

The sample of household heads had equal proportions, 48 (33.3%) of CHF active members, drop outs and those who had never enrolled with CHF. Summation of drop outs and those who had never enrolled equals to 96 (66.6%) of all interviewed household heads hence they are "non-members". However this does not reflect the actual proportion of members among households in the community because active members and dropout household heads were traced in the community in order to obtain their views and opinions. According to the DMO the current enrolment level in Rombo district was about 20% of all households in the district.

4.3.2 Membership status among exit patients

The results in figure 2 show membership status of the study respondents. In order to obtain the data the participants were asked if their households were at that time CHF members. The results shows that the majority, 117 (78%) of interviewed patients were active members of CHF while 33 (22%) were not members.

Figure 2: CHF membership status among Exit patients



4.4 Household heads' characteristics affecting CHF enrolment

4.4.1 Awareness and source of information about CHF

All interviewed household heads were aware of Community Health Fund (CHF). They reported to have learnt about it from different sources as shown in Table 4. Among 48 CHF members, majority 33 (68.8%) got information from health staff; 14 (29.1%) from village leaders; and 1(2.1%) from neighbours. Among 96 non-members, again the majority 59 (61.5%) got information from health staff; 25(26%) from village leaders; 7(7.3%) from neighbors and 5(5.2%) from friends. The difference in source of information between members and non-member was not statistically significant (P>0.05)

Table 4: Sources of CHF information by membership status

Source of information	Membership status					
	Members n =48		Non-members n =96		Total N = 144	
	Frec.	%	Frec.	%	Frec.	%
Village leaders/Meetings	14	29.1	25	26	39	27.1
Neighbours	1	2.1	7	7.3	8	5.5
Friends	0	0.0	5	5.2	5	3.5
Health Staff	33	68.8	59	61.5	92	63.9
Total	**48**	**100**	**96**	**100**	**144**	**100**

P=0.12

4.4.2 Household heads' knowledge on CHF operations among members and non-members

The results in Table 5 shows that among 48 CHF members, 43(89.6%) had correct knowledge about CHF operatios; 4(8.3%) had no correct knowledge and 1(2.1%) could not explain.While among 96 non-members the majority 65(67.7%) of household heads had no correct knowledge about CHF operation; Only 28(29.2%) had correct knoeledge and 3(3.1%) could not explain. The difference in correctness

of knowledge between members and non-members was statistically significant ($p<0.005$).

Table 5: Household heads' knowledge about CHF operations by membership status *

Knowledge	Membership status					
	Members n=48		Non-members n=96		Total N=144	
	Frec.	%	Frec.	%	Frec.	%
Correct	43	89.6	28	29.2	71	49.3
Not correct	4	8.3	65	67.7	69	47.9
Cant explain	1	2.1	3	3.1	4	2.8
Total	48	100	96	100	144	100

P Value = 0.000

**Measurement criteria is described in chapter 3 section 3.5.6 A.*

4.4.3 Membership status and household head's preference of health facilities

All 48(100%) CHF members reported to use public health facility first when they fall sick. While among 96 non-members, only 74(77.1%) of household heads use public health facility first when they fall sick; and 22(22.9%) use private health facility first. The difference in choice of health facilities between members and non-members was statistically significant ($p<0.05$) Table 6.

Table 6: Choice of health facility by membership status

Preferred Health Facility	Member n=48		Non-members n=96		Total N=144	
	Frec.	%	Frec.	%	Frec.	%
Public Facility	48	100	74	77.1	122	84.7
Private facility	0	0.0	22	22.9	22	15.3
Total	48	100	96	100	144	100

Fisher's Exact Test = 0.002

4.4.4 Household heads' main source of income and CHF membership status

Table 7 bellow shows that among 48 CHF members, the great majority 45(93.8%) were small scale farmers; and 3 (6.2%) petty traders. While among 96 non-members 56(58.3%) were small scale farmers and 40(41.7%) petty traders. The difference in source of income between members and non-members was statistically significant. ($p < 0.05$)

Table 7: Household heads' main source of income by CHF membership status

	Membership					
Source of income	**Member**		**Non-members**		**Total**	
	n=48		**n=96**		**N=144**	
	Frec.	**%**	**Frec.**	**%**	**Frec.**	**%**
Small scale farming	45	93.8	56	58.3	101	70.1
Business/petty trade	3	6.2	40	41.7	43	29.9
Total	48	100	96	100	144	100

p Value=0.006

4.5. Household heads' opinions on factors for low enrolment

4.5.1 Factors for joining the scheme

Household heads who were CHF active members were asked to mention reasons that motivated them to join the scheme. Their responses are shown in Table 8. The majority 41 (85.4%) said that they were motivated to join the scheme by understanding that health care cost will be reduced; 31 (64.5%) said they were attracted by increased availability of drugs in health facilities; 18 (37.5%) said they joined when they became aware of the scheme; 16 (33.3%) said they joined when they got money for paying a fee. Other reasons mentioned were: Presence of a chronically ill person in the household, Low cost of treatment when a patient is admitted in the district hospital, persuasion by clinicians and influence of neighbour and relatives.

Table 8: Factors for joining CHF mentioned by member household heads*

Factors	Frequency (n=48)	%
Awareness about CHF	18	37.5
Financial ability	16	33.3
Availability of drugs in public health facilities	31	64.5
Less cost of health care services	41	85.4

** Participants were allowed to mention more than one factor*

4.5.2 Factors for drop out

Household heads that dropped out of the scheme were asked to mention reasons that contributed to their dropping out. Table 9 shows that majority 39 (81.2) of them mentioned shortage of drugs in a health facility; 35(72.9%) said non-members get better services; 27 (56.2%) mentioned long waiting time; and 22 (45.8%) mentioned lack of money.

Table 9: Respondents reasons for dropping out of CHF*

Factors	Frequency (n=48)	%
Lack of money	22	45.8
Long waiting time in public health facilities	27	56.2
Always drugs are not available at public health facilities	39	81.2
Non-members get better services	35	72.9

** Participants were allowed to mention more than one factor*

4.5.3 Factors that discourage the majority from joining the scheme

Household heads both members and non-members were asked to give their opinion on the factors that discourage majority in the community from joining the scheme. Their responses are shown in Table 10. Among 48 members, all 48 (100%) mentioned lack of money as a factor for not joining the scheme; 20 (41.7%) long waiting time; 8 (16.7%) shortage of drugs; 4 (8.3%) inadequate sensitization; and 3 (6.2%) bad language of staff. While among 96 non-members, 73 (76%) mentioned lack of money; 47(49%) shortage of drugs; 44 (45.8%) long waiting time; 5 (5.2%) inadequate sensitization; and 3 (3.1%) bad language of staff. There was a statistically significant difference in the number of participants who mentioned shortage of drugs between members and non-members. Another factor found was less perceived risk of illness.

Table 10: Reasons for not joining the scheme by households' membership status *

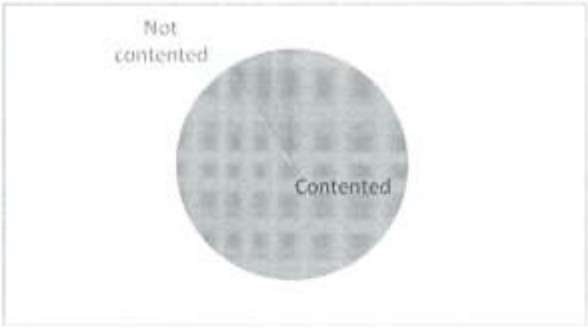
Reasons for not joining	Membership status						P-value
	Members		Non-members		Total		
	n=48		n=96		N=144		
	Frec	%	Frec	%	Frec	%	
Bad language of staff	3	6.2	3	3.1	6	4.1	0.67 (Fishers exact)
Long waiting time	20	41.7	44	45.8	64	44.4	0.12
Shortage of drugs	8	16.7	47	49	57	39.5	0.000
Inadequate sensitization	4	8.3	5	5.2	9	6.3	0.73 (Fishers exact)
Lack of money	48	100	73	76	121	84	0.43

**participants were allowed to mention more than one reason*

4.6 Satisfaction with Service Package Given to CHF members

Exit patients were asked if they got all services they needed from the health facility. Majority 149 (99.3%) of 150 exit patients said they got all the services required from the health facility; however one patient said he bought some drugs by his money from a drug shop. The 117 exit patients who were current CHF members were asked whether they think service package they receive as CHF members was enough. Figure 6 shows that majority 106 (90.7%) of CHF members in the exit interviews reported that they were contented with the service package. However, 11 (9.3%) reported that they were not contented and they would like other services to be added like presence of diagnostic laboratories in rural dispensaries and dispensaries to provide services for 24 hours.

Figure 3: Exit patients' contentment with service package



4.7 Arrangements for CHF members as compared to non-members when they visit health facilities.

All exit patients reported that there were no different arrangements for CHF members when they visit health facilities. Health staff also were asked whether there were special arrangements for CHF members when they visit health facilities. All interviewed health staff said that there are no special arrangements for CHF members. Through the in-depth interview with health staff it was found that both CHF members and non-members follow the same queue and they were attended at the same places for consultation, diagnostics and pharmacy. Health staff were further asked whether there were different and special services for CHF members. All

interviewed health staff said there was no different and special service for CHF members. The results from the in-depth interview also found that CHF members receive the available services just like other patients.

> *"Even if there is shortage of one drug or a particular service both members and non members will be affected equally, there is no special services for CHF members"* said one clinician from a rural health centre

4.8 Exit patients' opinion on health staffs' practices during their interaction with patients

Exit patients were asked to give their opinions on the practices of health staff in the facilities they attended. Figure 7 shows that the great majority 149 (99.3%) of 150 exit patients said generally health staffs have good practices and only one exit patient said health staff have bad practices.

Figure 4: Exit patients' opinion on practices of health staff



Ext patients were provided with a list of practices which are regarded by community and health professionals as bad to be done by health staff when they are interacting with clients. They were asked to choose from the list any practice they had encountered during this or any other visit to the respective health facility. None of the respondents selected any bad practices from the list (Table 11). Exit patients were further asked to mention any other bad practice they have encountered when they visited the health facility. One of them said that when the health facility in-charge is

not around, some health staff in that rural health facility leave the work place before time, or they go out of the offices and leave patients in the queue.

Table 11: List of potentially bad practices to be done by health staff

Practice
They didn't greet me
They didn't listen attentively to my complaints
They were too in hurry that they didn't have time to answer my questions
They asked me about payments at the first place
They asked me for some money although I had CHF card

Exit patients were also given a list of good practices expected from health staffs' when they are interacting with clients. Participants were supposed to choose from the list good practices they had encountered in the facility during this visit or any other visit to the respective health facility. Almost all exit patients choose all the good practices from the list (Table 12).

Table 12: Good health staff practices encountered by exit patients*

Practices	Frequency N=150	%
They greet and welcome me warmly when I enter their area of service	150	100
They examined me kindly	150	100
They treated me with compassion	150	100
They gave me clear explanation on how to use medication	150	100
Politely they asked me about payment and explain to me about the available ways of payment	149	99.3

**Participants were allowed to choose more than one practice*

A group discussion with 8 women who were admitted in general ward in one of the rural health centres was carried out for the aim of getting more in-depth information

about health staffs' practices. All the women said, generally health staff in that facility and the neighbouring dispensaries had good practices.

> *"Even if a clinician or nurse talks to you with a raised tone of voice, then you do not have to get angry because he/she is teaching you for your own benefit"* said one woman.

There after they were further asked whether they could drop out from CHF if the health staff become rude at them.

> *"No! CHF is for our own benefit if we leave it then it is us who will get loss and not the health staffs"* said another woman.

4.9 Health staffs' opinions on usefulness[1] of CHF in Rombo district

Health staff were asked if they thought that CHF has any benefit to them, community members, and to health sector at large. All health staff reported that CHF was beneficial. There after they were further asked to mention the benefits of CHF to them. Their responses are shown in table 13. Majority 31 (86.1%) of health staff mentioned improvement of their working environment; 21 (58.3%) of health staff said CHF has improved availability of drugs and other supplies; 11 (30.5%) of health staffs said it simplify work because patients come to the hospital earlier; and 5 (13.9%) of health staff said CHF has no benefit to them.

Table 13: CHF benefit to health staffs by different cadres*

	Staff cadres							
	Clinicians		Nurses		Technician		Total	
Benefits	Frec	%	Frc	%	Frec	%	Frc	%
Improve work environment	11	35.5	20	64.5	0	0.0	31	86.1
Improve availability of Drugs	9	42.9	12	56.1	0	0.0	21	58.3
Simplify work as patient comes earlier	5	45.5	6	54.5	0	0.0	11	30.5
It has no benefit to me	1	20	3	60	1	20	5	13.8

**Participants were allowed to mention more than one benefit*

During the in-depth interview it was found that majority of health staff believe that they benefit from CHF because of that 20% the health facility get back from CHF membership contributions.

> *"We can hire a person to cut the grasses, to tide the fence, to fetch some water and even we can get a cup of tea with this CHF money"* said one nurse from rural dispensary.

Majority also said that with CHF availability of drugs and other working tools like gloves, syringes have improved to a large extent.

> *"These days we don't have that problem of telling patients go buy drugs, go buy syringe, we have plenty of supplies"* said one nurse from a health centre.

However a few staff do not believe that they benefit from CHF.

> *"As a health staff I don't benefit any thing because CHF is a fund for people in the community"* said one clinician from a rural health centre.

Health staff from the district hospital appeared to have a slightly different opinion about CHF benefit to them. One health staff from the district hospital said

> *"Getting lump sum each month is easier than collecting payments from each patient as you know people here are just borderline economies and when they fall sick their economic condition become worse, so sometimes you may find a patient has no money but if he is a CHF member then we are sure that we will get our money. It is easy for us to claim the money from CHF through DMO and Council Director"* Said one clinician from the district hospital.

Further more another staff from the district hospital said

> *"For us it is a loss because we don't get CHF money on time, sometimes we run short of supplies but at least for out of pocket we collect money daily we get money everyday for our expenditure"* Said one nurse from the district hospital.

Health staff were again asked to mention the benefits they thought community members receive in joining the scheme. All 36 (100%) of interviewed health staff said that CHF protect members from falling into poverty due to the costs of health care; and 21 (58.3%) of health staffs said CHF improves health care seeking behaviours to community members (Table 14).

Table 14: CHF benefit to community members as mentioned by staff of different*

	Staff cadres							
	Clinicians		Nurses		Technician		Total	
Benefits	Frc	%	Frc	%	Frc	%	Frc	%
Reduce chances of falling into poverty due to health care costs	12	33.3	23	63.9	1	2.8	36	100
Improve health care seeking behaviours	7	33.3	14	66.7	0	0.0	21	58.3

*participants were allowed to mention more than one benefit

During the in-depth interview it was found that the great majority of staffs believe that CHF is very useful when a household member falls sick especially during the rain seasons where many household would not have enough money to meet their needs. It protects them from selling cattle or household assets due to cost of health care. One health staff had these to say

> *"example if a person breaks his/her leg during the period of food shortage the household will have no option but to sell a cow or a goat or even a piece of land so that they can get money to take the patient to the district hospital. But when the household has joined CHF then there is no fear of costs, only money for transport is required because when they reach in the hospital they will get every thing free including food"* said one clinician from a rural dispensary.

Health staff were also asked to mention benefits they thought the health sector in general might gain from the presence of CHF. Data in table 15 show that majority 32 (88.9%) of staffs said CHF improves the availability of finances for health care; 7 (19.4%) of staffs said it reduces costs of health care because patients seek health care earlier; and 3 (8.3%) of staffs said CHF has no benefit to the health sector (Table 15).

Table 15: Benefit to the health sector as reported by different health staff cadres*

	Staff cadres							
	Clinicians		Nurses		Technician		Total	
Benefits	Frc	%	Frc	%	Frc	%	Frc	%
Improve availability of finances for health care	10	31.3	22	68.7	0	0.0	32	88.9
Reduces coast of health care as patients seek care earlier	2	28.6	5	71.4	0	0,0	7	19.4
It has no benefit to health sector	2	66.7	0	0.0	1	33.3	3	8.3

* *Participants were allowed to mention more than one benefit.*

It was also found that the great majority of health staff believe that before CHF come into being there were shortage of drugs and other supplies. As well before CHF health facilities were receiving drugs and supplies from Medical Store Department (MSD) only while with CHF, DMO is allowed to order drugs for his health facilities from a private pharmacy.

> *"These days we get drugs twice a month, before drugs from MSD are finished the other drugs come from the DMO, even if you run short of one drug you can borrow it from the neighbouring facility because you are sure of getting yours soon"* said one clinician from a rural dispensary.

Health staffs were further asked whether they would like all community members to join CHF. All of them said they would like all households in the community to join CHF. In the in-depth interview it was found that all health staff are fond of CHF because of its benefits.

> "*We do not benefit from out of pocket payment because all the money goes to the council, but with CHF we benefit because there is that subsidy/top up from the government and also we get 20% back to our facility*" said one clinician from a rural dispensary.

Health staff were also ready to join the scheme if they were not government employees and hence not members of National Health Insurance (NHIF). Even one of them reported to have a CHF card because his family has many people that exceed the number of people who can be registered in his NHIF card.

CHAPTER FIVE

5.0 DISCUSSION

5.1 Situation of CHF enrolment

Level of CHF enrolment among households in Rombo district was found to be lower (20%) compared to the goal of the Ministry of Health which is to achieve 60% enrolment level in the CHF schemes [16]. Low enrolment exposes the scheme to the problem of adverse selection due to the reason that households whose members think of having high health risks might be dominant among the scheme members. Adverse selection denies the scheme that quality of sharing the risks between unhealthy and healthy people [1].To minimize the likelihood of adverse selection, Rombo CHF have to increase enrolment and retain members in order to maintain correct mix of members who can create a meaningful cross subsidization of risks between high risk and low risk individuals [1, 11].

5.2 Characteristics of household heads

5.2.1 Awareness about CHF

Awareness of CHF was high among household heads, health staff and exit patients. Having high awareness was a good characteristic of a household head and can predict high level of enrolment. However awareness alone can not be sufficient factor to maintain high enrolment level. Other factors like knowledge, preference of using public health facility versus private, willingness and ability to pay has important influence in maintaining high enrolment to the scheme. Furthermore, given that health staffs were vital messengers of CHF scheme in Rombo district, their practices were also likely to have considerable influence on performance of the scheme and hence its level of enrolment [36].

5.2.2 Knowledge on CHF operations among household heads

The study found a statistically significant difference in corectiness of knowledge about CHF operations between members and non-members (Table 5).The proportion of household heads with correct knowledge was higher (89.6%) among members as compared to those among non-members (29.2%). This finding reflects that knowledge about CHF was an important determinant of a household head's decision in joining, dropping out or not joining the scheme. The results also indicate that more

than half of the population had no correct knowledge about CHF operations. That means more community education and sensitization is needed in order to increase enrolment.

5.2.3 Choice of health facilities among household heads

Rombo district health profile shows that hundred percent of households are located within 0-10km distance from a public rural health centre and 99.3% are within 0-5km distance from a public dispensary while the national average is 0-10km from a rural health centre and 0-5 from a dispensary [38]. Despite the short distance from households to a public health facility still a considerable proportion of household members prefer using a private health facility. Table 6 shows that 22.9% of CHF non-members preffer going to private health facility first when they fall sick while all CHF members reported to prefer public health facilities.The difference in preference of private health facilities between members and non members was statistically significant. For this reason it was necessary for the scheme to involve more private providers in its scope of operations so that it could attract even those households whose members prefer using private facilities. Lack of sufficient involvement of private health providers is likely contributory factor for low enrolment.

5.2.4 Household heads' main source of income

Main source of income for households was found to be small scale farming and petty trade (Table 7). The proportion of petty traders among non-members appears to be higher (41.7%) as compared to 6.2% of members. This creates an impression that household heads that had regular incomes were not willing to join perhaps because they were sure of having some money to pay out of pocket whenever they fall sick. Petty traders have more regular incomes because business can be done through out the year while small scale farmers' incomes fluctuate according to the seasons of the year.

5.3 Household heads' opinions on factors for low enrolment

5.3.1 Factors for joining the scheme

Among the factor motivated people to join the scheme (Table 8) includes: reduced health care cost; awareness of the scheme; increased availability of drugs; financial ability; good attitudes of health staff in public health facilities; presence of a chronically ill person in the household; Low cost of treatment when a patient is

admitted in the district hospital, persuasion by clinicians and even pressure from neighbours and friends. Most of these factors reflect lack of proper understanding about community health insurance funds. The spirit of sharing health care costs between the wealthier and less wealthy people and between high risk and low risk people might not be conceived in the mindsets of the population in Rombo. Hence insuring against health risks might not be considered as a priority. This has negative consequence in both the community members and the scheme itself. If presence of a chronically ill people in the household become the factor for joining, then the scheme is likely to suffer the effects of adverse selection as the great portion of its members will be high risk ones. Therefore the cost of running the scheme would be higher than what the scheme collects. On the other side, not joining the scheme would deny community members of financial protection for health care.

5.3.2 Factors for drop out and not joining the scheme

Low enrolment results from both factors for drop out and not joining the scheme (Table 9 and 10). Among the factors there was a misconception that non-members get better services because they pay some money directly in the health facility which was mentioned by a considerable proportion (72.9%) of household heads that dropped out of the scheme. The notion that paying out of pocket is better might be among the fallacies that exist among people who have no correct information and knowledge about CHF. Furthermore this contradicts with the fact that both CHF members and non- members use the same arrangements and they receive the same services in the public health facilities.

In addition peoples who dropped out said that they were also disappointed by the short period of services (14 days only) when a member is admitted in the district hospital. The factor that duration of CHF services being 14 days only should not be under estimated because it was found that considerable proportion (10%) of in-patients stay in the district hospital for more than 14 days. The disappointments encountered by previous members may signify the effect of disagreement which might have resulted from non-involvement of community members in decision making on how the scheme should be operated. From the the literature it was found that community participation in decision on how the scheme should be operated is

necessary in order for community members to realize its value and join willingly [24].

Lack of money is the factor which appears to be common for drop outs, and not joining CHF. A study done by Msuya in rural Tanzania on impact of CHF on access to health care also found lack of money as a major factor contributed to non-enrolment to CHF schemes [11]. In Rombo district lack of money might have its basis from the fact that majority of community members depends on small scale agricultural activities as their main source of income. Even most of petty traders rely much on agricultural products for their trade commodities. Productivity in small scale agriculture in Rombo district depends only on weather conditions including rainfall. For more than a decade now Rombo has been receiving unreliable rainfalls. This means many households have been experiencing shortage of agriculture products both for food and for trade and therefore their incomes also have been affected.

However, lack of money as a factor for dropp out or not joining CHF seems to be more on lack of willingness to insure against health risks instead of the actual financial inability of paying membership fee. In reality TShs 5,000 appears to be relatively too little to be raised by a household because it worth only one grown chicken. This implies that there is a need for more community education on the importance and benefits of insuring for health.

Otherwise lack of money can be worked-out by a change in CHF policy, for instance deciding on a fixed time for registration process. Management by involving community members should agree on the suitable time of doing membership payments. In Rombo the most suitable period would be during harvest season as it is known that majority of Rombo households depends on small scale farming and their incomes are more likely to increase during harvests. Many other Community Health Funds have become successful by following this regulation of collecting payments during harvest season [16, 43]. Having an agreed fixed time of payments may as well serve to close the loop-hole for drop out and not joining the scheme. Community

members would not have that reason of waiting until they fall sick before joining the scheme.

Shortage of drugs in public health facilities was mentioned by household heads as a factor for both drop out and not joining the scheme. Contrarily, availability of drugs was again mentioned by CHF members as among the factors that motivated them to join the scheme.In addition exit patients reported to be contented by service package they receive from the public health facilities. Furthermore, health staffs reported that CHF improves availability of drugs. Hence perhaps households' heads who mentioned shortage of drugs as a factor for drop out or non-enrolment might not be well informed of the improvement that had occured in the public health facilities since the establishment of CHF.

Long waiting time in public health facilities is a problem known to affect patient satisfaction to health care and consequently to CHF as well. It has also been mentioned as a factor for not joining the scheme. This might be contributed by reasons like shortage of health staff and incorrect mix of staff cadres which is widely known to affect public health sector [44, 45]. Long waiting time can be intervened by policy action for example setting regulations that specified group of population would be attended at a specified time period or certain types of illnesses to be attended in a specified days of a week to avoid over crowding of patients.

Less perceived risk of illness was also mentioned as a factor for not joining the scheme. It signifies that some community members join CHF just because they are risk averse other wise if they were sure of staying healthy for the whole year they would not join. In reality illness is uncertain and cost of treatments may be catastrophic hence Rombo people needs to be educated in order that many of them could realize the true meaning of community insurance.

5.4 Contentment of beneficiaries with CHF benefit package

Majority of exit patients who were CHF members show great contentment with the service package they received from public health facilities (Figure 3). With this delight we would expect higher enrolment of community members to the scheme. However, the views of exit patients might be different from that of the majority in

the community. It could be of practical value if health staff could inspire their patients who are active CHF members to take a role of peer educators to their fellow community members and reveal to them the importance of joining CHF.

5.5 Arrangements for CHF members in health facilities

There were no special arrangements for CHF members when they visit health facilities. This implies that there minimal likelihood of discriminations or intimidation against CHF members by health staff. For instance if there is a problem of too long queue it means both members and non-members would suffer equally. Any effort done to improve quality of health care provision would benefit both CHF members and non-members.

5.6 Practices of health staffs

The practices of health staffs were found to be highly accepted by exit patients (Figure 4). However patients may be tolerant to some degree of harsh practices from health staff for example, patients may consider a word said with raised voice as a point of education for their benefit. This can be related to the observable fact that patients tend to be indifferent to bad practices as they consider health staff to be superior and knowledgeable and hence put themselves at subordinate position [46]. Furthermore, it has been found by Shaw that majority of customers who are not satisfied with the services, they never complain instead they silently seek the same services elsewhere [16]. Little or no complains might not necessarily mean that people are happy with the practices since patients may encounter bad practices from health staff instead of complaining they might choose not to use public health facility anymore. These passive unsatisfied people when they stop using public facilities they will definitely drop out or not enrolling with CHF.

5.7 The opinions of health staff on CHF usefulness

All health staff believe that CHF is beneficial to them, to community members and to the health sector (Table 13, 14 and 15). This reflects that even health staff were not happy with the previous situation in the public health facilities. Before CHF, public helth facilities were characterised by shortage of drugs and other working tools. Health staff are now feeling better with the improvements that have been brought by

CHF. Therefore we can be confident that health staff in public health facilities would like to see a sustainable CHF.

However, negative influence may arise from the health staff in the district hospital which is not purely public. The district hospital has a considerable influence on CHF performance because it is the only hospital in the district which is accredited by CHF and hence it is a district referral hospital. The responses from district hospital staff seem to differ from the other staff. Perhaps it is because the district hospital does not collect fees from CHF members hence it does not get that 20% incentive, instead it receives payments for the services it offer to CHF members. The staff in the district hospital seems to be more conscious about their payments than health care financial protection for community members. As we can learn from the two staffs in the district hospital; one likes CHF because it simplifies the way of collecting payments and also it assure the hospital to get paid even if the patient does not have money at instant. Another staff definitely prefer out of pocket for the sake of collecting funds for every day's expenses in the hospital.

Furthermore, there is an agreement that if a patient genuinely needs to stay in the hospital for more than 14 days then the physician should write a special request letter to CHF management to justify as to why CHF should continue to pay for that particular patient. Yet the compliance on this agreement is being questioned by this study as we have seen in the previous paragraphs, 14 days duration of CHF services in the district hospital has been mentioned as a factor for both drop out and not joining the scheme. However, this study did not establish whether the practices of health staff in the district hospital have effect on CHF enrolment. There is a need for further studies to explore more about the influence of private providers on CHF performance in Rombo district.

5.8 Conclusion

The study found that awareness among both community members and health staff was very high; Practices of health staff were highly accepted; Health staff were very optimistic on usefulness of CHF. However, lack of knowledge about CHF operations among household heads was found to have a significant negative effect on enrolment. Lack of fixed time period for collecting payments also was found to

create a loophole for drop out and not joining the scheme. All the factors found to contribute to low enrolment in Rombo CHF scheme could be intervened through policy change and increased accountability. It is not uncommon for a new scheme like this to face some implementation challenges. It is necessary to find correct solutions for the challenges and look forward to positive growth.

5.9 Policy implication and Recommendations

Although this study gives a short analysis of implementation problems in Rombo CHF scheme; it also offers some perception to numerous issues of policy importance concerning CHF operations.

1. Lack of knowledge among community members on how CHF is operated was found to affect enrolment level. We recommend the Management to put more effort on community education through frequent sensitization meetings. Other stakeholders like religion leaders should be involved in the sensitization.

2. Rombo CHF scheme has no fixed period of collecting payment from its members that means households join at any time they feel the need to. We recommend that Rombo CHF management should agree with community members of a specific time period of collecting payments.

3. Significant proportion of Rombo people prefers using private health centres and dispensaries. We recommend the scheme to establish partnership with more private health providers so that those who prefer private facilities should equally benefit.

6.0 Area for future research

There is a need to explore the influence of private health sector on CHF performance in Rombo district.

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