EXPLORING THE EFFECTS OF USER FEES, QUALITY OF CARE AND UTILIZATION OF HEALTH SERVICES ON ENROLMENT IN COMMUNITY HEALTH FUND, BAGAMOYO DISTRICT, TANZANIA.

By

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A Dissertation Submitted in Partial Fulfillment of the requirements for the Degree of Masters of Medicine in Community Health of the Muhimbili University of Health and Allied Sciences

Muhimbili University of Health and Allied Sciences

November, 2012

CERTIFICATION

The undersigned certifies that has read and hereby recommends for acceptance of dissertation entitled '*Exploring The Effects Of User Fees, Quality Of Care And Utilization Of Health Services On Enrolment In Community Health Fund in Bagamoyo District, Tanzania'* in partial fulfillment of the requirements for the degree of Masters of Medicine (Community Health) of Muhimbili University of Health and Allied Sciences.

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Date

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DEDICATION

To Jo-Marie, Davidson and Tumaini.

ABSTRACT

Background: The co-existence of Community Health Fund (CHF) and user fees in Tanzania as health financial mechanisms have affected to CHF enrolment. However, little is known about the effect of user fees on CHF enrolment, non-enrollment and drop-out.

Objectives: The study aimed at exploring the effects of coexistence of user fees and Community Health Fund scheme, quality of care and utilization of health services on CHF enrolment, non-enrollment and drop out in Bagamoyo District, Coast Region, Tanzania.

Methods: An exploratory cross sectional community and health facility study was conducted in Bagamoyo District between April and May 2012. The study involved heads of households who were categorized in four groups; CHF members from community (63), non CHF members from the community (60), CHF members from health facilities (145) and non CHF members from health facilities (144). The study participants were interviewed using a semi-structured questionnaire. Univariate and multivariate analyses were done to find factors associated CHF enrollment, non-enrollment and drop-out.

Results: Although user fee was not pointed as the reason for not joining CHF, CHF members were significantly more likely to pay higher amount of user fee than non CHF members ($p < 0.01$). Being a CHF member was associated with non- payment of user fees and higher expenditure on health services. Furthermore, health services utilization, although slightly lower among non CHF members, was not statistically different between CHF and non CHF members ($p = 0.09$). Poor quality of health services at health services and poor referral mechanisms were the main reasons for dropping out from CHF.

Recommendations: The co-existence of user fees and CHF should be re-visited. Efforts should be taken to improve quality of health services and referral mechanisms in the public health facilities in Bagamoyo in order to reduce unnecessary distress to the CHF members, decrease drop out and improve the performance of CHF in Bagamoyo.

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ACRONYMS

CHF - Community Health Fund

MHO - Mutual Health Organizations

MOHSW – Ministry of Health and Social Welfare

NHIF - National Health Insurance Fund

TIKA – Tiba kwa Kadi (Treatment by Health Card).

TZS - Tanzanian shillings

URT - United Republic of Tanzania

VEO - Village Executive Officer

WHO – World Health Organization

CHAPTER 1: INTRODUCTION

1.1 Background

The world is facing challenges in financing and providing health care for its 1.3 billion poor people especially those who live in low- and middle-income countries[1]. Many poor people lack access to effective and affordable health interventions, largely because of weaknesses in the financing and delivery of health care[1, 2, 3].

World Health Organization (WHO) health financing policy emphasizes that the health system as a financing strategy is a key determinant to population health and well-being[4]. This is particularly true in the poorest countries where the level of health spending is still insufficient to ensure equitable and universal access to needed health services and interventions.

In Tanzania, after independence and before 1990, health services were fully funded by the government through taxation, and provided without charge for all Tanzanians[5]. In the year 1990, the government changed its health financing policy: while the government continued to be the main health system financier, individuals were required to contribute for health services[5]. To facilitate individual contributions, different health financing mechanisms were introduced namely; user fees, health insurance, and community health funds (CHF). Currently, Tanzania uses a mixture of health financing mechanisms: taxation, donor funding, health insurance (both private and national), user fees and CHF[5,6].

Out of pocket health spending through user fees was introduced in Tanzania in 1993 as additional resource for health services in Tanzania[5]. They are being paid at the point of service delivery, the health facility. They have the potential to improve the quality of health services and working conditions but also impose financial barrier to access the health services to the poor especially when sick during times without cash in hand. User fees also divert much needed resources from the individuals for other essentials like child's education fees or food[13].

Health insurance policy was also introduced in Tanzania in the year 1993[5]. This health financing mechanism covers mainly the formal employees with regular incomes both in public and private sectors. The schemes require monthly subscription premiums. The coverage of

National Health Insurance Fund (NHIF) in Tanzania as at July 2010 was about 3%[6], that is for formal employees and their families. These formal health funding mechanisms do not solve the challenge on how to finance health services to over 70% of Tanzanians residing in rural areas who are also involved mainly in the informal economic sector.

Apart from user fees and formal health insurance scheme like NHIF, Tanzania also introduced Community Health Fund (CHF) in 1996[5], a voluntary health financial scheme aimed to cover the informal sector in rural areas[7]. Its equivalency, Tiba kwa Kadi, (TIKA), covers for informal sector in urban areas[7]. The Fund provides its members with access to health services from health facilities within the respective districts. This was an initiative by the government to make health services affordable and accessible to the rural and in informal sector population[7]. Its advantage is that it allows one to pay contributions when one is healthy and drawing on them in the event of illness later. CHF also provides additional resources for the provision of health services. Anecdotal evidence has associated low CHF enrolment with lower out of pocket spending for health.

Although CHF has been implemented in Tanzania for more than 15 years, reports show that although it has been in operation in 119 councils by the year 2011, several challenges have been shown to retard CHF success[8,9]. The main challenge is low CHF coverage. In 2011, the average CHF coverage was reported to be 10%[8], lower than the national target of 70%[10] set in 2010. Secondly, CHF faces massive dropouts as experienced in councils like Nzega[11] and Hanang[12].

The government spending for health through taxation in the year 2010 was about 12.9% of the total national budget. However, this allocation accounted to only about 64% of all health expenditure in 2010. The remaining proportion was funded by other health financing mechanisms such as formal health insurance 3%, user fees 0.9% and CHF which amounted to 3.1bn out of 908bn of total health expenditure (0.3%)[6]. In 2009/10, Tanzania's user fees amounted to 7.8bn while CHF expenditure was 3.1bn[6]. These two financing mechanisms are

used at the district level of health care to supplement the government allocation for health services.

Although user fees forms the major source of funding for health services in the districts[6], it creates challenges to the implementation of CHF, both in the negative and positive ways. One, when set low, user fee diverts people from enrolling to CHF as people opt for user fees, while on the other hand, the low user fee cannot cover the gap left by the national health budget allocation[22]. However, at the same time the user fees fail to provide adequate health services to the communities as the amount collected would be inadequate which in turn would discourage people from joining CHF. User fees have also been shown to be a barrier for the poor and other vulnerable populations from accessing health services[25].

This study therefore aimed to explore the effects of co-existence of the user fees on the CHF enrolment, disenrollment and dropout. The paper explicitly tries to find out if user fee and quality of health services at health facilities provide the barrier to enrolling in CHF. Quantitative approach was used using individual interviews. The first chapter of this dissertation presents the introduction in which background of the theme, problem statement, conceptual framework, rationale and objectives of the covered are also explored. Chapter two presents the literature review with particular attention to user fee and CHF in which the main arguments with regard to benefits and effects of both user fee and CHF are reviewed. Chapter three deals with methodology. While chapter four covers results, chapters five and six are about discussion and conclusion and recommendations respectively. Various references used in the preparation of this dissertation are shown in chapter seven.

1.2 Problem statement

The majority of Tanzanians reside in rural areas and engaged in the informal sector[14]. This group comprises of about 70% of all the Tanzanians[14], is difficult to reach with formal health insurance mechanisms. It is also the population group that can be temporarily or partially excluded from health care when user charges must be paid at the point of seeking care. This is due to poverty and irregular or seasonal revenues that do not always provide households with the cash needed to seek care when illness occurs. Therefore, CHF was seen as the most viable

option for improving access to health services and providing financial risk protection for these populates.

CHF started in Tanzania in 1996. However despite CHF being operational in 119 out of 133 councils for more than 15 years in some of the councils in Tanzania, it is still underperforming[8]. As of September 2011, only 9 per cent of Tanzanians were members of CHF and 52 per cent of councils had CHF enrolment of 3% or lower[8]. This is less than the government target of 70 per cent[10] and the revised target of NHIF of 30 per cent by 2010 (20 per cent in CHF and 10 per cent in NHIF)[15]. Bagamoyo coverage of CHF was 2.5 per cent according to CHF report of September 2011[10].

In all districts where CHF is implemented, the respective health facilities charge user fees. Co-existence of user-fees has been shown to challenge the CHF performance. For example low user-fees have been shown to attract people away from pre-payments and low user-fees are associated with massive drop of CHF enrolment in Hanang, from 23% in 1999 to 2.2% in 2001[12]. Low user fees have also been found to affect enrolment (drop out) in Nzega.[11]

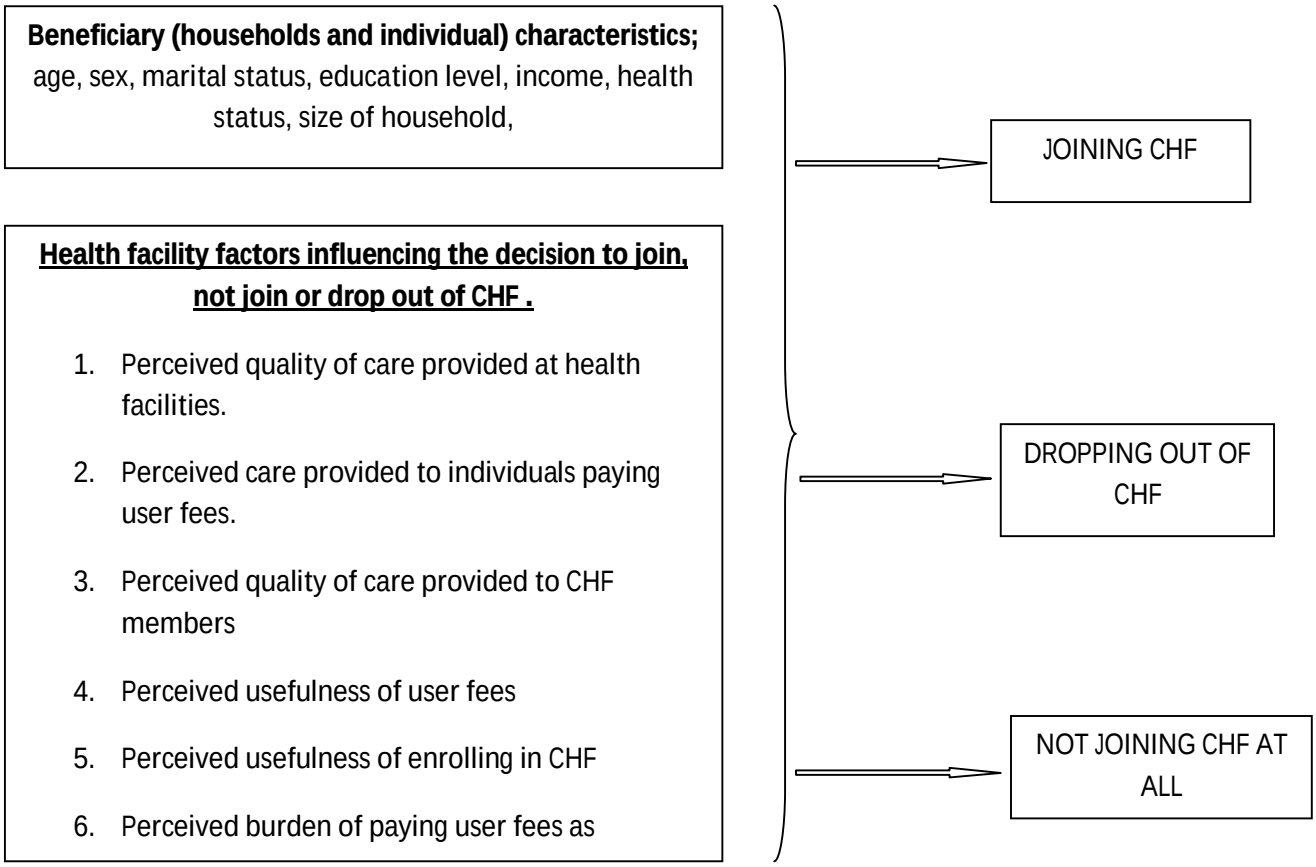
Waiver system and exemption have been introduced to reduce the impact of user fees scheme by excluding those who cannot afford to pay for health services and thus have more access to health services. With majority of Tanzania living below poverty line, of concern is to find that stakeholders continue promoting and supporting user fees in the absence of effective exemption and waiver system. This has negatively affected the accessibility of health services to the majority of Tanzanians.

Despite the fact that user fees have been seen to affect CHF enrolment[11, 12], little is known about the effect of user fees in relationship to all aspects of CHF, namely; enrolment, non-enrollment and drop-out. Other factors like quality of health services and health services utilization were also explored.

1.3 Conceptual framework of factors influencing enrollment, non-enrollment and drop out from CHF

At community level both the health care providers and beneficiaries are important actors in the implementation of CHF. Being a prepayment scheme, any alternative paying scheme to CHF invariably affects the decision making of head of household in the enrolling in CHF. Quality of care provided at health facilities greatly affects the decision of the household to join the CHF. Health service utilization is another determinant for enrolling or not enrolling into CHF. Household heads may opt for user fees knowing that they may pay the CHF premiums and not use it as they may not get sick or that paying for the user fees may be cheaper than paying the CHF premium. Another important factor to the enrolling or not enrolling into the CHF is the perceived quality of care received bearing in mind one paying for user fees or enrolled in CHF may have a choice of health providers.

Figure 1: Conceptual framework of factors influencing enrollment, non-enrollment and drop out from CHF.



Source: Author.

1.4 Research questions

1. What characteristics of households may affect CHF enrolment and non-enrolment?
2. What characteristics of health facilities may affect CHF enrolment and non-enrolment?
3. What effect does the user fees has on CHF enrolment and non-enrolment?
4. What are the effects of user fees on the health services utilization to both the CHF and non-CHF members?

1.5 Rationale

This study was designed to explore for the effects of quality of care, user fees and health services utilization on the enrolment, non-enrolment and dropout from CHF. The findings from the study would assist policy and decision makers in Bagamoyo to understand these effects of co-existence of user fees among others on CHF enrolment. Furthermore the findings would assist the decision makers on how to improve the performance of CHF in Bagamoyo district.

This study adds on the knowledge on the effects of co-existence of user fees and CHF and quality of care provided at health facilities on the CHF enrolment and dropout in Tanzania to the studies already done on the barriers of CHF enrolment.

The findings shed some light on what can be done to increase CHF enrolment, to reduce CHF non enrollment and drop out regarding the coexistence with user fees and quality of care provided at the health facilities. Evidence based policy decisions could be made based on the study findings and may help to strengthen the CHF in Bagamoyo District.

1.6 Objectives

1.6.1 Broad objective

To explore the effect of user fees and quality of health services provided at health facilities on CHF enrolment, non-enrolment and dropout in Bagamoyo district.

1.6.2 Specific objectives

1. To explore the perceptions of the people who have never joined CHF on the usefulness of user fees as compared to joining CHF.

2. To explore the perceptions of the people who have dropped out of CHF membership on the usefulness of user fees as opposed to joining CHF.

3. To find out the perceptions on the quality of health services provided to the individuals paying user fees and the CHF members.

4. To find out the amounts of user fees paid by the CHF and non CHF members for health services.

5. To determine the proportion of CHF members and non- CHF members' incomes used to pay user fees and the Community Health Fund premiums.
6. To assess the health services utilization among CHF members and non- CHF members.

CHAPTER 2: LITERATURE REVIEW

2.1 Health financing systems.

In 2010 WHO reported that about 150 million people globally suffer financial catastrophe each year, and 100 million are pushed into poverty because of direct payments for health services through user fees[13]. Developing countries, Tanzania included, need to adapt their financing systems continually to raise sufficient funds for their health systems. In many lower-income countries, more people work in the informal sector, making it difficult to collect income taxes and wage-based health insurance contributions.

Health financing system is concerned with the mobilization, accumulation and allocation of money to cover for the health needs of the people[16]. Health financing must consider both sources of revenue for health care (i.e., the type of payment or contribution mechanism, agents that collect these revenues) and how they will allocate their resources to purchase services[17].

There are several methods that can be used to support health services. They include the general systems of taxation used to finance government expenditures and the ministries of health; donor assistance that is specifically earmarked for health projects; charitable donations targeted to private voluntary health providers, such as church missions; user fees; and health insurance

Faced with budget constraints and at the same time trying to reduce government dependency as in budgeting on provision of health services, many countries introduced or raised the user fee at public facilities[3]. User fee was an essential policy response to health care financing crisis. It could have improved the quality of health services at public services and thus benefit the poor who mainly use them. Furthermore the user fees could have enabled the government to redirect the funds to other essential programs like cost-effective preventive services.

2.2 CHF and Other Alternative Methods for Health Financing in Tanzania.

The health financing system in Tanzania is highly fragmented with many different financiers and modes of financing. Public taxation and thus budgeting is one method of financing the Tanzania health system. In 2009/10, the government was the largest source of public spending, with 36% of the public expenditure[6]. The system also includes a large proportion of external financing, with a significant part of that being off-budget. Other methods Tanzanian government uses for health financing are user fees, out of pocket payments, social health insurance as in community funding and private health insurance among others. Tanzania introduced user fees in 1993 after a study by Mujinja and Mabala showed that 80% of Tanzanians were prepared to pay for health services in Tanzania[18]. User fees are official payments made at the point of service by patients. This showed a great willingness of Tanzanians to pay for user fees or any alternative method.

An alternative method that the government of Tanzania embarked on is a Community Health Fund (CHF)[5], a voluntary scheme for the informal sector. CHF provides Tanzanians in rural areas especially in some districts with access to sustainable health services through their councils[7]. The CHF pilot scheme was initiated in Tanzania in 1996 in Igunga district and in 2001 it was launched for spreading and implementing in the whole country by phases[7]. This was part of the government's endeavors to make health care affordable and available to the rural population and the informal sector. As of September 2011, about 119 out of 133 councils all over Tanzania were implementing CHF[8].

Membership to the CHF is voluntary and is implemented at the district level[7]. A membership fee is agreed upon after discussions involving community members themselves, and each participating household within the district contributes the same membership fee[7]. Each household is given a health card that entitles the household to a basic package of primary health care throughout the year. Normally, coverage is for the household head, the spouse and other household members below the age of 18[7]. Furthermore, CHF includes individual membership for CHF for individuals who are above 18 and institutional members like schools

and economic groups[7]. Households that do not participate in the CHF are required to pay user fees on an individual basis at the health facilities at the point of use.

2.3 Challenges for various health financing schemes in Tanzania.

Despite the fact that CHF has been on implementation for more than a decade in several districts in Tanzania, it still experiences a number of challenges including very low enrolment[8]. As of September 2011, only 9% of Tanzanians were enrolled in CHF with 119 out of 133 councils practicing CHF[8]. This is short of government target of 70%[11] and the revised target of NHIF of 30% by 2010 (20% in CHF and 10% in NHIF)[15].

Various challenges face CHF in Tanzania which contribute to its low enrolment[10]. These include; poor quality of health services at the facilities, poor administration capacity at the district level[10], low knowledge on the part of individuals regarding the principles of health insurance, low sensitization regarding CHF and adverse selection[12,19,]. Adverse selection is a result of low enrolment as a consequence of voluntary nature of CHF[17, 20].

The scheme with voluntary membership has the risk of adverse selection, which can lead to healthy people to leave the pool and eventually the costs of supporting the scheme to spiral and scheme being not sustainable[21]. Eventually, the sick people may be excluded as well because the costs of supporting the scheme may become too high for the scheme authorities and thus the sustainability of the fund will become a challenge and subsequently it may fail[21]. For the case of Tanzanian CHF which has a small pool, the sick are more likely to enroll CHF leading to limited cross subsidization from the healthy to the poor and limited capacity to provide health services. All these will lead to threatened viability and sustainability of the scheme which will lead to the scheme being unattractive to the healthy people.

User fee as an alternative to CHF in Tanzania has its challenges. In 1987 when introducing user fees[2], the World Bank argued that user fees would improve efficiency and equity by increasing health revenues, increase quality and coverage by reducing frivolous demand and shift patterns of care away from costly in-patient to low-cost primary healthcare services while protecting the poor through exemptions[2]. User fees, when examined under these headings,

have not fulfilled the expectations set for them when they were established. The costs of collecting fees are high and the transparency of their use is often low.

2.4 EFFECTS OF HEALTH FINANCING MECHANISMS ON HEALTH SEEKING BEHAVIOR.

2.4.1 Effects of User fees on health seeking behavior.

Charging user fees at health facilities is likely to present a barrier to access. Yet, a shortage of resources at the facility level may contribute to failure to deliver quality services, and this also presents a barrier to access. If users of public services like health are involved in their payments, a more responsible attitude towards the use of such services is attained and thus limits the misuse of such services. This system may in turn curb moral hazard[36]. Studies have shown that households' decisions about whether to seek health care and the type of health care used were influenced by factors such as quality of health care, proximity of the health facility among others, rather than cash prices[3, 20, 33]. It is known that demand for health services by low-income households are more sensitive to price changes than the demand by other households and user fees are more likely to hurt the poor. On the other hand it was assumed that introduction of user fee may actually increase the utilization of health services by reducing the total cost of seeking care of acceptable quality at the public health services as the retained fees revenues are used to improve the coverage and quality of health services[22]. But this can only occur where fees are retained and reinvested in quality and thus utilization can increase, though this is relatively uncommon. In quasi-experimental study by Litvack and Bodart[23], combined effect of user fees with improved quality of health services (measured in terms of availability of drugs) on utilization of health services were compared in health facilities that were charging and those that were not charging user fees. Results showed probability of using health services increased significantly for the population in the health centers with user fees schemes because they had better quality of services due to cost recovery schemes. The results also showed that the probability increased for all incomes groups and the relationship between the utilization and the income was less clear.

The potential for raising revenues of the user fees has in practice proven to be mixed and generally below the anticipated 10-20 per cent of total government recurrent health expenditure[33]. The user fee collection has been ranging between 5-10 per cent of total government recurrent health expenditure[13]. Some authors have argued that user charges can generate vital resources at the local level and help improve quality of health services in facilities[22]. Others have highlighted how the user fees provide barriers to the poor families to access health service. Recently, several international campaigns have advocated the removal of user fees, especially for primary care services[23]. Removing user fees could improve service coverage and access, in particular among the poorest socio-economic groups, but quick action without prior preparation could lead to unintended effects, including quality deterioration and excessive demands on health workers. Data from Lesotho[24] showed that increasing user fees led to a drop in utilization in the public sector, while uptake of services in private not-for-profit facilities did not change. Invariably this will point to the need for people on prepayment schemes like CHF.

2.4.2 Effects of health insurance on Health Seeking Behavior.

Health problems are prevalent in many societies. The existence of signs and symptoms of ill health in any community constitute a statistical norm.

Health insurance is not a widely adopted health financing mechanism in Africa, Tanzania included. Health insurance coverage implies that people are not deterred from seeking care and at the same time are protected against the financial risks of falling ill, as the burden of patients to pay out-of-pocket will be eliminated or substantially reduced. Health insurance can be voluntary or mandatory like social health insurance scheme.

The aim of social health insurance scheme is to provide to the populations affordable, equitable access to health services for rural population and informal sector communities throughout the year[7].

The risks with insurance schemes include moral hazards and adverse selection. The scheme with voluntary membership has the risk of adverse selection, which can lead to healthy people

to leave the pool and eventually the costs of supporting the scheme to spiral and scheme being not sustainable[21]. Eventually, the sick people may be excluded as well because the costs of supporting the scheme may become too high for the scheme authorities and thus the sustainability of the fund will become a challenge and subsequently it may fail[21]. For the case of Tanzanian CHF which has a small pool, the sick are more likely to enroll CHF leading to limited cross subsidization from the healthy to the poor and limited capacity to provide health services. All these will lead to threatened viability and sustainability of the scheme which will lead to the scheme being unattractive to the healthy people.

2.5 Co-existence of different Health Financing Mechanisms in Tanzania and their effects

There are several reasons for combining different health financing mechanisms in one country. For example combining user fees and self-financing health insurance can have mutually reinforcing effects on sustainable sources of financing for health care. First, user charges are essential to stimulating self-financing health insurance schemes. Countries cannot undertake widespread promotion of self-financing health insurance schemes without first imposing user fees in government facilities, especially hospitals[33]. The reason is simply that if people can obtain health care for free or at a uniformly low cost, they will not have much incentive to pay insurance premiums to cover unexpected health hazards. Second, when health insurance begins to cover costs associated with expensive hospital overhead and treatments, public sector subsidies for curative care can more effectively be withdrawn from services used primarily by the rich and then retargeted to poor clients[33].

A study in Tanzania has shown that positive results were seen for reinvestment of CHF funds while no positive results were seen with user fees charges[25]. The same study also concluded that user fees lead to self-exclusion and marginalization of both vulnerable and other people from accessing the health services in the area of study[25].

Among other countries in Africa, Tanzania does not have high user fees and since 1996, she has tried to attract and enroll its population into CHF[6]. A World Health survey of 1993 put Tanzania in category one for user fees countries[33], that is having a cost recovery program for

health dominated by user fees system. Yet the enrollment rate to CHF remains low with coverage nationwide of 9% of the eligible population[8], and those who enroll tend to be the elderly and the sick[10].When Ghana shifted to user fee system in 1999, and patients had to pay fairly high user fees, voluntary prepayment plans such as the community-based mutual health organizations (MHOs) flourished, growing from 4 MHO funds in 1999 to 157 by 2002[26]. In 2003, Ghana was able to pass legislation to establish social health insurance nationwide, relying on the MHOs as a building block[26].

Although Tanzania adopted user fees and promoted self-financing health insurance to help restore efficiency and equity to her national health system, several challenges were and are still evidenced. This paper looked for the effect of user fees regarding enrolment, non-enrolment and drop-out from CHF using Bagamoyo District as an example.

CHAPTER 3: METHODOLOGY

3.1 Study design

A cross-sectional exploratory study was carried out in April and May 2012 in Bagamoyo District. The study aimed at collecting information about the outcomes of co-existence of user fees and CHF on CHF enrolment and non-enrollment (including drop out from CHF). Semi-structured questionnaire was administered to the participants at the household level while exit interviews were conducted to patients who were leaving the health facilities. Both CHF and non CHF members were interviewed to assess the link with and outcomes of user fees on CHF enrolment and disenrollment, including drop out from CHF.

3.2 Study area

This study was conducted in Bagamoyo District, Coast region. Bagamoyo District is estimated to have 277,678 habitats comprising 60,254 households[27]. Having a total area of 9,842m^2, Bagamoyo is the second largest district in Coast Region, next to Rufiji District[27]. The district has 6 divisions, 16 wards and 82 villages[27]. Bagamoyo District has only one hospital, 5 health centers and 49 dispensaries.

The study area was purposeful selected due to the fact that Bagamoyo District had dramatic drop out of CHF members between June and September 2011. In June 2011, a total of 4,565 households (coverage of 7.6%) were CHF members in Bagamoyo[15]. Surprisingly, in September 2011, only 1,576 (2.6%) households were CHF members[8]. This dramatic drop in the number of CHF members within a short period needed a thorough and systematic investigation. Another reason for choosing Bagamoyo district is its representation of typical semi urban and rural areas; as well as the presence of both CHF and non CHF members in the area.

3.3 Study population

Participants in the study were recruited from the community and from health facilities.

The study participants were heads of households. Both CHF and non CHF members heads of households from the selected study area were included in the study.

3.4 Sample size estimation

3.4.1 Sample size for household heads in the households.

Sample size was calculated using the following formula designed for cross sectional studies[28]:

$n = z^2 [p (1-p)]/ \varepsilon^2$ where:

n = minimum required sample size for each group (CFH and non CHF members)

z = standard, corresponding to 95% confidence; 1.96

p= CHF coverage in Bagamoyo district, 2.6%[8].

ε = maximum likely error taken as 5%

Hence, $n = 1.96^2 * 0.026 (1-0.026)/0.05^2$

n = 39 is the minimum sample size required for each group from the households.

In this, study 63 heads of CHF households and 60 heads of non-CHF households were interviewed, making a total of 123 heads of households from the community. The aim was to get participants almost twice the minimum sample size for each group to increase the power of the study.

3.4.2 Sample size for health facilities exit patients

The study sample size for health facilities participants was calculated using the following formula designed for cross-sectional studies[28];

$n = z^2 [p (1-p)]/ \varepsilon^2$ where;

n = minimum required sample size for each group (CHF and non-CHF members)

p = CHF dropout rate at Bagamoyo between June 2011 and September 2011 taken as 5%**

z = standard, corresponding to 95% confidence; 1.96

ε = maximum likely error taken as 5%

$n = 1.96^2 *[0.05 (1-0.05)]/0.05^2$

**** CHF coverage in Bagamoyo District, June 2011 was 7.5% [15] while CHF coverage in Bagamoyo District, September 2011 was 2.5%[8]**

n = 72 is the minimum sample size required for each group (CHF and non CHF) from health facilities.

In this study a total of 145 heads of CHF households and 144 heads of non CHF households were interviewed, therefore a total of 289 participants were interviewed as exit patients. The aim was to get participants twice the minimum sample size for each group to increase the power of the study.

Total sample:

This study was able to attain a total of 412 participants as follows;

Households: 63 and 60 CHF and non CHF members respectively

Health facilities: 145 and 144 CHF and non CHF members respectively

3.5 Inclusion and exclusion criteria

Inclusion criteria

Households:

(a) **CHF member:** For a participant to be included into this study she/he was supposed to be a head of the household or a spouse; active CHF member, residing in the selected villages.

(b) Non CHF member: For a participant to be included into this study she/he was supposed to be a head of the household or a spouse; non CHF member; residing in the selected villages.

Health facilities:

(a) **CHF member:** For a participant to be included into this study she/he was supposed to be a head of the household or a spouse; active CHF member, attending any of the selected health facility.

(b) Non CHF member: For a participant to be included into this study she/he was supposed to be a head of the household or a spouse; non CHF member; attending any of the selected health facilities.

Exclusion criteria:

Households:

(a) **CHF member:** Participants were excluded to participate if they did not give consent to participate.

(b) **Non CHF member:** Participants were excluded to participate if they did not give consent to participate**.**

Health facilities:

(a) **CHF member:** Participants were excluded to participate if they did not give consent to participate**.**

(b) **Non CHF member:** Participants were excluded to participate if they did not give consent to participate**.**

3.6 Sampling process

Multistage sampling process was employed to get the study participants at the household level. The first stage involved selection of villages and health facilities. Wards were not involved because CHF members register at the lowest level of health delivery which is at village level, corresponding dispensary. The second stage involved selection of study participants.

Selection of villages and health facilities

A list of villages with active CHF was obtained from the District CHF coordinator. From this list, three villages; Zinga (population 4,022, CHF members 39), Kaole (population 1,384, CHF members 82) and Kerege (population 3,415, CHF members 92) were randomly selected from a total of 9 villages that had active CHF scheme in Bagamoyo District. At the study time, only 9 villages in Bagamoyo District had active CHF schemes, out of 82 villages. Only 3 villages were selected due to available resources to represent the 9 villages at Bagamoyo District.

Each of selected villages had only one public health facility serving the villagers. Therefore, the health facilities in these villages were selected for the recruitment of study participants for the exit interview. Additionally, Bagamoyo District hospital was also included in the study because it is the highest referral level in the district.

Selection of study participants from households

The lists of active CHF members were obtained from the Village Executive Officers (VEOs) of Zinga, Kerege and Kaole. One list containing all CHF members from the three villages was compiled. Each CHF member was assigned a number and the number was fed in the computer. A total of 76 (twice the minimum sample size of 38) CHF members were randomly selected using computer generated random number tables. However, only 63 out of 76 CHF members who were randomly selected were available for the household interview, others were not available at their homes after three visits. Three attempts were done to trace the participants before excluding them.

Each CHF member was asked by the research team to mention one non CHF member who was recruited for the household interview. A total of 60 non-CHF members were interviewed in their households.

Selection of study participants from health facilities

At the health facilities both CHF and non-CHF members were recruited consecutively as they exited the health facilities until the required number was attained. We were able to interview 145 CHF members and 144 non CHF members for the exit interviews.

Before the recruitment took place informed consent was requested from all the participants. The research team ensured no participant was double recruited to the study by asking the participants if they had been interviewed at their households or at health facilities about CHF within the time period of this research.

3.7 Recruitment of research assistants

This study recruited four (4) form six leavers for the purpose of assisting the principal investigator in the collection of data. Two (2) research assistants were males and 2 were

females. The research assistants were all trained for three days prior to commencement of the study. Part of their training involved actual collection of data at Kiromo village and Kiromo dispensary which were selected for pre testing the questionnaire.

3.8 Data collection tool

Interviewer assisted semi-structured questionnaire with open and close ended questions was administered to the participants. The interviews were conducted in households and during exit from the health facilities. Research assistants and the Principal Researcher visited the selected households in the villages and health facilities to administer the questionnaires.

The questionnaire was written in English and translated to Kiswahili to make it understood by the study participants. Back translation of the questionnaire to English was performed to remove ambiguity. Pre-testing of the questionnaire was conducted at Kiromo dispensary and Kiromo village.

Variables

The following is a list of variables that were considered to study the effect of co-existence of user fees and community health fund on community health fund

The dependent variables are:

- CHF membership, ever dropping out of CHF, never joining CHF

The independent variables used for the study are:

- Age, sex, marital status, education status, average monthly income, user fees used for previous one month prior to study, average monthly health spending on health as a proportion of monthly income, health service utilization, distance to health facility usually attending, perceived quality of care, perceived usefulness of CHF and perceived usefulness of user fees.

Definition of main study variables

- **CHF member:** Individual who has paid current annual CHF membership premiums and appears on the village CHF members list.
- **CHF premiums:** Fee paid annually for annual CHF membership.
- **CHF drop out:** Individuals who had some period of non-renewal of CHF membership.
- **User fees:** Fees paid by patients at point of care for health services.
- **Monthly income:** Average amount of money that the household earns in a month as estimated and reported by head of households.
- **Proportion of respondents' income used to pay user fees and/or CHF premium:** Average amount of money spent for user fees and CHF premiums household divided by monthly income and expressed as percentage.

3.9 Data Management and Analysis

Data cleaning and editing was done both in the field and back from the field in Dar es Salaam. The Principal Researcher went through all the questionnaires daily to check for completeness and adherence to what was supposed to be collected; and to compare the information from different interviewers for the coherence of participants' responses. Daily field meetings were conducted to give feedback to the research assistants and resolve arising issues. Randomly selected questionnaires were used to check the completeness and correctness of the data after data entry and thereafter data cleaning was performed.

Data coding schedule was developed. Codes and scores from the respondents were developed from various responses collected. Numerical coding and scoring was used in this study. The coded data were entered in the computer using SPPS version 20 software.

Analysis was done using SPSS version 20 to produce summary statistics. Quantitative data were summarized using mean and categorical variables were summarized using proportions. Students' t-test was used to test associations between continuous variables while Chi square was used to test associations between proportions. Frequencies and descriptive tables were generated after a univariate analysis. Multivariate regression analysis was used to find for the

association between the CHF enrolment/ non-enrollment and payment of user fees. The outcome variables in the multivariate analysis were CHF membership (ever enrolled in CHF) and ever drop out from CHF. P value of less that 0.05 was considered to be significant for the association between the dependent and independent variables.

3.10 Ethical Issues

Ethical clearance was sought from the Muhimbili University of Health and Allied Sciences (MUHAS) Research review board.

Permission to conduct study in Bagamoyo district was obtained from the District Council Director of Bagamoyo District, who provided an introductory letter to be presented to the village executive officers (VEO) and clinicians in charge of the selected study areas. Furthermore, the principal investigator had audience with the VEOs and clinicians in-charge to get permission to conduct the study within areas of their jurisdiction.

Written and signed informed consent was obtained from the participants after explaining to them the purpose of the study. Thumb print was used for participants who could not write. Participants had the right to participate or not to participate in the study; or to withdraw at any time during the interview. Confidentiality was always maintained by making the interview in the private place.

The research findings will be released to the Bagamoyo District as feedback and to the other relevant bodies and audiences. The results are also presented in this dissertation to be submitted to the School of Public Health and Social Sciences, Muhimbili University of Health and Allied Sciences.

3.11 Study limitations

Sampling error

Since the study was carried out in only one district, this is not a representative of Tanzania. However, many areas in Tanzania had had similar problems of low enrollment and drop out from CHF.

Recall bias

Study participants were likely to have problems in recalling responses to the interview, this would lead to recall bias in this study. This study addressed these biases by limiting the recall to a maximum of three months. Prompting techniques were also used to make respondents to think more about the issues.

Non-response bias

Some study participants from the sample were not available at their households to be interviewed and thus were excluded from the study. A total of 23 randomly selected participants from the three villages were not available for interview. At the health facilities, 2 participants refused to participate, citing that they were busy or had to go somewhere while some participants could have left the health facility before being interviewed unknowingly to the research assistant. The exclusion of these participants could have affected the generalisability (external validity) of the study. Three attempts were done to trace these participants before exclusion them.

CHAPTER 4: RESULTS

4.1 Recruitment points of study participants

A total of 412 heads of households were interviewed between April and May 2012. Participants were recruited from three villages and one district hospital as follows; 89 (21.6%) from Zinga village and dispensary, 130 (31.6%) from Kerege village and dispensary, 121 (29.3%) from Kaole village and dispensary and 72 (17.5%) from Bagamoyo district hospital. Overall, there were 208 (50.5%) CHF and 204 (49.5%) non CHF members (Table 1).

Table 1. Recruitment points of study participants.

	Households		**Health facility**		**TOTAL**	
	CHF (n=63)	Non CHF (n=60)	CHF (n=145)	Non CHF (n=144)	**CHF (n =208)**	**Non CHF (n = 204)**
Zinga	13	20	20	36	33	56
Kerege	28	20	46	36	74	56
Kaole	22	20	43	36	65	56
Bagamoyo District Hospital	0	0	36	36	36	36

Source: Study data

4.2 Characteristics of the study participants

Median and mean age of the participants recruited at households and health facilities were 38.0 and 39.4 years respectively, with a range of 20 – 85 years (SD ±12.12 years). The age group 31 - 40 had the highest proportion of respondents in both households 41 (67.1%) and health facilities, 87 (60.2%). Participants with 60 years and above were least represented in both household s 15 (24.3%) and health facilities, 14 (9.7%) (Table 2). Although there were more non CHF members below 41 years of age, there was no statistically significant difference between CHF and non CHF members by age groups in both households ($p = 0.209$) and health facilities ($p= 0.321$) (Table 2).

Overall, this study included 197 (47.8%) males and 215 (52.2%) females. There was no statistical difference between sex and CHF membership status both for the households (p=0.354) and health facilities (p = 0.213) participants (Table 2).

As shown in Table 2 below married respondents, 332 (80.6%), dominated the study participants. There were significantly less married CHF members than non CHF members recruited from health facilities (p = 0.001).

There was no statistically significant difference between CHF and non-CHF members by education status both for the households participants (p = 0.115) and health facilities participants (0.118) (Table 2).

Overall, the median monthly income of the respondents was 25,000 Tanzanian shillings (TZS). Majority of the participants, 280 (69.0%), earned an average of less than thirty thousand Tanzanian shillings per month (Table 2). CHF members from the health facilities reported to earn statistically lower monthly income than non CHF members recruited at facilities (p = 0.017). (Table 2). There was no statistically significant difference in monthly income between CHF and non CHF members recruited from households (p=0.079).

Table 2: Characteristics of study participants (n =412).

Variable	Household			Health facility			Total
	CHF (n=63) n (%)	Non CHF (n=60) n (%)	P value	CHF (n=145) n (%)	Non CHF (n=144) n (%)	P value	n (%)
Age (years)							
20 – 30	12 (19.0)	11 (18.3)		41 (28.3)	44 (30.6)		108(26.2)
31 – 40	15 (23.8)	26 (43.3)		41 (28.3)	46 (31.9)		128(31.1)
41 – 50	17 (27.0)	10 (16.7)	0.209	43 (29.7)	44 (30.6)	0.321	114(27.7)
51 – 60	10 (15.9)	7 (11.7)		12 (8.3)	4 (2.8)		33 (8.0)
60+	9 (14.3)	6 (10.0)		8 (5.5)	6 (4.2)		29 (7.0)
Sex							
Male	38 (60.3)	41 (68.3)		54 (37.2)	64 (44.4)		197(47.8)
Female	25 (39.7)	19 (31.7)		91 (62.8)	80 (55.6)		215(52.2)
Marital Status							
Married	58 (92.1)	56 (93.3)		100(69.0)	118(81.9)		332(80.6)
Single	5 (7.9)	4 (6.7)	0.3	45 (31.0)	26 (19.1)	0.001	80 (19.4)
Education Status							
No formal	5 (7.9)	3 (5.0)		14 (9.7)	11 (7.6)		33 (8.0)
Primary	57 (90.5)	51 (85.0)	0.115	110(75.9)	122(84.8)	0.118	340(82.5)
Sec & above	1 (1.6)	6 (10.0)		21 (14.5)	11 (7.6)		39 (9.4)
Monthly income (TZS)							
< 30,000	48 (76.2)	33 (55.0)		88 (60.7)	111(17.1)		280(70.0)
30-50,000	9 (14.2)	19 (31.7)	0.079	37 (25.5)	21 (14.6)	0.017	86 (20.9)
50,000 +	6 (12.5)	8 (13.3)		20 (14.5)	12 (8.3)		46 (11.1)

4.3 Respondents' user fees expenditure on health services one month prior the study

In this study population, 67 (24%) participants at households and 212 (76%) at health facilities, reported having paid some amount of fees one month prior to the study. Comparatively larger proportion, 185 (90.7%) of non CHF members had paid the user fees compared to CHF members, 94 (45.2%). CHF members are not supposed to pay user fees but when they visit other facilities than the ones they are registered to, like the district hospital with no referral document from primary facilities or another dispensary (private or public), then they are forced to pay.

The median user fee was reported to be 1,000TZS. Majority of the respondents, 66 (86.4%) at households and 150 (70.6%) at health facilities had paid less than 1000TZS, while 27 (9.7%)reported to pay more than 5000TZS.

All CHF participants 11, (100%) compared to 54 (96%) of non CHF members form the households who paid user fees in one month preceding the study interview, reported to have paid 1000 TZS or less as user fee (table 3). On the other hand, table 3 shows that, CHF members interviewed at health facilities were more likely to have spent higher amounts as user fees compared to non CHF members interviewed at health facilities ($p < 0.001$).

Table 3: Comparison of respondent user fees expenditure one month prior to study by CHF membership status (n=279).

User fees paid (TZS)	Households			Health facility		
	CHF (n = 11)	**Non CHF (n = 56)**	**p**	**CHF (n = 83)**	**Non CHF (n = 129)**	**P**
<1,000	11 (100)	54 (96.4)		46 (55.4)	104 (80.6)	
1001-5,000	0 (0)	1 (1.8)	0.817	25 (30)	11 (8.5)	<0.001
>5,000	0 (0)	1 (1.8)		12 (17.6)	14 (10.9)	

4.4 Proportion of monthly income used to pay user fees and/or CHF premium

Table 4 compares the proportions of monthly incomes for both CHF and non CHF members incurred as health expenditure. Respondents reported that CHF premium was 10,000 TZS paid annually per household. The user fees in public health facilities in Bagamoyo were reported to be 1,000 TZS and 2,000 TZS for out and in patients' services respectively. However, respondents reported to have visited private health facilities as well, whose fees varied from one another. It was noted that, alongside the annual CHF premiums, CHF members reported to had paid some extra amount of money as user fees.

A total of 49 (77.8%) household participants and 54 (48.3%) health facility participants reported to have had spent between zero and five percent (0 - 5%) of their monthly income on health services as user fees and/or CHF premiums. (Table 4).

Compared to CHF members, non-CHF members at the health facilities were significantly more likely to have had spent a smaller proportion of monthly income on health ($p < 0.001$). For instance 76.4% of non- CHF members as compared to only 48.3% of CHF members at health facilities had spent less than 10% of their monthly income on health a month prior to this study, (Table 4).

In summary, Table 4 shows that on average in one month, non- CHF members were more likely to use lesser proportions of their monthly income for health services compared to CHF members at the facilities.

Table 4: Comparison of respondents proportion of monthly income used to pay user fees and/or CHF premium three months prior to study (n=412)

	Households			Health facility		
Average monthly health spending as a proportion of monthly income	CHF (n = 63) n (%)	Non CHF (n = 60) n (%)	p	CHF (n = 145) n (%)	Non CHF (n = 144) n (%)	p
0-5%	49 (77.8)	54 (90)		70 (48.30	110 (76.4)	
6-10%	10 (15.9)	4 (6.7)	0.136	45 (31)	17 (11.8)	<0.001
Above 10%	4 (6.3)	2 (3.4)		30 (20.7)	17 (11.8)	

4.5 Health services utilization among CHF members and non- CHF members

Table 5 compares health service utilization among CHF and non-CHF members. Health services utilization although slightly lower among the non-CHF members, was not statistically different for both CHF and non-CHF members in both households (p = 0.61) and at health facilities (p = 0.12) (table 5).

Moreover the frequency of visits to health facilities by members of the households was not statistically different between CHF members and non CHF members (table 5). About 9 (4.3%) CHF members compared to 7 (3.4%) of non-CHF members had visited health facilities twice within one month (p = 0. 58) while none of the respondents had visited health facilities more than three times (data not shown in the table 5).

Table 5: Health services utilization among CHF members and non- CHF members (n=408)**

	Household (n = 120)			**Health facility (n= 288)**		
Visited health facility when sick last time	**CHF-member (n=207)**	**Non-CHF**	**P value**	**CHF member**	**Non CHF**	**P value**
	n (%)	**n (%)**		**n (%)**	**n (%)**	
Yes	61 (98.4)	56 (96.6)	0.61*	145 (100)	140 (97.3)	0.12*
No	1 (1.6)	2 (3.4)		0 (0)	3 (2.1)	

****Four respondents (1 CHF member and 3 non-CHF members) did not recall being sick.**
*** Fishers' exact test was performed for cells less than 5.**

4.6 Respondents' perceptions on the quality of health services provided to the individuals paying user fees.

Table 6 shows the perceptions of both CHF and non-CHF members with regards to quality of services provided to the individuals paying user fees. This table shows that 5 (2.5%) of the non-CHF members and none of the CHF members perceived that people paying user fees were more satisfied with the health care provided ($p = 0.03$). Moreover, more CHF members 157 (75.5%) compared to non-CHF members (73.5%) disagreed to the perception that people paying user fees were more satisfied with the health care provided ($p = 0.03$) (Table 6).

Regarding perceptions on the quality of health provided to people paying user fees, there was no statistical difference between CHF members and non CHF members as shown in Table 6 below.

Table 6: CHF members and non CHF members' perceptions on the quality of health services provided to the individuals paying user fees (n=412)

	CHF members (N = 208)		Non-CHF members N = 204)		
	Agree/ Strongly Agree n (%)	Disagree/ Strongly disagree n (%)	Agree/ Strongly Agree n (%)	Disagree/ Strongly disagree n (%)	P
People paying user fees are attended first before CHF members	1 (0.5)	126 (60.6)	2 (1)	168 (85.1)	1.00**
People paying user fees have better relationship with health care providers	21 (10.1)	136 (65.4)	9 (4.4)	126 (61.8)	0.06*
People paying user fees have better access to health services in their areas	0 (0)	167 (80.3)	1 (0.5)	152 (74.5)	0.25**
People paying user fees perceive the attitude of health care workers as good	0 (0)	123 (59.1)	3 (1.5)	139 (68.1)	0.25**
People paying user fees wait longer to be attended by the health care workers	0 (0)	168 (80.8)	0 (0)	162 (79.4)	0.09**
People paying user fees are more satisfied with the care given	0 (0)	157 (75.5)	5 (2.5)	150 (73.5)	0.03**
People paying user fees have better health outcome	0 (0)	178 (85.6)	1 (0.5)	174 (85.3)	0.49**

***P for χ^2test**

****Fishers' exact test was performed for cells less than 5.**

Totals do not add to 100% because respondents who answered 'not sure' are not presented on the table

4.7 Respondents' perceptions on the quality of health services provided to the CHF members.

Figure 2 compares the perceptions of both CHF and of non CHF members on the quality of health services provided to the CHF members. From this figure we can deduce that, 5.4% of non CHF members compared to none (0%) of the CHF members perceived that CHF members were attended first before those paying user fees ($p < 0.01$) (figure 2). Furthermore, fewer CHF members (85.6%) compared to non-CHF members (90.7%) perceived that CHF members have better health outcomes ($p = 0.01$) (Figure 2).

Only 5.8% of CHF members compared to 2.0% of non CHF members perceived CHF members waited longer to be attended by health care workers ($p = 0.07$) (Figure 2).

Furthermore, when asked about their perceptions on the amount of CHF annual premiums, almost all CHF members 207 (99.5%) perceived the premium charges not expensive.

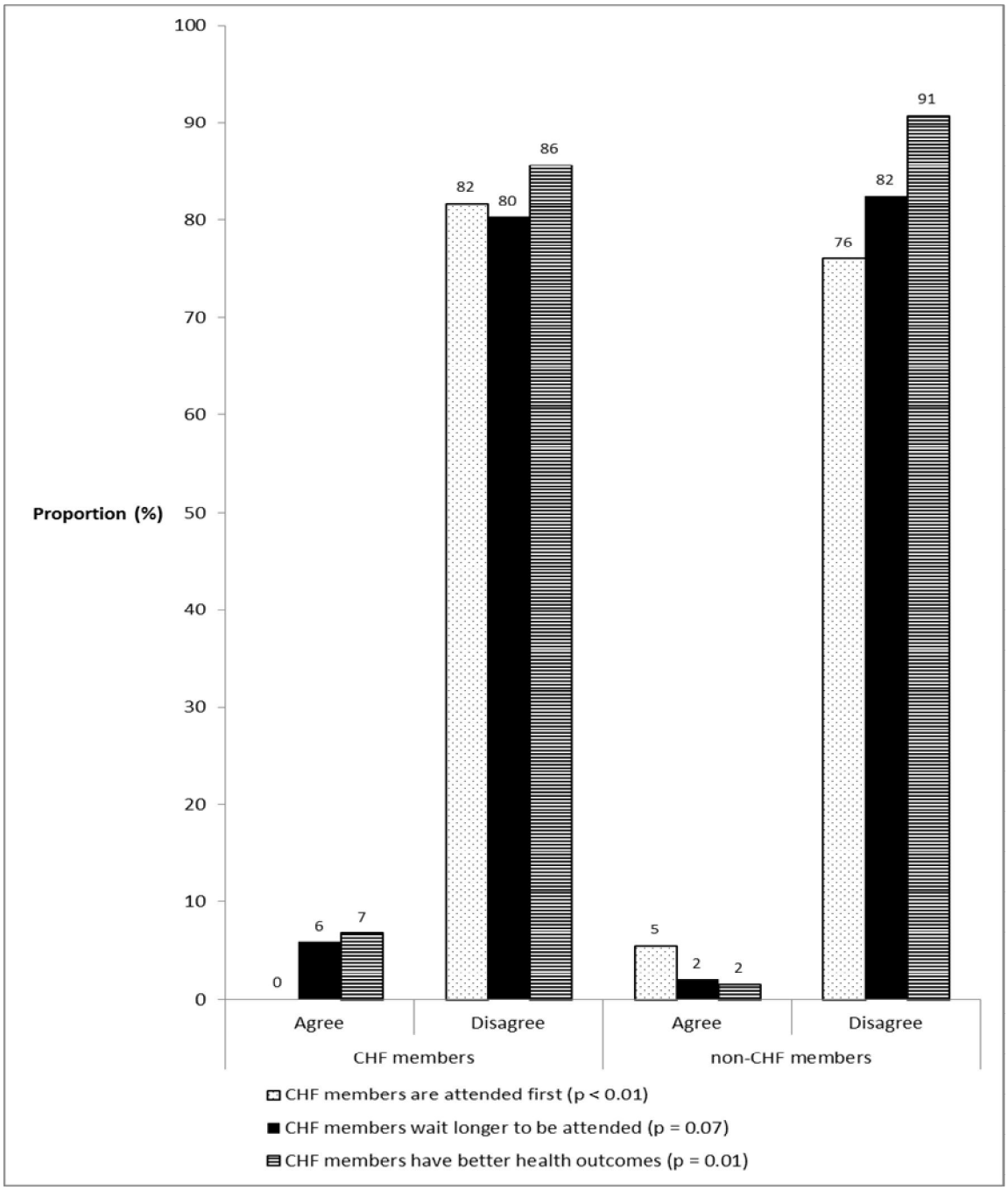


Figure 2: Comparison of respondents' perceptions on the quality of health services provided to the CHF members by CHF membership status (n = 412)

- **p for χ^2 test**
- **Fishers' exact test was performed for cells < 5**
- **Totals do not add to 100%; respondents who answered 'not sure' are excluded**

4.8 Perceptions of CHF members and of respondents' who had never joined CHF on the usefulness of user fees as compared to joining Community Health Fund (CHF)

In Table 7, we compared perceptions of CHF members and of respondents who had never joined CHF scheme on usefulness of user fees as compared to joining CHF schemes in their areas.

Table 7 shows that, a significantly larger proportion of CHF members (75.9%) compared to proportion of respondents who had never joined CHF scheme (36.9%) perceived user fees amounts were too high ($p< 0.01$) (Table 7).

Majority of both CHF members (80.6%) and respondents who had never joined CHF (86.0%) perceived that user fees prevented people from accessing health services (Table 7). Higher proportions of CHF members (76.0%) and non-CHF members (74.3%) agreed that user fees reduced the amount of money available in the households for investments and other needs (Table 7).

Table 7 shows that higher proportion of respondents who had never joined CHF (61.5%) compared to CHF members (54.8%) perceived user fees helped to improve the quality of services at the health facilities. However, the difference was not statistically significant ($p = 0.06$)

Table 7: Perceptions of CHF members and of respondents' who had never joined CHF on the usefulness of user fees as compared to joining Community Health Fund (CHF) (n=387)

	CHF members (N = 208)		**Never joined CHF (N = 179)**		
	Agree/ Strongly Agree n (%)	**Disagree/ Strongly disagree n (%)**	**Agree/ Strongly Agree n (%)**	**Disagree/ Strongly disagree n (%)**	**P value**
User fees amounts are too high	158 (75.9)	37 (17.7)	66 (36.9)	66 (36.9)	<0.01
User fees amounts discourage people from joining CHF	39 (19.8)	133 (63.9)	27 (15.1)	101 (56.4)	0.74
User fees prevent people from attending at health facilities when sick	167 (80.3)	11 (5.3)	154 (86.0)	7 (3.9)	0.45
User fees help to improve the quality of services at the health facilities	114 (54.8)	44 (21.2)	110 (61.5)	25 (14.0)	0.06
User fees reduce the amount of money available in the households for investments and other needs	156 (76.0)	28 (13.5)	133 (74.3)	20 (11.2)	0.57
User fees improve the relationship between health care providers and clients	20 (9.6)	97 (46.6)	13 (7.3)	92 (51.4)	0.32

4.9 Perceptions of respondents who had ever dropped out of CHF and CHF members who had never dropped out of CHF on the usefulness of user fees as opposed to joining CHF.

Table 8 compares the perceptions of the people who had never dropped out of CHF to the perceptions of the people who have ever dropped out of CHF on the usefulness of user fees as opposed to joining CHF.

Larger proportion of people who had dropped out from CHF (80%) compared to CHF members who had never dropped out from CHF (57.7%), perceived user fees charges being too high ($p < 0.01$) (Table 8). However, more of respondents who have dropped out of CHF (69.7%) compared to CHF members who had never dropped out from CHF (44.9%), disagreed to the perception that user fees discourage people from joining CHF ($p < 0.01$) (Table 8).

A larger proportion of CHF who had never dropped out of CHF compared to those who had ever dropped out of CHF perceived that user fees improved both the quality of services at the health facilities ($p < 0.01$) and the relationship between health care providers and clients ($p = 0.01$) and (Table 7).

Table 8: Comparison of perception of respondents who had ever dropped out of CHF membership and of CHF members who had never dropped from CHF on the usefulness of user fees as opposed to CHF (n=233)

	CHF members who had never dropped out from CHF (N = 78)		**CHF members who had ever dropped out from CHF (N = 155)**		**P**
	Agree/ Strongly Agree n (%)	**Disagree/ Strongly disagree n (%)**	**Agree/ Strongly Agree n (%)**	**Disagree/ Strongly disagree n (%)**	
User fees amounts are too high	45 (57.7)	22 (28.2)	124 (80.0)	26 (16.8)	<0.01
User fees amounts discourage people from joining CHF	29 (37.2)	35 (44.9)	20 (12.9)	108 (69.7)	<0.01
User fees prevent people from attending at health facilities when sick	59 (75.6)	6 (7.7)	126 (81.3)	7 (4.5)	0.29
User fees help to improve the quality of services at the health facilities	57 (73.1)	2 (2.6)	71 (45.8)	48 (31.0)	<0.01
User fees reduce the amount of money available in the households for investments and other needs	52 (66.7)	19 (24.4)	121 (78.1)	14 (9.0)	<0.01
User fees improve the relationship between health care providers and clients	15 (19.2)	41 (52.6)	8 (5.2)	69 (44.5)	0.01

4.10 Reasons for dropping out from CHF membership

CHF members who had dropped out of the CHF scheme were asked to provide reasons that prompted them to drop out of CHF. As illustrated by Figure 3, the main reasons reported were as follows: poor quality of health services 86 (55.5%), poor referral mechanisms to the higher level health facilities 33 (21.3%); and the necessity to pay extra money apart from CHF premiums 24 (15.5%). Other reasons for CHF drop out included: high CHF premiums 10 (6.5%); and poor CHF leadership 2 (1.5%).

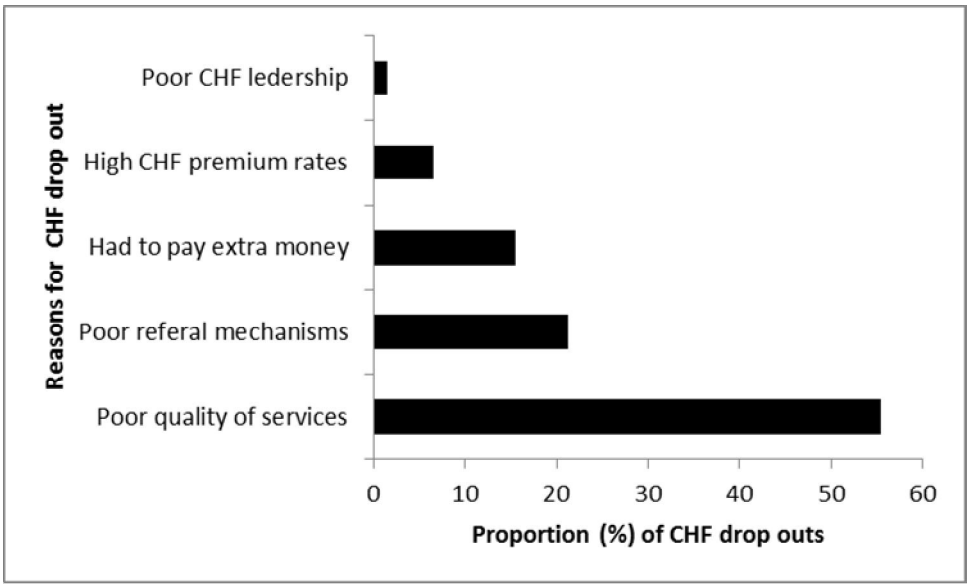


Figure 3: Respondents' reasons for dropping from CHF membership

4.11 Factors associated with CHF membership

Table 9 shows results of multivariate analysis of factors associated with being an enrollee of CHF scheme in Bagamoyo.

As shown in Table 7, CHF member was 98% less likely to have had paid user fees (OR 0.02; CI: 0.01 – 0.05; p< 0.01). However, when paid user fees, CHF member compared to non CHF member was 78% less likely to have paid less than 1000TZS (OR 0.22; CI: 0.11 – 0.465; p< 0.01) and were 60% less likely to spend less than 0.5% of monthly income on health expenditure (OR 0.40; CI: 0.20 – 0.81; p = 0.01).

Table 9: Multivariate logistic regression model for factors associated with CHF membership (n = 412).

	OR	95% CI	p-value
Age < 39years	0.56	0.28 – 1.12	0.10
Male sex	0.72	0.36 – 1.46	0.37
Married	1.56	0.68 – 3.58	0.29
Paid < 1000 TZS for user fees	0.22	0.11 – 0.46	<0.01
Spent <5% of monthly of income on health	0.40	0.20 – 0.81	0.01
Attended health facility when last ill	7.25	0.24 – 221.75	0.26
Ever paid user fees	0.02	0.01 – 0.05	<0.01

4.12 Factors associated with dropping from CHF scheme

Table 9 shows the predictors for dropping out of CHF schemes. Compared to all other respondents, those who dropped out of CHF, were 90% less likely to have had paid user fees (OR 0.10; CI: 0.06 – 0.18; $p < 0.01$). Those who paid user fees were twice as likely to have had paid user fees less than 1000 TZS (OR 2.23; CI: 1.21 – 4.12; $p = 0.01$) and were 67% more likely to have had spent more than 0.5% of their average monthly income for health services (OR 0.33; CI: 0.19 – 0.55; $p < 0.01$).

Table 9: Multivariate logistic regression model for associated with dropping out from CHF scheme

	OR	95% CI	p-value
Age < 39years	0.97	0.61 – 1.56	0.91
Male sex	0.91	0.57 – 1.45	0.68
Married	0.99	0.55 – 1.78	0.96
Paid < 1000 TZS for user fees	2.23	1.21 – 4.12	0.01
Spent <5% of monthly of income on health	0.33	0.19 – 0.55	<0.0001
Attended a health facility when last ill	0.56	0.07 – 4.32	0.58
Ever paid user fees	0.10	0.06 – 0.18	<0.0001

CHAPTER 5: DISCUSSION

5.1 Introduction and summary of findings.

This study aimed at exploring the role of user fees on CHF enrolment, non-enrolment and dropout in Bagamoyo district.

Compared to non-members, CHF members were less likely to have had paid user fees, however when they paid user fees they were more likely to have paid higher amounts and spent a higher proportion of their monthly income on health. Second, despite the fact that CHF members spent more on health compared to non CHF members, there was no significant difference in health service utilization between CHF and non CHF members. Third, less CHF members compared to non CHF members perceived that CHF members had better health outcome and waited longer to be attended. Fourth, higher proportion of non CHF members perceived that those who pay user fees are more satisfied with health care provided. Fifth, people who dropped out of CHF perceived that user fees amount were too high but disagreed that user fees discouraged people from joining CHF.

5.2 Comparison of user fees, health expenditure and proportion to monthly income between CHF and non-CHF members

CHF members were more likely to spend more on health services as user fees compared to non CHF members. Similarly, CHF member were more likely to have had spent higher proportions of their monthly income for health services. This finding seemed to negate the notion that CHF scheme was cheaper[29]. World Health Organization (WHO) survey in three countries found that members of community financing schemes reported lower out-of-pocket expenditures on health[29]. Poor health services at the public health facilities in our study area may have necessitated the clients to seek care at other health facilities than the ones they are registered to, hence needed to pay user fees. Indeed, our CHF respondents mentioned several other health facilities they visited including private ones in Bagamoyo and near-by Dar es Salaam wards. This could have happened when CHF members visited any health facility other than the one they were registered in or visited the district hospital without a referral

letter, or example when dissatisfied with services or need some advanced care like surgery or laboratory investigations. On the contrary, non CHF members do not pay any premium, rather, pay user fees as they utilize health services. Thus the health expenditure for CHF members included the annual CHF premiums (calculated as monthly here) and user fees paid during the visits to the health facilities.

There is typically unreliable supply of drugs, for example, the three dispensaries visited had minimal supply of essential drugs and none of them had Malaria drugs. In another study, Turkson reported that poor quality of health care in rural Ghana resulted in loss of customers and revenue ultimately contributing to low effectiveness and efficiency[30]. Should there have been no possibility of paying user fees, perhaps everyone would have joined CHF and the risk pooling would result to a larger fund which would have been able to improve the health system and quality of health care in Bagamoyo.

Another reason that could explain the difference in expenditure for health between CHF and non-CHF member could have been poor health status necessitating more frequent use of health services[20] or differential health seeking behavior between CHF and non CHF members[31]. It has been shown that CHF member have higher health seeking behavior than non-CHF members[31]. However, in our study there was no statistically significant difference in health service utilization in one month prior to study between CHF and non-CHF member. Moreover, in this study CHF and non-CHF members did not differ in terms of their monthly income.

5.3 Effect o payment of user fees on health services utilization and quality of health services perceived.

Charging user fees can affect the use of health services but in this study it was found that there was no difference in health care utilization between CHF and non CHF members. This negates the study by Laterveer in Tanzania[32] who found that user fees had negatively impacted the use of health care by the rural poor population, particularly women and children. This can be explained by the low coverage of CHF in our study area thus the impact of utilization is not

evident. Another study by Mujinja[18] showed great willingness of Tanzanians to pay for health services.

This study also found out that, more non-CHF members compared to CHF members perceived that people paying user were more satisfied with the health care provided. This is similar to what Shaw and Laterveer found that health care providers preferred user fees in Tanzania and Uganda respectively [32,33]. Unlike CHF premiums which are retained at the district levels[7], all the user fees were retained at the health facilities and were used to recover operating costs and pay for workers incentives [32,33]. This may imply that, the preference of health care providers to people paying user fees may be a motivation for people not joining CHF membership.

Also this study found that a significantly higher proportion of CHF members compared to those who have never joined CHF perceived that user fees charges were too high. In Ethiopia, Barnett found out that user fees were very expensive especially at health centers and hospital level[34]. But in this study also, those who had never joined CHF disagreed that user fees discourage people from joining CHF. This is contrary to the notion that user fees were expensive. Respondents who have never joined CHF schemes have not had the opportunities that CHF schemes provides or they may have not heard of the benefit of risk pooling, and therefore may not see the importance of joining CHF. Indeed a greater proportion of non-CHF members had paid user fees compared to only CHF members. If all these were motivated to join CHF then the fund would have been larger, hence enabling improvement of health services in Bagamoyo.

This study also found that non CHF members perceived that CHF members were attended first before those paying user fees. This may be a reason for prompting people to join CHF. Furthermore, less CHF members compared to non-CHF members perceived that CHF members had better health outcome. Being a second measure for quality of service explored in this study, CHF members were perceived to be receiving a better quality of health compared to non CHF member. On the other hand, greater proportion of CHF members perceived that they (CHF member) waited longer to be attended at the health facilities. These contradicting

perceptions may fall short of new CHF enrollees' expectations causing them to dropout of CHF schemes.

In this study it was also found that respondents regarded CHF not expensive. In Bagamoyo user fees were reported to be 1,000TZS and 2,000 TZS for out and in patient health services at all level of health facility. CHF premium was 10,000TZS per household per annum. This was in line with the original hypothesis for the community based health insurance that pooling of risk reduced financial barriers to health care by reducing the costs for health care[29] while avoiding the unnecessary reduction in the amount of money in the households for the other needs and for investment. A study by Russell[35] found out that households, in order to mobilize resources, may sacrifice other basic needs such as food and education, with serious consequences for the household or individuals within it.

5.5 Factors associated with dropping out from CHF

This study found out that people who had dropped out of CHF perceived that user fees amount were too high. This finding corroborates some with earlier reports that user fees are regarded expensive[34]. Unexpectedly, although agreed that user fees were high, people who dropped from CHF disagreed that user fees did not discourage people from joining CHF. Poor quality of health services and referrals were the reason provided by the majority of the respondents as the main reasons for dropping out. This is not a new finding in health system as it was also reported earlier in Tanzania that poor quality of health services is the main reason for low enrollment and poor performance of CHF. Moreover, it has been shown that seeking health services in a rural setting is not limited to a particular facility serving the area, rather quality of services is the major determinant to selection of health facility attended[30].

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

In conclusion, this study found out the following:

1. Poor quality of health services and poor referral mechanisms were the main reasons for dropping out of CHF.

2. Co-existence of user fees and CHF dis-favored CHF members who spent more on user fees and had significantly higher amounts of their monthly income spent for health services compared to non CHF members.

3. There was no difference in health care utilization between CHF and non-CHF members.

4. Compared to CHF members, respondents who had dropped out of CHF perceived user fees to be expensive but disagrees that user fees discourage people from enrolling to CHF.

5. Respondents who had dropped out from CHF perceived that CHF members were favored in health care provision while CHF members perceived that health care system did not favor CHF members.

6.2 Recommendations

It is therefore recommended that:

1. The government should ensure that efforts are taken to improve quality of health services in the public health facilities in Bagamoyo in order to reduce unnecessary distress and expenses to the CHF members, decrease drop out and improve the performance of CHF in Bagamoyo.

2. The co-existence of user fees and CHF should be revisited. It is thought that increasing user fee charges could increasingly attract people to join CHF or provide significant amount of money to improve health services at the health facility level.

Areas for future research

Two areas have been identified for future research from this study;

1. The effects of private health sector on enrolment, disenrollment and dropout from community health fund in Bagamoyo district

2. Comparing the effects of high and low rates of user fees among two different districts on enrolment, disenrollment and dropout from community health fund.

CHAPTER 7: REFERENCES

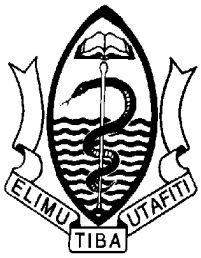
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APPENDICES

Appendix 1: Consent form (English)



MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS

INFORMED CONSENT FORM

ID NO: ……..

Greetings,

My name is **Dr Lawrence Lekashingo**, I'm a resident studying Masters of Medicine in Community Health at School of Public Health and Social Sciences in Muhimbili University of Health and Allied Sciences, Dar es salaam. I am doing research on The Effects Co-existence of User Fees and Community Health Fund (CHF) on CHF Enrolment, Disenrollment and Dropout in Bagamoyo District.

Purpose of the study

The purpose of the study is to find out how user fees affect CHF enrolment in CHF scheme

Participation

If you agree to participate in the study you will be interviewed through a structured questionnaire to answer questions related to the CHF scheme and user fees.

Confidentiality

Your information will be treated with great confidential and it will be used for study purpose only. Identification number will be used instead of names.

Risks

It is not expected that any harm may happen to you because of participating in this study.

Right to withdraw and alternatives

To participate in this study is completely voluntary. You can freely choose not to participate in this study and even if you have already accepted to participate in this study you can quit at any time if it is necessary. No penalty or loss will be encountered upon refusal to participate or withdraw from the study

Benefits

If you choose to participate in this study you will provide your views and contribution that will be useful in improving CHF scheme for the betterment of your family, the district and the nation at large.

Who to consult

If you ever have questions about this study, you should contact the study coordinator or the Principal Investigator; **Dr Lawrence Lekashingo**, Muhimbili University of Health and Allied Science (MURAS), P.O. Box 65001, Dar es salaam.Tel:0753-780238

If you have questions which need further clarification you have a right to call **Prof M**. **Aboud**, Chairman of Senate Research and Publications Committee, MUHAS, P.O. Box 65001 Dar es salaam. Tel: 2150302-6

Signature

Do you agree?

Participant agrees……..Participant does not agree……

I……. have read the content in this form, my questions have been answered, I agree to participate in this study

Signature of Participant. ……. .

Signature of Researcher ……

Date of signed consent ……

Appendix 2: Consent form (Kiswahili)

CHUO KIKUU CHA SAYANSI ZA AFYA MUHIMBILI

SHULE YA AFYA NA SAYANSI YA JAMII

IDARA Y A UTAFITI

FOMU Y A RIDHAA

NAMBA YA USAJILI

Hujambo?

Ninaitwa **Dr Lawrence Lekashingo**, ni mwanafunzi wa shahada ya uzamili wa afya ya jamii katika chuo kikuu cha Afya ya Tiba eha Muhimbili, Nasomea shahada ya uzamili ya Afya ya Jamii. Nataka kufanya utafiti kuhusu sababu zinazochangia mwamko wa wananchi kujiunga na Mfuko wa Afya wa Jamii kuendeana na malipo ya fedha za papo kwa hapo wanapoenda kutibiwa katika hospitali.

Madhumuni ya utafiti

Utafiti huu unalenga kugundua visababishi vinavyochangia wanajamii kujiunga na kutijiunga na mfuko wa afya wajamii kuendeana na ulipaji wa pesa za papo kwa papo .

Nini kinahitajika iIi kushiriki

Ukikubali kushiriki kwenye utafiti huu utajibu maswali toka kwenye dodoso kadiri utakavyo ulizwa na mtafiti.

Usiri

Taarifa zitakazokusanywa kupitia dodoso hili zitakua siri na hakuna ntu yeyote atakayeambiwa ulichosema.Taarifa zitaingizwa kwenye ngamizi kwa kutumia namba za utambulisho

Hatari

Hakuna hatari yeyote itakayotokea kwako kutokana na ushiriki wako kwenye utafiti huu.

Haki ya kujitoa au vinginevyo

Ushiriki katika utafiti huu ni wa hiari .Kutokushiriki au kujitoa kutoka kwenye utafiti hakutakua na adhabu yeyote na hutapoteza stahili zako zozote endapo utaona ni vema kufanya hivyo.

Faida

Kama utakubali kushiriki kwenye utafiti huu utapata fursa ya kutoa mchango wako kuhusu maboresho ya utendeshaji wa mfuko wa afya yajamii kwa manufaa yako na familia yako na pia kwa manufaa ya watu wote wa wilaya ya Bagamoyo na taifa zima kwa ujumla.

Endapo utapata madhara au la

Hatutegemei kupata madhara yoyote kutokana na ushiriki wako katika utafiti huu.

Nani wa kuwasiliana naye

Kama kuna swali kuhusianan na utafiti huu unaweza kuwasiliana na mhusika Mkuu Dr Lawrence Lekashingo wa Chuo Kikuu cha Afya na Sayansi ya Tiba Muhimbili. S.L.P 65001 DSM. Simu 0753-780238. Ikiwa una maswali zaidi unaweza kuwasiliana na **Prof M. Aboud**, Mwenyekiti wa Seneti, Kamati ya Utafiti na Uchapishaji, Chuo Kikuu cha Muhimbili. Tel: 2150302-6

Je, Umekubali?

Mshiriki amekubali…….. Mshiriki hajakubali . ……...

Mimi…….. nimesoma maelezo kwenye fomu

hii, maswali yangu yamejibiwa na nimeridhika.Nakubali kushiriki katika utafiti huu.

Sahihi ya Mshiriki…….. ...

Sahihi ya mtafiti ……

Appendix 3: Questionnaire (English)

QUESTIONNAIRE FOR THE EFFECTS OF CO-EXISTENCE OF USER FEES AND CHF ON THE ENROLMENT IN CHF IN BAGAMOYO:

SECTION A: IDENTIFICATION

Questionnaire Number……
District name……..
Street/village Name (health facility for exit questionnaire)……
Name of Interviewer ……...
Respondent id (name/sr #)…….
Date of Interview: Date……..Month…….Year……..

SECTION B: PERSONAL CHARACTERISTICS

1. Sex *(a) Male, (b) Female*
2. Marital status *(a) single (b)married (c) living together with no marriage (cohabiting) (d) divorced (e) widowed*
3. Religion of the respondent: *(a) Islam (b) Christian (c) Traditionalist (d) None*
4. What is the age of the respondent; age in years……
5. What is your highest level of education you attained?
   (a) None, b) Primary education,(c) Secondary education (O-level),
   (d) Secondary Education (A-level), (e) Technical and Vocational Training,
   (f) College (Diploma), (g) University level, (h) Adult Education
6. What is your main occupation or main source of income?
   (a)Farming, (b) Fishing, (c) Petty Trade, (d) Trade (e) Casual labour
   (f) Mechanics, (g) None/unemployed/looking for job (h) Private employee
   (i) Disabled (j) Pupil/Student (k) Retired/old.

SECTION C: HEALTH CARE SERVICES UTILIZATION.

CHF member or non-member

7. When did you last fall sick? (a) Past 1 week (b) Past 1week to 1month
   (c) More than one month ago (d) Don't remember
   If don't remember skip to question 12

8. What were you suffering from in the last visit? **Report all the episodes**
   ……..
   ……..
9. When you fell sick in the last episode, did you go to the health facility?
   (a) Yes (b) No
   IF NO GO TO QUESTION 11
10. Which facility; ……..
11. If not, why not? (a) Poor quality of health services at the health facility
    (b) Distance to the health facility (c) No money to pay for health services
    (d) High prices of health services (e) Usually go to traditionalists (f) Not a member of CHF

12. When was the last time you or any member of your household attended at a health facility?
    (A) Past 1 week (b) Past 1week to 1month (c) More than one month ago (d) Don't remember

    If the participant/member attended in the past one month please list all the episodes, types of illness, kind of health facility attended and amount paid in each visit.

Episode	**Type of illness**	**Health facility attended (disp, HC, private, tradition) and name**	**How much did you pay**
1			
2			
3			
4			
5			

13. Have you ever paid user fees when attending for health services at a health facility (a) Yes
    (b) No

14. Are you registered as a beneficiary of CHF in this facility? (a) Yes (b) No

15. How far is the health facility from your home? ……..

16. Is this the facility that you usually attend to when confronted with an illness episode? (a) Yes (b) No

17. How did you pay for this episode? (a) User fees (b) CHF (c) Exemption (if qualify)

SECTION D: PERCEPTIONS ON CHF USEFULNESS AND CHALLENGES.

18. Are you a member of Community Health Fund in your district? (a) Yes (b) No

If member of CHF, ask questions 19, 20.

19. How much do you pay as a CHF premium per year? …….Tsh

20. Is this amount (a) Too high (b) Normal (c) Too little (d) Do not know

21. On your opinion, the following are importance of joining CHF

CHF importance	***Strongly agree***	***Agree***	***Unsure***	***Disagree***	***Strongly disagree***
Helps to improve the quality of health services at facilities					
Increase accessibility of health services to the individuals					
Provides assurance of health services when one gets sick					

22. On your opinion, CHF has the following challenges

CHF challenges	***Strongly agree***	***Agree***	***Unsure***	***Disagree***	***Strongly disagree***
Poor health services					

Poor referral mechanisms					
Takes long to get Registered					
poor leadership					
Expensive					

If the participant had been a member of CHF.

23. Have you ever joined and dropped from CHF? *(a) Yes, (b) No*
If no skip to Q25

24. Why did u drop out of CHF? (a) Poor health services (b) poor referral mechanisms (c) takes long to get registered (d) poor leadership (d) affordability (e) had to pay extra costs at health facility

SECTION E; PERCEPTIONS OF AMMOUNT AND USEFULENESS OF USER FEES

25.

User fees	***Strongly agree***	***Agree***	***Unsure***	***Disagree***	***Strongly disagree***
Amounts are too high					
Discourage people from joining CHF					
Prevent people from attending at health facilities when sick					
Help to improve the quality of services at the health facilities					
Reduce the amount of money available in the households for investments and other needs					

Improve the relationship between health care providers and clients					

SECTION F: PERCEPTIONS OF QUALITY OF CARE PROVIDED TO INDIVIDUALS PAYING USER FEES

26.

	Strongly agree	***Agree***	***Unsure***	***Disagree***	***Strongly disagree***
People paying user fees are attended first before CHF members					
People paying user fees have better relationship with health care providers					
People paying user fees have better access to health services in their areas					
People paying user fees perceive the attitude of health care workers as good					
People paying user fees wait longer to be attended by the health care workers					
People paying user fees are more satisfied with the care given					
People paying user fees have better health outcome					

SECTION G; PERCEPTIONS OF QUALITY OF CARE PROVIDED TO CHF MEMBERS

27.

	Strongly agree	***Agree***	***Unsure***	***Disagree***	***Strongly disagree***
CHF members are attended first before people paying user fees					
CHF members have better relationship with health care providers					
CHF members have better access to health services in their areas					
CHF members perceive the attitude of health care workers was good					
CHF members wait longer to be attended by the health care workers					
CHF members are more satisfied with the care given					
CHF members have better health outcome					

SECTION H; PROPORTION OF CHF AND NON CHF MEMBERS' INCOMES USED TO PAY USER FEES AND CHF

28. What are your sources of income? Mention: (a)……. (b) …….. (c) ……..
29. What is your average income per month from all these sources? .....

THANK YOU FOR YOUR PARTICIPATION

Appendix 4: Questionnaire (Kiswahili)

DODOSO LA KUANGALIA ATHARI YA KUWEPO KWA MALIPO YA PAPO KWA HAPO NA MFUKO WA AFYA WA JAMII KUHUSIANA NA KUJIUNGA KWENYE MFUKO WA AFYA YA JAMII KWA WILAYA YA BAGAMOYO

SEHEMU A: UTAMBULISHO

Nambari ya dodoso ……
Jina la Wilaya……
Jina la kituo cha afya (mtaa/kijiji kwa dodoso la nyumbani) …….
Mtaa/village Name ……
Jina la mdadisi……
Utambulisho wa mhojiwa (nambari) …….
Tarehe ya udadisi: Tarehe……..Mwezi……Mwaka……..

SEHEMU B: HABARI BINAFSI

30. Jinsia (a) Mme (b) Mke

31. Hali ya ndoa *(a)hajaoa/hajaolewa (b) ameoa/ameolewa (c) kimada (d) talaka/tengana (e) mjane*

32. Dini ya mshiriki (a) Muislam (b) Mkristo (c) Dini ya asili (e) Hana dini

33. Umri wa mshiriki; Miaka ……

34. Kiwango cha elimu cha juu ulichofikia:
*(a)Hajasoma (b)Elimu ya msingi(c)Elimu ya sekondari (O-level),(d) Elimu ya sekondari (A-level), (e) Chuo cha ufundi(f) Chuo (Diploma), (g)Chuo kikuu (h) Elimu ya watu wazima (i) Nyingine; taja****……***

35. Kazi yako ni nini au chanzo kikubwa cha kipato chako?
*(a)Mkulima (b)Mvuvi (c) Biashara ndogondogo (d)Biashara (e)Kibarua (f) Fundi magari (g)Sina kazi (h)Nimejiajiri (i)Kilema (j) Mwanafunzi (k) Mstaafu/mzee (l)Nyingine; taja****……***

SEHEMU C: MATUMIZI YA HUDUMA ZA AFYA.

Kwa mwanachama na ambaye sio mwanachama wa Mfuko wa Afya ya Jamii (CHF)

36. Mara ya mwisho umeugua lini? (a) Wiki moja iliyopita (b) Kati ya wiki moja iliyopita na mwezi mmoja (c) Zaidi ya mwezi mmoja uliopita (d) Sikumbuki
    Kama hakumbuki nenda mpaka swali la 12.
37. Ulikuwa unaugua nini kwa hiyo mara kwa mwisho? **Orodhesha matukio yote ya kuugua**……..
    ……..
38. Ulipougua kwa mara ya mwisho, ulienda kwenye kituo cha afya?
    (a) Ndiyo (b)Hapana
    KAMA HAPANA NENDA KWENYE SWALI LA 11
39. Kituo gani? ……..

40. Kama hapana, kwanini? (a) Huduma mbovu za afya katika kituo cha afya (b) Umbali mrefu mpaka kituo cha afya (c) Sikuwa na hela za kulipia huduma za afya (d) Gharama za juu kulipia huduma za afya (e) Siku zote huwa naenda kwa waganga wa jadi (f) Sio mwanachama wa CHF

41. Ni lini mara ya mwisho umeenda au mtu yoyote wa kaya yako ameenda kwenye kituo cha afya? (a) Wiki moja iliyopita (b) Kati ya wiki moja iliyopita na mwezi mmoja (c) Zaidi ya mwezi mmoja uliopita (d) Sikumbuki. **Kama mshiriki/mwana kaya ameenda kituoni kipindi cha mwezi mmoja uliopita, tafadhali orodhesha matukio yote, maradhi aliyokuwa nayo, kituo cha afya alichoenda na kiasi alicholipa kwa kila alipoenda.**

Tukio	**Ugonjwa aliokuwa nao**	**Kituo cha afya alichoenda (zahanati, kituo cha afya, binafsi, serikali) na jina. Mganga wa kienyeji**	**Kiasi gani cha fedha ulilipa**
1			
2			
3			
4			
5			

42. Umeshawahi kulipa malipo ya papo kwa hapo unapoenda kutibiwa kwenye kituo cha Afya? (a) Ndio (b) Hapana

43. Je umeandikishwa kama mwanachama wa CHF kwenye kituo hiki? (a) Ndio (b) Hapana

44. Kuna umbali gani kutoka nyumbani kwako mpaka kituo cha afya? Km ……..

45. Je hii ndio kituo ambacho siku zote huenda unapougua? (a) Ndio (b) Hapana

46. Ulilipiaje huduma za afya ulipoenda hii mara ya mwisho? (a) Malipo ya papo kwa hapo (b) CHF (c) Kusamehewa (Kama mzee, kilema au mtoto)

SEHEMU D; MAWAZO KUHUSIANA NA UMUHIMU WA MFUKO WA AFYA YA JAMII

47. Wewe ni mwananchama wa Mfuko wa Afya ya Jamii? (a) Ndio (b) Hapana

Kama ni mwanachama wa mfuko wa afya ya jamii uliza maswali 19-20

48. Kiasi gani unalipa kama ada ya Mfuko wa Afya ya Jamii? …….Tsh

49. Je, kiasi hiki unakionaje? (a) Juu sana (b) Kawaida (c) Kidogo sana (d) Sifahamu

50. Kwa mawazo yako, yafuatayo ni mambo muhimu yatokanayo na kujiunga na Mfuko wa Afya ya Jamii (CHF)

Umuhimu wa kujiunga na CHF	***Nakubali kabisa***	***Nakubali***	***Sina hakika***	***Sikubali***	***Sikubali kabisa***
Inasaidia kuboresha huduma za afya kwenye vituo vya afya					
Inaongeza upatikanaji wa huduma za afya kwa wananchi					
Inaleta uhakika wa kuapata huduma za afya pindi mtu anapougua					

51. Kwa mawazo yako, Mfuko wa afya ya jamii una changamoto zifuatazo

Changamoto za CHF	***Nakubali kabisa***	***Nakubali***	***Sina hakika***	***Sikubali***	***Sikubali kabisa***
Huduma mbovu za afya					
Uhamishaji mbovu wa wagonjwa kwenda vituo vya juu					

Inachukua muda mrefu kuandikishwa kituoni ukienda kutibiwa					
Uongozi mbovu					
Ghali (gharama za juu)					

52. **Kama alishawahi kuwa mwanachama wa CHF;**

Ushawahi kuwa mwanachama wa Mfuko wa Afya ya Jamii katika wilaya yako na kisha kujitoa? (a) Ndio (b) Hapana

Kama hapana, nenda swali la 25

53. Kwanini ulijitoa kwenye CHF? (a) Huduma mbovu za afya (b) Uhamishaji mbovu wa wagonjwa kwenda vituo vya juu (c) Inachukua muda mrefu kuandikishwa kituoni ukienda kutibiwa (d) Uongozi mbovu (d) Ghali (gharama za juu) (e) ilibidi nilipie hela zaidi nilipoenda kutibiwa kituoni

SEHEMU E; MAWAZO KUHUSIANA NA VIWANGO NA UMUHIMU WA FEDHA ZA PAPO KWA HAPO.

54.

Malipo ya papo kwa hapo	***Nakubali kabisa***	***Nakubali***	***Sina hakika***	***Sikubali***	***Sikubali kabisa***
Viwango viko juu sana					
Yanawafanya watu wasijiunge na CHF					
Yanawafanya watu wasiende vituo vya afya pale wanapougua					
Vinasaidia kuboresha huduma za afya kwenye vituo					
Yanapunguza hela					

kwenye familia kwa ajili ya matumizi mengine muhimu na kuwekeza					
Yanasaidia kuboresha mauhusianokati ya wagonjwa na watoa huduma					

SEHEMU F: MAWAZO KUHUSIANA NA UBORA WA HUDUMA ZA AFYA WANAZOPATIWA WATU WANAOLIPA MALIPO YA PAPO KWA HAPO

55.

	Nakubali kabisa	***Nakubali***	***Sina hakika***	***Sikubali***	***Sikubali kabisa***
Watu wanaolipa malipo ya papo kwa hapo huwa wanahudumiwa kabla ya wanachama wa CHF					
Watu wanaolipa malipo ya papo kwa hapo huw na mauhusiano mazuri zaidi na watoa huduma kwenye vituo vya afya					
Watu wanaolipa malipo ya papo kwa hapo huwa wanapata huduma za afya kwa urahisi zaidi kwenye maeneo yao					
Watu wanaolipa malipo ya papo kwa hapo huwa wanaona kuwa mtizamo wa watoa huduma za afya kuwa ni mzuri					
Watu wanaolipa malipo ya papo kwa hapo huwa wanasubiri zaidi kabla					

ya kuhudumiwa na watoa huduma za afya					
Watu wanaolipa malipo ya papo kwa hapo huridhishwa zaidi na huduma za afya wanazopewa					
Watu wanaolipa malipo ya papo kwa hapo hupata matokeo mazuri zaidi ya matibabu					

56. **SEHEMU G: MAWAZO KUHUSIANA NA UBORA WA HUDUMA ZA AFYA WANAZOPATIWA WANACHAMA WA CHF**

	Nakubali kabisa	***Nakubali***	***Sina hakika***	***Sikubali***	***Sikubali kabisa***
Wanachama wa CHF huwa wanahudumiwa kabla ya watu wanaolipa malipo ya papo kwa hapo					
Wanachama wa CHF huwa na mauhusiano mazuri zaidi na watoa huduma kwenye vituo vya afya					
Wanachama wa CHF huwa wanaweza huduma za afya kwa urahisi zaidi kwenye maeneo yao					
Wanachama wa CHF huwa wanaona kuwa mtizamo wa watoa					

huduma za afya kuwa ni mzuri					
Wanachama wa CHF huwa wanasubiri zaidi kabla ya kuhudumiwa na watoa huduma za afya					
Wanachama wa CHF huridhishwa zaidi na huduma za afya wanazopewa					
Wanachama wa CHF hupata matokeo mazuri zaidi ya matibabu					

SEHEMU H; UWIANO WA VIPATO KWA WANACHAMA NA AMBAO SI WANACHAMA KWENYE MALIPO YA PAPO KWA HAPO NA CHF

57. Ni vipi vyanzo vyako vya uchumi na kipato? Vitaje: (a)……. (b) …….. (c) ……..
58. Ni nini wastani wa kipato chako kwa mwezi kutoka kwenye vyanzo vyako vyote hivi? ……..

ASANTE KWA USHIRIKI WAKO