CHALLENGES ENCOUNTERED BY COMMUNITY HEALTH FUND IN PROVISION OF HEALTH CARE SERVICES IN DODOMA MUNICIPAL COUNCIL

By

Nestory Limbanga Hinju

A Research Report Submitted in partial fulfillment of the Requirements for Award of the Degree of Masters of Health System Management (MHSM) of Mzumbe University

2017
CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled; Challenges Encountered by Community Health Fund in Provision of Health Care Service in Dodoma Municipal Council in partial fulfillment of the requirements for award of the degree of Master of Health systems Management of Mzumbe University.

___________________________
Major Supervisor

__________________________
Internal Examiner

________________________
External Examiner

Accepted for the Board of the School of Public Administration and Management

____________________________
DEAN / SCHOOL BOARD

DECLARATION COPYRIGHT

I, Nestory Limbanga Hinju declare that the dissertation titled “challenges encountered by community health fund in provision of health care service in Dodoma municipal” is my original work carried out by me under the supervision of MR Richard Ngowi.
COPYRIGHT

©

This dissertation is a copyright material protected under the Berne Convention, the copyright Act 1999 and other international and national enactments in that behalf, on intellectually property. It may not be reproduced by any means in full or part, except short extracts in fair dealings, for research or private study, critical scholarly review or discourse with an acknowledgement, without the written permission of Mzumbe University, on behalf of the author.

ACKNOWLEDGEMENTS

I would like to take his opportunity to thank god for protecting me and enabling me to do and complete this report.
Secondly, I give my thank to my field supervisor, Mr. Richard Ngowi for his moral support and directions.

I would like also to thank the Dodoma Municipal director for allowing me to conduct my research work on his municipal area: without forgetting a great effort given by CHF coordinator of the Dodoma municipal, for his hospitality and support when I was conducted my research work.

However special thanks should go to my beloved wife Naomi and my daughter Maria for giving me moral support during all my study and field work.

Lastly, I would like to thank all people without mention their names for supported me in completing his report but I appreciate their support.

<table>
<thead>
<tr>
<th>TERM</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>The group of people living together and sharing the common interest</td>
</tr>
<tr>
<td>Fund</td>
<td>The same of money set apart for special purpose.</td>
</tr>
<tr>
<td><strong>Per capital income</strong></td>
<td>The ratio income received from all source to the person contribution of social insurance divided to the total population.</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Pilot</strong></td>
<td>The test of a new idea in small area before it is introduced everywhere.</td>
</tr>
<tr>
<td><strong>Prepayment</strong></td>
<td>The situation whereby an individual is required to pay (in advance) before getting the services.</td>
</tr>
<tr>
<td><strong>Scheme</strong></td>
<td>A plan or system for doing or organizing something.</td>
</tr>
<tr>
<td><strong>Variable</strong></td>
<td>Something which repents something that can vary in quality or size.</td>
</tr>
</tbody>
</table>
ABSTRACT

Community Health Fund (CHF) is the scheme which was established by the CHF Act of 2001, so as to identify possible mechanisms for accessing basic health care services particularly among the population in rural areas. In Tanzania, the scheme was first introduced in Igunga as a pilot district in 1996. The general objective of the study was to determine the challenges encountered by community health fund in provision of health care services in Dodoma Municipal. Specific
objectives of the study were to assess the availability of the essential drugs through CHF in the health facilities, to assess the time spent by CHF members to access health services in health facilities, to identify the availability of the health personnel in the health facilities to provide health services under CHF scheme and to assess CHF awareness among the community members.

This study was conducted in Dodoma municipal council which has a population of 410,956 people according to national census of 2012. During the study the researcher applied a case study design where both probability and non-probability sampling methods were used. The sample size consisted of 105 respondents of which 1 was ward executive officer, 3 health care providers, 1 CHF coordinator and 100 heads of households. Data collected was analyzed and edited so as to ensure accuracy by using statistical package for social science programme (SPSS).

During the study the researcher got the following findings encountered by community health fund in provision of health care services in Dodoma Municipal: 72% of the respondents said could argue that waiting time when accessing health services through CHF scheme is a challenge, 47% of the respondents said that they were able to pay for the services. However, they could not join the scheme due to lack of awareness. 90% of the respondents argued to have a little knowledge on the CHF package while 72% pointed out unreliable health services as one of challenges encountered by CHF in provision of health services. 86% of the respondents stated that lack of sensitization is one of the challenges encountered by the CHF scheme in provision of health services.

In order to address the Challenges encountered by CHF in provision of health services; The government should make a detailed review on the amount of contributions among CHF members and that CHF membership should be mandatory for all the people in the country and not voluntary. Drug audit should be a common practice in health facilities and that uniform mechanism of accessing health services should be practiced among both NHIF and CHF members. The government should also employ enough health staff in health facilities in order to improve to quality of health services provi
# TABLE OF CONTENTS

CERTIFICATION....................................................................................................................i
DECLARATION COPYRIGHT...................................................................................................ii
COPYRIGHT..........................................................................................................................iii
ACKNOWLEDGEMENTS.........................................................................................................iv
DEFINITIONS OF KEY TERMS..............................................................................................v
LIST OF ABBREVIATIONS AND ACRONOMYS.....................................................................vi
WEO   - Ward Executive Officer..........................................................................................vi
ABSTRACT............................................................................................................................vii
TABLE OF CONTENTS..........................................................................................................viii
LIST OF TABLES....................................................................................................................xiii
LIST OF FIGURES..................................................................................................................xiv
CHAPTER ONE.......................................................................................................................1
1.0 INTRODUCTION.............................................................................................................1
1.1 Background information...............................................................................................1
1.2 Statement of the problem and significance of study....................................................2
1.3 Research Gap................................................................................................................3
1.4 Research Objectives.......................................................................................................4
   1.4.1 General Objective..................................................................................................4
   1.4 Specific Objectives....................................................................................................4
1.5 Research Questions ........................................................................................................... 4
1.6 Scope of study .................................................................................................................. 4
1.7 Conceptual Framework ................................................................................................... 4
Figure 1: Theoretical framework ......................................................................................... 6
CHAPTER TWO ..................................................................................................................... 7
LITERATURE REVIEW ....................................................................................................... 7
2.0 Introduction ..................................................................................................................... 7
2.1 Global Community Based Health Insurance Fund ....................................................... 8
2.2 Community Health Fund in China .............................................................................. 8
2.3 The Basic Insurance for Urban Employees .................................................................. 8
2.4 The Basic Medical Insurance for Urban Residents ..................................................... 8
2.5 The New Rural Cooperative Medical Insurance ....................................................... 9
2.6 Health Insurance in Ghana ......................................................................................... 10
2.7 The Package Given by the Health Scheme in Ghana .................................................. 11
2.8 Services excluded in Package in Ghana Health Insurance ......................................... 11
2.9 Kenya Community Health Insurance (Jamii Bora Health Insurance) ......................... 11
2.10 Rwanda Community Health Insurance Scheme ....................................................... 12
2.11 Burundi Community Health Insurance Scheme ....................................................... 13
2.12 Uganda Community Health Insurance ....................................................................... 13
2.13 SHU’s current programming is in four areas which are: ......................................... 13
2.14 Meaning and origin of CHF in Tanzania ................................................................... 15
2.15 Origin of CHF in Tanzania ......................................................................................... 15
2.16 Operation of the Community Health Fund ............................................................... 16
2.17 Accountability and Management of CHF .................................................................. 17
2.18 The potential of the CHF ......................................................................................... 18
2.19 Community Participation and decision-making ......................................................... 18
2.20 Quality of services and drug availability .................................................................... 19
2.21 Challenges Facing Community Health Fund ............................................................ 19
2.22 Dropouts CHF members ........................................................................................... 19
2.23 Sustainability of the CHF ......................................................................................... 20
2.24 CHF Designing Issue ............................................................................................... 20
2.25 The responsibility of NHIF to CHF .......................................................................... 21
2.26 CHF Contribution ..................................................................................................... 21
2.27 Accessibility of CHF Member To Health Service .................................................... 21
2.15 Groups Enrolment in CHF ................................................................. 22
2.16 Medicines availability ................................................................. 22
2.17: Waiting time .............................................................................. 23
2.17: Skilled health workers ................................................................. 23
2.18 Customer care in CHF ................................................................. 24
2.19 Waiver and Exemption ................................................................. 24

CHAPTER THREE .............................................................................. 26

RESEARCH METHODOLOGY .................................................................. 26

3.1 Introduction .................................................................................... 26
3.2 Selection of the study area ............................................................. 26
3.4 Population and location of the study area ........................................ 26
3.5 Research Design ............................................................................. 26
3.6 Data collection methods and instruments ........................................ 27
3.6.1 Questionnaire .............................................................................. 27
3.6.3 Observation: ................................................................................ 27
3.6.4 Documentary review(Available information) .................................... 28
3.6.5 Editing: ........................................................................................ 28
3.6.6 Coding: ........................................................................................ 28
3.11 Data analysis and presentation ..................................................... 29
3.12 Ethical consideration .................................................................... 29
3.4 Sampling Design ............................................................................ 29
3.4.1 Sampling Frame ......................................................................... 29
3.4.2 Sampling Unit .............................................................................. 29
3.4.3 Sample Size ................................................................................ 29
3.6 Data Processing, Analysis and Presentation ...................................... 30
3.6.1 Data Processing ......................................................................... 30
3.6.2 Data Analysis ............................................................................. 30
3.6.3 Data Presentation ....................................................................... 30
3.7 Limitations of the study ................................................................. 30

CHAPTER FOUR .................................................................................. 31

4.0 DATA ANALYSIS AND DISCUSSION ........................................... 31
4.1 Characteristics of Respondents ..................................................... 31
4.2 Respondents sex distribution ......................................................... 32
4.3 Relationship between the level of income and CHF enrolment .......... 32
4.4 Relationship between marital status and CHF enrolment ............... 33
4.4.1 Relationship between level of education with enrollment to CHF membership

4.4.2 Relationship between respondents occupation and enrollment to CHF membership

4.5 Awareness Creation

4.5.1 Community awareness about CHF

Table No 4.6 Community awareness about CHF

Figure 2: Community awareness about CHF

4.5.2 Benefits of the CHF scheme

Table 4.7 Benefits of the CHF

4.5.3 CHF membership--- Transferred to Literature review

Table 4.8 CHF Members

Figure 4: Benefits of the CHF

4.5.4 Other reasons for not joining CHF scheme

Table 4.9 Reason for not joining CHF

Figure 5: Reasons for not joining CHF

4.5.5 Relationship between availability of Essential drugs and enrollment to CHF insurance scheme

Table 4.10 Essential drugs

Figure 6: Essential drugs

4.5.6 Drug supply by MSD and Prime Vendors to health facilities

Table 4.11 Drugs supply by health facility

Figure 7: Drugs supply by health facility

4.5.7 Missing prescribed drugs

Table 4.12 Drugs supply by health facility

Figure 8: Drugs supply by health facility

4.5.8 Waiting time to receive services at health facility

Figure 8 Waiting time

4.5.9 Challenges encountered by CHF members when receiving services

Table 4.14: Awareness on the Challenges encountered by CHF members

Figure 9: Challenges encountered by CHF

4.5.10 Establishment of the CHF - Should Transferred to literature review

4.5.11 Community acceptance to CHF

Table 4.15 Household joining the CHF

Figure 10 Households joining CHF

4.5.12 The obstacles encountered by CHF scheme
LIST OF TABLES

Table 4.1 Respondent Characteristics...............................................................36
Table 4.7 Benefits of the CHF........................................................................38
Table 4.8 CHF Member..................................................................................40
Table 4.9 Reason of not joining CHF...............................................................41
Table 4.10 Essential drugs............................................................................42
Table 4.11 Drugs supply by health facility....................................................43
Table 4.12 Drugs supply by health facility....................................................44
Table 4.13 Waiting time................................................................................45
Table 4.14: Challenges encountered by CHF...............................................47
Table 4.15 Household joining the CHF..........................................................49
LIST OF FIGURES

Figure 1: Theoretical Framework.................................................................6
Figure 2: Community awareness about CHF....................................................38
Figure 3: Benefits of the CHF........................................................................39
Figure 4: Benefits of the CHF........................................................................40
Figure 5: Reason of not joining CHF...............................................................41
Figure 6: Essential drugs.................................................................................42
Figure 7: Drugs supply by health facility............................................................43
Figure 8: Drugs supply by health facility............................................................44
Figure 8: Waiting time......................................................................................46
Figure 9: Challenges encountered by CHF.......................................................47
Figure 10: Household joining the CHF.............................................................50
CHAPTER ONE

1.0 Introduction

This chapter consists six sub-sections, namely Background Information, Statement of the Problem, Research Objectives, Research Questions, Scope of the Study and Conceptual Frame Work.

1.1 Background information

Before independence health services in Tanzania were determined by the economic, social and political requirements of colonial rulers rather than be the health needs of the country population. During that period Colonial economic policy put more emphasis in the production of cash crops for export with little emphasis on health services. Health services were meant for colonial rulers and few African minority leaving the majority in poor health service conditions. Soon after independence, health services in Tanzania were provided free of charge. However, world economic hardship from the late 1970s to 1980s caused economic hardship in different sectors in most developing countries, Tanzania being among them. The situation caused most of the sectors in Tanzania to fail in providing essential services like education, water, health services and development of the country. In order to reduce such burden, most of the African countries started introducing user fees (cost sharing) so that people can assist the government in meeting their needs on health service (Bura M, 1999).

The introduction of user fees caused many African countries to rely much on out of pocket payment during the time of need of health services (Bennett, et al, 2004). However, this had a harmful impact to the poor households which could not be capable to afford to pay money from their pocket. This made African nations to have the need of seeking a new financing option which could solve the problems of a new system. One of such options was prepayment scheme known as Community Based Health Fund (CBHF) whereby people were asked to pay before they access health services at health facilities.

The CBHF scheme program is considered as a mechanism of health-related risk sharing administrated at lower level where members contribute towards access to health services before they fall sick. There are various designs of CBHF schemes with common characteristics. These include voluntary membership, nonprofit character, pre-payment of a
contribution into a fund and entitlement to a specific benefit (Jutting J, 2004). In Tanzania also there exists a CBHF scheme simply known as Community Health Fund (CHF). This is a form of pre-payment scheme designed for rural and poor people.

CHF scheme was introduced in Tanzania in 1996, starting with Igunga as a pilot district, which later was extended to other districts with an intention of covering the whole country (MOH, 1999). Specifically, the objectives of the CHF are to; Mobilize financial resources from the community for the provision of health care services to its members, provide good quality and affordable health care services through sustainable financial mechanism and improve health care services management in the community by making decisions and contributing on matters affecting their health.

CHF operation relies mainly on members contributions. The government has the task of providing the matching fund to the scheme from the amount collected through contribution from other sources like donors and councils (URT, 2001). But, studies conducted in different areas show that the dropout rate from CHF membership has been increasing, even in the areas that have been in operation for long time such as in Igunga District and Singida region (Shaw, P. 2002). This has some effects on the revenue generation, and if it is widespread, may pose problems for the CHF sustainability.

This study is trying to see the challenges encountered by CHF in provision of health care services in Dodoma Municipal Council.

Community Health Fund (CHF) is a scheme established by the CHF Act of 2001, so as to identify a possible mechanism for accessing basic health care services particularly to the population in rural areas. Its basic aim is to raise additional health fund, aiming at improving the access of health care for the poor and vulnerable groups (Munishi, 2001). CHF is based on the concept of risk sharing whereby members of CHF are required to contribute a small amount of money, on regular basis, to share the risk of paying a much larger amount of money as health care user fees whenever they fall sick.

Since when CHF scheme was introduced in Tanzania, different studies have been conducted in relation to its ineffective performance and weakness. However, the problem is still there to persist. Here is the gap where the researcher was interested to find out other challenges associated with the scheme that hinder effective provision of health services in the
back to the community. CHF scheme started in Dodoma Municipal in 2007. Since its introduction, more than half of its members have not been active members because of not paying an annual contribution fee. Only 20% of community cumulatively join the scheme annually (Municipal CHF Coordinator Report, 2016).

1.2 Statement of the problem and significance of study

This study tried to look at the challenges encountered by the CHF scheme in provision of health care services in Dodoma Municipal. CHF in Dodoma is supported by two Non Government Organizations (NGOs) which are Community Based Health Initiatives (CBHI) and Health Promotion and System Strengthening (HPSS) sponsored by Swiss Agency for Development and Cooperation SDC. The slogan used is "Improved CHF". The programme works as National Health Insurance Fund (NHIF) scheme. These organizations play an analytical role of identifying opportunities where CHF design has to be updated in order to better serve the population. The Organizations dealing with reformed or improved CHF work in close collaboration with Dodoma Region and district councils and administration so as to re-organize Community Health Funds (CHFs) in order to develop the Insurance Management System (IMIS). This is an information technology system for supporting the business process of improved CHF scheme to ensure availability and precision of information, to accelerate operation and reduce fraud. With IMIS CHF members are portable that they can access health service benefits at an facility.

Improved CHF has four main objectives which are; provision of a sustainable financial mechanism which enable community members to contribute to their health costs, improvement of access to health care for rural communities and those in informal economy, improvement of the quality of health care through equipment, supplies and human resources and promotion of decentralization and community empowerment with the aim of improving health care management (HPSS, 2019).

However, during implementation of improved CHF scheme a number of weaknesses have been experienced. Examples of such weaknesses are low enrollment, shortage of medicine and medical instrument, Health workers, infrastructure, satisfaction of members and dropout of people from CHF membership compared to the target (85%) of community to join the CHF (Kamuzora, et al, 2004). Up to the September 2016 only 10.6 % of members enrolled in the scheme in Dodoma municipal (NHIF Report June 2016). This is a gap where the
researcher was therefore interested to find out challenges leading to these weaknesses in provision of health services in Dodoma Municipalit

1.4 Research Objectives

1.4.1 General Objective

The general objective of this study was to explore the challenges encountered by community health fund in provision of health care services in Dodoma Municipality.

1.4 Specific Objectives

1.4.1 To examine the availability of the essential drugs through CHF in the health facility.
1.4.2 To assess the time spending by CHF members to get health services in health facility.
1.4.3 To assess the availability of the health personnel in the health facility to render the services under CHF scheme.

1.5 Research Questions

1.5.1 What is the status of the availability of essential drugs through CHF in the health facility?
1.5.2 What time, does the CHF member spend to get health services in the health facility?
1.5.3 Does health facility have enough staff to render the health services?

1.6 Rationale of study

The study will enable policy makers, donors, and planners, at various levels, in Tanzania to look out the mechanism to reduce the challenges of CHF, so that they can lay down strategies to combat such challenges in the implementation of CHF and hence achieve the intended goals of the CHF so that CHF members will obtain better services. Apart from that, the study is important in assisting other researchers in tackling other problems raised in CHF.

1.7 Conceptual Framework

Challenges encountered by CHF in the provision of health care service in Dodoma municipal council. This depends on different variables as indicated in the figure 1. Independent
variables have effect on the dependent variables which finally may result into provision of the quality of health services to the CHF members.

Among the major means to minimize the challenges encountered by CHF in the provision of health care in Dodoma, was the factor to increase the CHF members. This is because, if there is an improvement of health services through CHF scheme, then more CHF members will increase to the scheme. But, if it does not provide some of the services required, some members may decide to drop out of CHF membership. On the other hand the number of members joining the scheme increases with improvement in quality of health services provided.

The availability of drugs, reduced duration of waiting time, increase package of service and health facility staff availability may be among the factors of removing the challenges encountered in the provision of health care services in Dodoma municipal.

**Figure 1: Theoretical framework**

![Theoretical framework diagram](image-url)

- **Independent Variables**
  - Availability of drugs
  - Prolonged waiting time in receiving health service
  - Awareness of CHF member
  - Availability of the health staff

- **Dependent Variable**
  - Good service delivery
  - Short waiting time
  - Satisfaction of member
  - Increase enrolment of the CHF member
  - Quality of health service delivery
CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

Developing countries face many challenges in their development. One of the challenges is disease burden. African Governments spend more funds in health care provision to their people. Community Based Health Financing (CBHF) emerged as a possible response to the existing challenges in the health financing system, like constraints in economic sector and low organizational capacity (Carin, 2003). CBHF is a mechanism whereby community members (households) finance costs associated with health services, offering them greater involvement in the management of community financing scheme (Carin, 2003).

2.1 Theoretical Review

Health Ministries in the late 1980s in Africa were generally guided in part by United Nations Children and Education Fund (UNICEF) in the cooperation with the World Bank and Health Organization. African countries shifted their health care strategies to a subsidized, fee-for service model that involved active community participation (Cries, 1998).

Early in 1987, a group of African Health Ministries convened a conference in Bamako Mali to discuss for the community involvement in health care at the local level. The imposition of user fees at public health facilities across many health systems in Sub-Saharan Africa in the 1980s resulted to the access of the health care services to be diminished in health facility level. In some ways, CBHF scheme was viewed as a means of implementing one of the
central tenants of the Bamako Initiative. Local community members should be involved in both the collection and control of revenue for health care and they will be part and parcel of it in all health matters (Jakab & Krishnan, 2004).

After Bamako declaration some of the countries in Africa started an experiment with local health insurance schemes to a large extent because of breakdown in government health services and the need to find alternative means to finance local health services. These programs could be divided into two main parties which are a formal sector (often employment-related) and informal sector (non-employment). It should be noted that, schemes were to be controlled by groups of rural community residents by making Governance committee to run the scheme (Atim, 1998).

Following Bamako declaration the Government of Tanzania started to establish Community Based Health Insurance (CBHIF) as government revenue collection to supplement health burden on health care services provision through community participation. Since its beginning, the rural community has found an improved access to health care as well as improvement of quality of health care services. In addition to that significant improvements on resources mobilization have been realized.

2.2 Global Community Based Health Insurance Fund Schemes

The early year of 1970s and 1980s many African countries began the post-colonial period with the aim of raising the health status of their people and providing free or heavily subsidized health care to their people appear to have been important in shaping national approaches to health care in Sub-Saharan Africa and especially in West Africa. Difficult economic times, disease burden and civil war in Africa in the 1970s and 1980s resulted in the leaving behind of this universal health goal by almost all sub-Saharan African countries (Criel, 1998).

2.3 Community Health Fund in China

In 1990 China Government Established Three New Health insurance Systems in order to cover universal coverage to all resident of china, the goal of universal coverage was to provide safe, effective, convenient, and affordable basic medical services to all urban and rural residents. Three major health insurance schemes were established. They included the
basic insurance for urban employees, the basic insurance for urban residents and new rural cooperatives medical insurance (Edoardo M. 2015).

2.3.1 The Basic Insurance for Urban Employees

The Urban Employees Basic Medical Insurance (UEBMI) is compulsory based on employment. It provides basic medical insurance coverage for urban employees in both the public and privates institutions. This scheme covers all people living and working in towns and cities in China (Edoardo M. 2015).

2.3.2 The Basic Medical Insurance for Urban Residents

In 2007, the State Council issued guidelines to launch the Urban Residents Basic Medical Insurance (URBMI). According to the guidelines, the URBMI covers primary and secondary school students who are not covered by the UEBMI (including students in professional senior high schools, vocational middle schools, and technical schools), young children, and other unemployed urban residents on a voluntary basis.

The government also provides a smaller amount of subsidies, compared to the premium contributions. The premium of the policy is determined by the local government, according to the local economic level, the medical care expense level, and the participants’ household income level. There are extra government subsidies for low-income families, disabled students, and young children (EDOARDO M. 2015).

2.2.4 The New Rural Cooperative Medical Insurance

Before the introduction of new rural cooperative medical insurance, about 90% of the rural population was left without any type of health insurance coverage. People lived in poor condition and there was a need to provide health care to the people living in rural area. The government of china in corroboration with council in 2003, they made the decision on further enhancement of the rural health care system, which aimed at re-establishing the new rural cooperative medical insurance (NRCM). The NRCM scheme covered the rural residents on a voluntary basis in order to avoid needs caused by catastrophic expenses from infectious and endemic diseases. The NRCM provided partial coverage for all kinds of medical expenses, excluding some outpatient expenses and drug expenses. The reimbursement caps vary by local economic development levels. The initiation and expansion of the NRCM diminished
the disparities in health insurance coverage. However, it is still unknown whether the expansion helped reduce disparities in other healthcare areas, such as healthcare utilization and cost. (Edoardo M. 2015).

2.6 Bamako Convention on Health Care

In 1987 UNICEF convened a meeting in Bamako Mali for larger community involvement in health care at local level. The imposition of user fees at public health facilities across many health systems in sub-Saharan Africa in the 1980s resulted in diminished levels of access to health care services. In some ways, CBHF schemes can be viewed as a means of implementing one of the central tenants of the Bamako initiative. Local community members should be involved in both the collection and control of revenue for health care in their area (Jakab & Krishnan, 2004).

From that time, some of the countries started to experiment with local health insurance schemes in large part because of the breakdown in government health services and they needed to find alternative means to finance local health services. These schemes are divided into two parts, formal sector (often employment-related) schemes and informal sector. The informal sector involves the rural community residents (Atim, 1998).

Regardless of the various views from expertise and researchers in relation to the origins of community-based health fund which resulted to the diverse in analyses of the origins of community-based health financing, it is observed that, from the early 1990s to present time there has been rapid growth and establishment of these organizations areas in Africa in general and in West Africa in particular. Therefore, they can be explained in different views according to how those organizations work in relation to the environment. For example, a recent article, presents data from eleven francophone West African countries. According to this article, there were 76 functional community health insurance schemes in these countries in 1997; 199 in 2000, 348 in 2003 and an estimated 626 in 2006. In Benin, Burkina Faso and Mali, the estimated number of community health insurance schemes was 24 in 1997, 71 in 2000, 128 in 2003 and 282 in 2006 (Ndiaye S, at el 2007).

The rate of growth for these schemes has been exciting, it is important to keep in mind that, small proportion of the population is insured by the scheme. For example, the estimated number of beneficiaries in Benin, Burkina Faso and Mali in 2006 was a little over half a million people out of a combined population of about 36 million in the three countries (Ndiaye S, at el 2007).
2.4. Community Health Based Fund in West Africa

2.4.1 Health Insurance in Ghana

Ghana is a West African country which started the new health insurance in 2000 after election of president John Kufuor, who removed cash and carried system replacing with an equitable insurance scheme that ensured that, treatment provided first before the payment.

In Ghana there are three types of the health insurance schemes known as District Mutual Health Insurance, Private Commercial Health Insurance and Private Mutual Health Insurance Scheme. The district mutual health insurance scheme operates in every district in Ghana and the government gives subsidy to the scheme. This type of insurance is like Community Health Insurance Scheme in Tanzania. It is mutual because community members pay premium to the health insurance scheme and the government gives subsidy to the health insurance scheme. It is voluntary in mode of enrolment in the health insurance. To sign up for the district mutual health insurance scheme, one needs to get to the district assembly where he resides or looks for the officers of the scheme and register. He will fill a form, offering some basic personal information and he will be asked to present at least two passport pictures. He will also need to fill forms for dependants below 18 as well.

Apart from the premium paid by members, the district mutual health insurance schemes receive regular funding from central government. This central government funding is drawn from the national health insurance fund. Every Ghanaian worker pays two-and-a-half percent of their social security contributions into this fund and the VAT rate in Ghana also has a two-and-a-half percentage component that goes into the health scheme.

Another type is private commercial health insurance scheme. This is operated by private companies, and any citizen of Ghana can join in this scheme by paying their contributions directly to the insurance scheme.

The third type of insurance scheme is private mutual health insurance where people join the scheme through groups like church members, cooperatives and social groups. (Blanchet N, et al, 2012).

2.4.2 The Package Given by the Health Scheme in Ghana

Ghana community health insurance scheme is only the scheme which provides good package among the insurances in Africa. The health package provided by Ghana community health insurance includes out–patient department general and specialized consultation, diagnosis, X-
rays, ultrasound scanning, surgical operation and physiotherapy. In the inpatient department the services provide include general and specialized patient care, diagnostic test, blood and blood products, surgical operation, accommodation and food.

In dental department service provided are: extraction, incision and drainage and dental restoration. In the maternity unit they provide – antenatal care, normal delivery, assisted delivery and post-natal care. Also in the emergence department they provide medical emergence, surgical emergence, pediatric emergence and obstetric emergence (Blanchet N, et al 2012).

2.4.3 Services excluded in Package in Ghana Health Insurance

Services not included in health insurance of Ghana are cosmetic surgeries, all medical aids, HIV drugs, echocardiograph, photography, angiography, dialysis for chronic renal failure, organ transplant, heart surgery and brain surgery. Others include cancer treatment other than breast and cervical, mortuary services, abroad treatment and diagnosis, all medical examination for visa, driving license and alike (Blanchet N, et al 201).

2.27 Kenya Community Health Insurance (Jamii Bora Health Insurance)

In Kenya, the community health problems are covered by Jamii Bora Health Insurance (JBHI). This is sponsored by Jamii Bora Trust. The Jamii Bora Trust (JBT) Microfinance institute was well-known in 1999 and by the year 2010 it had over 110 branches, with over 277,000 members, spread all over Kenya. This organization serves poor peoples, self-employed peoples and informal workers who are engaged in small business and have no regular salaries. The aims of Jamii Bora Trust is to help families, however poor, miserable, and hopeless to get out of poverty. The data show membership has grown from 50 to over 13,000 (Mwaura J 2012).

The members pay annual health insurance premium KShs 1,200 (US$ 16) per member. The Jamii Bora Insurance covers the principle member and up to four children who are less than 18 years. Also members can buy insurance for their spouses and/or pay an extra premium for any additional children beyond the four covered under the scheme.

The jamii bora member can either pay the full annual premium at one time or make weekly payments of KShs. 30 (US$ 0.40) for 50 weeks, throughout the year. The jamii bora health insurance is the insurer and it has contracts with over 70 hospitals all over Kenya to provide inpatient services. The jamii bora health insurance partner hospitals are either public or faith-based. The insurance covers only inpatient treatment costs and it has no co-payments,
exclusions, nor cost restrictions. All members of jamii bora insurance are eligible to join the health insurance on voluntary basis. However, it is compulsory for all members of JBT who have loans to pay health insurance. Members may voluntarily choose to continue their membership even after they have finished their loan repayments (Mwaura J 2012).

2.28 Rwanda Community Health Insurance Scheme

After genocide in 2004 the population of Rwanda went down because about one million people died during the civil war. Also health infrastructure was destroyed by the civil war and people were not in good health during that time. The government of Rwanda established community health insurance scheme which aimed to cover all health related problems in Rwanda. The most important health insurance in Rwanda is Community based health insurance known as, Mutuelle de santé which is credited for reducing infant mortality rate in Rwanda. About 70 per cent of mothers giving birth were covered by the scheme. Community health insurance currently covers over 90 per cent of the population in Rwanda. The purpose of this health scheme is to reduce children mortality rate in order to increase the population of Rwanda after genocide (Collins, 2015).

2.29 Burundi Community Health Insurance Scheme

The community health insurance in Burundi is known as lacarte d’assurance maladia which is a French phrase meaning Health Card Insurance Scheme. The scheme is implemented by the government of Burundi since 1984. People join in the health insurance scheme on voluntary bases (Source). The health system delivery in Burundi is divided in the four levels, National level, Province level, District level and family level.

2.30 Uganda Community Health Insurance

The Social Health Ugandans (SHU) is a local Non-Governmental Organization which provides health insurance to the people of Uganda. It is a country-wide operating NGO which envisions healthier families with simplified access to quality health care. It is mission is to improve the quality of health of Ugandans through Community Health Financing (CHF) approaches (Basaza R, 2008).
2.31 SHU’s current programming is in four areas which are:

Community Health Financing; The aim is to protect families from terrible health care related Expenditures; and to make ease access to quality health care services. SHU works with communities to form community health financing schemes. The schemes are of 3 types-all member-managed: health Insurance Schemes; health Credit Schemes; hybrid/ Mixed Health Insurance and Credit Scheme.

Women’s health and empowerment; where the social health insurance protects the pregnant women to attend all the four recommended Antenatal clinics, to deliver at a health facility and to attend post-natal care clinics and to enable women to actively participate in healthcare related decision making both at home and at community level.

Health care delivery; which aims at improving the quality of health care services provided to consumers through empowering communities to actively participate in deciding the services the health care facilities offer to them, establishing direct communication and feedback channels between the organized consumers and the health care service providers, forming community health insurance schemes which clear medical bills on behalf of members thus improving cost recovery on the part of the health care facilities.

SHU is currently operating in 7 Ugandan districts of Luwero, Nakaseke, Nakasongola, Bushenyi, Sheema, Masaka and Mubende(Basaza R, 2008).

2.5 Community Health Insurance Scheme in Tanzania

The Community Health Insurance Scheme in Tanzania serves and works at the district level government structures, as well as the local ward and village administrations. The directives, policy guidelines and subsidies are in the responsibility at the National Level through the Ministry of Health and Social Welfare (MOHSW) and President’s Office for Regional and Local Governments (PO-RALG). On the other hand National Health Insurance fund (NHIF) is presently charged with overall management of the CHFs.

At District Level: Council Health Service Board (CHSB) and District Health Management Team (DHMT) lead by the District Medical Officer (DMO) is the main body in management of CHF in the District. Community Health Fund is one of the major sources of fund which enable health facilities to procures medicine, medical equipment and other medical consumables used in provision of health services.
At Ward Level: Ward Development Committee (WDC) through the Ward Health Committee is responsible for community sensitization on CHF membership enrolment and managing the health facilities in all matter concerning health of the community in their respective areas.

At Village Level: Village Council through Village Health Committee and the Health Facility Governing Committee (HFCG) are responsible in supervision of provision of health services which include purchasing the medicine and medical supplies in the facility and collection of money from the community through household contributions.

According to the CHF Act of 2001, the district and municipal councils are given the authority over the CHF scheme in their areas. The CHSB is responsible for monitoring the operations and activities of the scheme, mobilizing and allocating funds, creating exemption criteria for poor households, verifying the collection and expenditure of funds, and reviewing reports from the WDC. The WDC is in charge of sensitizing and mobilizing community members to join the community health fund scheme, tracking the membership base, overseeing premium collections, evaluating CHF operations and providing recommendations. At the village level; Village Councils have their role in information provision and further community mobilization efforts. The Health Facility Governing Committee HFGC of each health facility, finally, is responsible for developing a budget and plan for the activities of the health facility, and assists in the enrolment of community members into CHFs and collecting the corresponding contributions (MOH 2005).

The structure places the CHSB to be overall health in charge in the district in “provider” and “purchaser” of health services. The CHSB is both responsible for the implementation of CHFs as well as for overseeing the operation of the health facilities. The District has the autonomy to create by-laws within their given area and manage the membership contributions at this level. The CHSB receives input from the District Medical Officer (DMO), the Council Health Management Team (CHMT), and the District Executive Director (DED), and decides on a mechanism to reallocate the CHF resources back to the individual health facilities or to spend them at district level (CHF Act of 2001).

2.5.0 Empirical literature review
2.5.1 Meaning and origin of CHF in Tanzania

Community Health Fund (CHF) is a form of community based health insurance scheme (CBHI) (Laterveer et al, 2004). It’s the prepayment insurance scheme designed to improve financial sustainability in health sector and increases access to health services especially for poor people most of them living in rural areas. The community join community health fund by voluntary bases (Shirima, 2006).

2.5.2 Origin of CHF in Tanzania

Tanzania had been providing free health service to her citizen since independence. However, there was crisis in economy which was experienced to hinder those services provided free by the government to the citizens. The economic crisis took place in 1980s and affected many sectors in Tanzania in relation to the provision of social services to the highest degree. On this basis, the government introduced cost sharing between government and the citizens or users in order to improve provision of services in various sectors, health sector being among them. In this introduced scheme the clients must pay a certain amount of money whenever they visit hospitals for treatment in any service demanded at health facility. The government of Tanzania introduced a system where the people could pay for their services before they fall sick, enabling them to receive treatment when they fall sick without addition of the money on the spot payment. It is now planned to spread CHF to all districts in Tanzania mainland in phases according to Bamako Mali initiative (Bura, 1999).

The government of Tanzania under the Ministry of Health had different strategies which aimed at improving health services to its people. For example, Tanzania national health policy (TNHP) aims to improve the health and well being of all Tanzanians with a focus on those most at risk, and encourage the health system to be more responsive to the needs of the people (MOH, 1999). The government has to put in place the mechanism for risk sharing and cross subsidization in order to ensure solidarity and equity (Ibid).

In doing so, the Tanzania development vision 2025 identifies health as one of the important sectors and given priority because it is the sector that deals with life and health, as it is well known that no health no life. Therefore, the main objectives of these strategies are to achieve high quality livelihood for all Tanzanians.
This is expected to be attained through strategies, which will ensure realization of the following health service goals:

Access to quality primary health care for all
Access to quality reproductive health service for all individuals’ appropriate ages
Reduction in infant and maternal mortality rate by three quarters of current levels
Universal access to clean and safe water
Life expectancy comparable to the level attained by typical middle-income countries
Food self sufficiency and food security
Gender equality and empowerment of women in all health parameters

Prepayment schemes are being hailed internationally as part of broader solution to health care financing problems in low-income countries (Bennett, 2004; Schneider, 2004). In this scheme, the literature has also shown a number of problems with such schemes that throw doubt on their practicality. Important issues are; limited coverage, with exclusion of the poor and those most in need of health care (Ekman et al. 2004 ). Lack of capacity by the scheme managers to manage insurance and negotiate with providers for better quality care (Bennett et al. 1998) and worries by rural villagers whether their payments to the schemes will be used for their benefit (Murdoch, 1995).

2.5.3 Operation of the Community Health Fund

To join CHF Membership is voluntary on bases and each household, within a district, contributes the same amount of membership fee, as agreed by the members themselves, and then given a membership card (URT, 2003). Normally, coverage is for the household head and other household members below the age of eighteen years.

At the district level, Community Health Service Board is the main body of the community health fund in the district. Its function is to collect money from community, to make sensitization of the community health fund to the community and to parches medical and medical supplies and distribute them to the health facility in the district.

To receive complains from members of CHF, report from health facility and suggestion from district medical officer and member of council management team on CHF operation (CHF Act of 2001).
2.5 Accountability and Management of CHF

Community health fund activities are operated in respective districts in the region. Each district has its own mandate in operation of CHF. The Community Health Service Board (CHSB) responsible for introducing the CHF scheme to the community and stakeholders including the ward development committee (WDC), the village council, households and health care providers; and supervision of financial management records and the operation of the health facilities.

Also, district councils are expected to conduct CHF sensitization activities in collaboration with the community members. The management of the CHF and how funds are accounted for, has only been the subject of a limited number of evaluations conducted at the district level (MOH, 1999; MOH, 2005).

Health consumers can express their feelings to the community health service board on serious governance issues such as abuses of power, financial mismanagement and corruption. The community health service board can make sure that, the health service beneficiaries and authorities work together. The community health services board can make sure that systems are generally in place to ensure that services given to the priority needs of beneficiaries. The management should ensure the appropriate collection of fees and allocation of these locally-generated resources to the community and health facility. Government has recently begun to publish information on priority in the health sector in the allocations for each district. This is an important development in enabling people to monitor public funds earmarked for critical services. Because this information is not disaggregated below the district level. However, it is not possible to monitor expenditures at the village or facility level.

Health consumers express dissatisfaction with critical governance issues such as abuses of power, financial mismanagement and corruption. While there exist some cases of health users and authorities working together, systems are generally not in place to ensure that services respond to the priority needs of the beneficiaries. Adequate management systems have not been instituted to ensure appropriate collection of fees and allocation of these locally-generated resources. Government has recently begun to publish information on priority of health sector on allocations for each district. This is an important development in enabling people to monitor public funds earmarked for critical services. Because this information is
not disaggregated below the district level, however, it is not possible to monitor expenditures at the village or facility level. (MOH, 2005).

2.6 The potential of the CHF

Community Health Fund provides evidence that, the scheme can provide protection of health care services to its members by significantly reducing the level of out of pocket payment for health care (Ekman, 2004).

While many schemes fail to cover the poor groups. CHF increases capacity of community participation in health related issues. It improves access to health facilities for the poor community in Tanzania. This is because members are likely to seek health services to formal health care providers compared to non members. Also CHF members reduce the use of traditional healers and the use of alternative medical care as self medication, especially for the poor people. Also CHF increases community participation in health related matter (Msuya et al, 2004).

2.6.1 Community Participation and decision-making

Community participation spirit is a very high in regard to health care priorities, deciding where funds should be allocated, and to monitor the expenditures of the community health fund. This removes the problem on health related matter in community and health providers. The community participation in health makes them know their right on health matter and community health fund operation in general. Now days the community can discuss the issue related to their health at village level and send them to district for the solution and the mechanism in place. Health facility governance committee on behalf of the community set together with health facility in charge make plan and priorities of their facility together. The community participation helps to restore the misunderstanding between health providers and community and create knowledge on community health fund per se. (HPSS 2016).

2.7 Quality of services and drug availability

CHF members from different areas in Tanzania were asked about the quality of health services provided by the CHF scheme. Most of them reported that, there are limited staff and equipment, many health facilities are plagued by chronic drug shortages and the condition of
health facility is not in good condition and long queue and long waiting time to get the service. Many Intervention are needed to solve that challenge a raised. (Betha R et al., 2009).

2.8 Challenges Facing Community Health Fund

Despite the evidence showing the improvement of CHF, there are some weaknesses facing CHF which include low rate of enrollment of the target population after 20 years of operation, which at 10% falls (Shaw, 2002). The barriers to enrollment identified by evaluations are; a widespread inability to pay membership contributions, the poor quality of available services, a failure among communities to see the rationale for protecting against the risk of illness, and a lack of trust in CHF operators and lack of skilled health personnel in the health facility in the urban and rural area (Kapinga and Kiwara, 1999, Chee et al. 2002, Shaw, 2002; URT, 2003).

Some of the people are not willing to join in the CHF, but they tend to join to the CHF scheme at the time when they fall sick in order to minimize immediate costs, adding to the unpredictability of health care costs for the pool (Bennett, et al., 2004). However some of CHF schemes have faced problems in collecting premiums, with many members who fail to pay or make late payments. Some member complain about long distance from their respective homes to the health facility (Huber, et al., 2004).

2.9 Dropouts CHF members

During the time of introduction of CHF members responded positively by joining CHF scheme in Tanzania since its establishment. However it was reported that some members started to drop. This hinders CHF objectives to be met. It should be noted that, one of CHF objective is to mobilize financial resources from the community members and then the government to top up through mobilization of different sources like donors and councils (URT, 2001).

In the early year of 2000 it was reported that dropout rate has been increasing, for example in Singida and Igunga. Although Igunga is the first district in Tanzania to exercise the community health fund scheme in Tanzania. More power, effort and fund where put in Igunga but the number of community health fund member goes down rapidly. (Shaw, 2002).
2.10 Sustainability of the CHF

The issue of sustainability is important for the long-term success of CHF in Tanzania. Despite being first introduced in Igunga in 1996, CHF began to spread to other districts in recent years. Thus, there is still a widespread lack of awareness about the program itself, including the benefits to join in the community health fund scheme. Where the scheme exists, member contributions commonly make up the largest portion of revenue, accompanying some combination of matching grants by the government and grants from district councils, donors, and other organizations (Mtei and Mulligan 2007).

This is problematic given that CHF membership enrollment is low and drop-out rates are increasing, which serves as a direct threat to CHF sustainability. Eventually, sustainability will largely depend on the success of the government and other stakeholders in creating the awareness of the general public to the benefits of community health fund, facilitating an increase in those who buy into the program. Community based health insurance schemes have the potential to be self-sustaining if the revenue generated from the purchase of cards, plus the grants from the government and other contributions are rolled back into the program at all levels. The collection of money from community health fund member should be kept in account of health facility to create ownership of the fund and trustful to the community (Mtei and Mulligan 2007).

2.11 CHF Designing Issue

No clear separation between purchaser and provider in their roles. The health in charge of the facility collect money from the community and send them to the district medical officer account. This create no ownership of the fund to health facility and community per say.

The CHF members has no place to give their view on the matter concerning CHF, only health service board member represent the complain of CHF member in the meeting and Some of the board member are not CHF member (HPSS report 2016)

2.12 The responsibility of NHIF to CHF

The government of Tanzania has given the National Health Insurance Fund (NHIF) responsibility of taking care of CHF after signing MOU. The councils collect money from the
community members and deposit in the CHF account in the district and then claims the matching fund from national health insurance fund. NHIF after making calculation they write a cheque to the councils on returns (HPSS report 2016).

In the delivery of health service in Tanzania its shows that, no difference between CHF members and non CHF members in receiving the service, that’s why non member are not attracted to join CHF(George K,2013)

2.13 CHF Contribution

The amount of contribution is determined on basis of acceptability of the political leader, not costs In the present market.
The CHF contribution are determined on the basis of social and political acceptability, not on actuarial calculations of frequency and severity of risk. The contribution reflect the acceptance of the population to pay a small amount of 3.5 to 7 USD per year for receiving primary level health care for the whole family, but they do not reflect the costs incurred for providing these services. The premiums have to be set at a socially acceptable level. In the present situation it is just unknown whether the scheme generates enough income to cover the costs incurred by the health centers’ and dispensaries. (CHF ACT of 2001).

People do not always know what they are supposed to pay, and which payment demands are valid or invalid. Official charges are not necessarily affordable. Unofficial charges are still in place, and exemption and waivers have not been effectively implemented. The quality of care in public facilities has not necessarily improved even with the additional funds generated from user fees. The amount of money contributed by CHF member is not enough to actual market cost . The ministry of health should look for actual cost of running the community health fund on their days to days activities on the community health fund. (Masuma M,2004)

2.14 Accessibility of CHF Member To Health Service

Actual Health services are often not accessed by the very poor community, and by women in particular. The main obstacles are health care charges, long distances from their house to facilities, inadequate and unaffordable transport systems, poor quality of care, and poor governance and accountability mechanisms. No improvements in availability of the essential drugs in facilities, continuing deficiencies and particularly the cost of drugs still make them unavailable to many poor community at rural area. The shortage of skilled health providers
in health facility, no serious concern on community to all actors in the sector including government, continues to persist. Discrimination against clients who are not able to pay and poor referral systems all result in low quality of care (Masuma M, 2004)

2.15 Groups Enrolment in CHF

The Pharm Access is the Non Government Organization from Netherland which deals with farmers in Africa. The Pharm Access implements CHF program in Kenya, Ghana and Tanzania. Its Aim among others are to improve health service in sub sahara Africa, including providing care to the people living with HIV.
The program also Aims at improving the areas with CHF conducted its operation to create a better understand among CHF service provider in the concerning countries (pharm Access 2014)

In Tanzania Pharm Access has come up with programe meant to improve CHF among coffee growers in Siha district known as improved community health fund (Ichf) in 2004

The (ichf) Program will help community member who were failing to access better medical service due to high cost to access the health service at low cost (Ippmedia 2016).

Also in the area of big plantation like tea plantation, coffee plantation and sisal plantation the farmers where sensitized to join the community health fund into groups. This it help to collect the money in larger amount at once to the community health fund. (Pharm Access 2014).

2.16 Medicines availability

Actual the Availability of medicines at the health facilities were influenced in the improvement of the quality of health services delivery. Therefore, more community participate on health services, the utilization of health facility will be more high acceptable, hence will increase access to health services, as a result of increase CHF memberships enrolment within the particular area. On the other hand, good collection of premium on CHF can results into an increase of medicines availability especially at the rural health facilities, thus quality of health services delivery will be improved. (Macha J. et al, 2012).

In understanding populations' opinions on quality of care is critical so that enable to
develop measures for increasing the utilization of primary health care services. The Availability of medicines at the health facilities will influence on the improvement in the quality of health services delivery. Therefore, good quality of healthcare will increase health services utilization and acceptability and will increases access to health services, and also may raise the number of CHF memberships within the particular area. (Gilson L, et al, 1995).

2.17: Waiting time

If Waiting time in receiving health service in health facility will be reduced it will be the factor of the community to join the CHF. Inadequate distribution of health facility in country is the factor which course congestion of people in health faculty. Waiting time in rural areas health facilities is one of the major challenges facing the health sector towards improving the quality of health facilities. The majority of the populations are poor and most of them are at higher risk of getting disease and who are frequently utilize health facilities are found at rural areas due to un-equal distribution of health facilities to compare to urban area, this course prolong the waiting time for CHF memberships. Reduced waiting time at the health facilities was influenced community to join the CHF memberships. (Thompson D. et al,1996)

2.17: Skilled health workers

The availability of skilled health staffs at the health facilities will improve the quality of health services delivery at the health facilities. The availability of health staffs especially at the rural health facilities will encourage more people to join the Community Health Fund. Some researchers had been pointed out and explained how presence of health staffs like doctors, nurses and others will motivate people to attend health facilities and enroll in the CHF scheme around particular area and CHF memberships among clients will increased. The presence of trained health staffs at the primary health care facilities will increases community, CHF memberships, and this is due to quality health services delivered to the community. Availability of health staffs is the central part in quality health care delivery. Presence of skilled health staffs at the health facilities, will influence on the Community Health Funds memberships. (Arnetz B., 1999).
2.18 Customer care in CHF

The Customer care is one of the most important components of health quality that, if well managed will be good results into good utilization of health care services. Bad behavior of health care professional can course low CHF membership enrolment, Poor customer care services provided by some of the nurses and other health staffs to clients it can cause customer dissatisfaction and can contribute to the low memberships for Community Health Funds (CHF) at the particular health facility. Good customer care to clients at the health facilities can promote health care services acceptable and may result into community health funds member joining into the scheme to increase and can promote better utilization of health services to the community. (Masuma m, 2004).

2.19 Waiver and Exemption

The purpose of community health insurance is to cover all community in the health insurance, But some of the community are very poor to join the CHF.

The government develop mechanism and criteria on how to identified the eligible people to get the exemption and waivers. The mechanism is that; the village will indentifies the eligible people to get exemption through village general meeting on open village ground and to vote for them to be exempted. This mechanism is not applicable during the process of selecting the waivers. The mechanism of selecting waiver is good for protecting vulnerable social groups and the poorest of the poor. The exemption scheme is poorly implemented partly because accountability mechanisms are not in place, and because health service providers are not following procedures that are often unclear to them(CHF Act 2001).

Although prepayment schemes are being held internationally as part of a solution to health care financing problems in low-income countries, literature has raised problems with such schemes. Some findings argue that district managers has a direct influence over the factors explaining low memberships, some of them collect money and spend it for other administrative issues other than those related to the provision of health services. Other studies have identified inability to pay for membership contributions and low health quality of care and lack of trust in scheme managers as other responsible factors. In addition, different studies identified other challenges in the implementation of CHF scheme. Such challenges include; inability to pay for memberships contributions due to lack of money, inadequate community
sensitization, poor quality of health care and lack of referral care, inadequate supportive supervision of health staffs by the district managers, weak institutional functions like health facilities governing committees, lack of political influence and low user fees set. All these factors have led to low CHF memberships. (Chee G.et al, 2002). Other factors causing low enrolment is lack of commitment among health providers, health facility governing committees and lack of support from political leaders. Also other factors may include inadequate number of health facilities available in the district council and lack of skills among the health care providers.

All the above mentioned factors create a gap of which the researcher was interested to conduct a study and find out what possible solutions could done to address the challenges in order to improve health insurance enrolment rate and improve health care services in the community.
CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides how systematically the researcher applied scientific procedures to solve the problem under study. Research methodology also gives the researcher necessary training in gathering material, participation in the field work whenever necessary and training in techniques for the collection of data appropriate for particular problems and use statistical questionnaires and controlled experimentation and recording evidence sorting it out and interpreting it (Kothari 2004).

Various steps were adapted by the researcher in studying the research problem by identifying and knowing methods or techniques that were relevant for the study.

3.2 Selection of the study area

The study was conducted in Dodoma municipal council which is one of the seven councils forming Dodoma region. Other councils include Chamwino, Kondoa, Mpwapwa, Kongwa, Bahi and rural Dodoma.

3.3 Reasons for selection of the area

The council was selected because it is one of the areas in the region where the CHF scheme has been operating since 2007. However, like in many other areas in the country where the scheme is executed a number of challenges have been outlined as major impediment to its achievement in improving health care to the community around and due to this reason attracted the researcher to conduct the study in order to identify contributing factors and find out possible solutions to address the problem.

3.4 Population and location of the study area

Dodoma Municipal is one of the seven councils in Dodoma region lying in the central part of Tanzania. The region is characterized by the semi arid climate. The Municipal is surround by six councils namely Bahi, Kongwa, Mpwapwa, Chamwino, Kondoa and Chemba.
Based on 2012 National Census Dodoma Municipal council has a population of 410,956. The Municipal lies between Longitudes 35°44'22.1" E and Latitudes 6°10'20.0'' S. The Municipal is the Tanzania Capital.


3.5 Research Design

When conducting the study the researcher used exploratory research design, intending to examine some possible solutions to the problem which was not well researched before. In this study the researcher examined the aspects of the study in a detailed manner. For example, not many researchers have conducted such a study on challenges encountered by community health fund in provision of health care services. Hence, the researcher could use such a research design to get detailed information on the problem under study.

3.6 Data collection methods and instruments

Data collection methods refers to all ways or techniques that the researcher used to get information related to the study topic. When conducting the study both primary and secondary data collection methods were used to collect information from the respondents.
The researcher employed both primary and secondary data to obtain the required information. The following enlisted instruments were therefore be used when collecting data.

### 3.6.1 Questionnaire

When an information from the respondents is obtained through filling a form provided one has to use a questionnaire which is an instrument with written questions to be attempted by the respondents in the written form(Kothari 2004). Questionnaire can be used to get information on the topic under study from many respondents from a wide range of respondents within a short time. The questionnaire was designed and distributed to special categories of respondents such as health workers, patients attending health services at health facilities, Dodoma municipal council residents and both political and religious leaders. Questionnaire comprised closed ended questions for easy data analysis and compilation. The same questionnaire was provided in both Swahili and the other in English languages.

### 3.6.2 Interview

An interview refers to the data collection technique which involves oral questioning of respondents, either individually or as a group. Answers to the questions posed during an interview can be recorded by writing them down during the interview itself or immediately after the interview.

During the study oral questions were administered through interview to individuals or groups of people who could not get questionnaires or had no time to fill in the questionnaire or illiterate. Structured interview questions were provided for easy analysis and compilation.

### 3.6.3 Observation:

Observation is one of the data collection methods which involves systematically selecting, watching and recording the behavior of the people by using both participatory and non-participatory observation, sitting in the secretary’s office listing concerned training and development matters(Kothari, 2004).

When conduct the study the researcher applied both participatory and non-participatory observation techniques to collect data from the respondents through observing a number of people coming to register for CHF enrollment at health facilities available in the council. He also participated on observation of how various registration forms available at health facilities were used in registering CHF members and the amount of funds provided for
registration. He also observed patients receiving treatment especially through the community health insurance scheme.

3.6.4 Documentary review(Available information)

Documentary review refers to the information processed from data collected by others. During the study the available data were used as a way of getting more information on CHF enrolment. The information was obtained from various sources in relation to the research problem or objectives. Some of the information was obtained from Dodoma municipal hospital health records. Moreover, other literatures were obtained from different institutions reflecting what others wrote about challenges on CHF implementation program. Most of the documentary review was conducted using health policy set up and some information could be accessed from Mzumbe university library. The documentary review sources included reports, books, journals, leaflets and hospital records which consisted the number of members and the amount of contributions. The data in these sources were analyzed quantitatively using tables, features, percentages, charts and circles and qualitatively using factual and logical interpretation of the study findings.

3.6.5 Editing:

This is the process of checking to detect and correct errors and omissions. When conducting the study, data that were obtained from interviews and questionnaire were checked in order to ensure completeness, accuracy and uniformity.

3.6.6 Coding:

This refers to the process of assigning numerals or other symbols to answers so that responses can be put into a limited of classes/categories. During the study, data obtained from the respondents were checked into meaningful categories of information so as to enable proper reading. Tabulation, regarding to editing, classification and coding, the information of similar categories was transformed into table for presentation of statistics.
3.11 Data analysis and presentation

After the data were collected the researcher used both quantitative and qualitative methods to develop an analysis. The quantitative method was applied in manipulating of the mathematical data by doing some simple calculations.

3.12 Ethical consideration

Before collecting information from the respondents, the researcher ensured that no violation of human rights could be committed through collection of data by ensuring that no respondents could be harmed in collecting data using any method. He could also first seek for permission from respective authorities before collecting data from respondents. Personal privacy of those who helped in research was not disturbed and the researcher ensured the informants that whatever discussed would remain confidential without disclosing the information to unauthorized people.

3.4 Sampling Design

3.4.1 Sampling Frame

The sampling frames consisted 3,4 and 6 respondents from households in Dodoma.

3.4.2 Sampling Unit

The sampling unit consisted of Community Health Fund coordinators from Dodoma Municipal Hospital, Ward Executive Officers(WEOs), health care providers from Dodoma Municipal Hospital, Village Executive Officers and convenience heads of households from Dodoma municipality.

3.4.3 Sample Size

During the study two simple random sampling and Non probability sampling techniques were used. Simple random sampling was used to obtain names of health facilities by listing the number of health facilities with each one having an equal chance of being selected for the study.

The general Formula for calculating the sample size:
\[
n = \frac{N}{1 + N(e)^2}
\]

Whereby:

\( n \) = Sample size

\( N \) = Population number of households

\( e \) = Level of precision = 0.05

\[
n = \frac{N}{1 + N(e)^2} = \frac{410956}{1 + 3460(0.05)^2} = 476
\]

3.6 Data Processing, Analysis and Presentation

3.6.1 Data Processing

Data was collected, processed and edited so as to ensure the accuracy and then being coded before starting to analyze.

3.6.2 Data Analysis

Data collected such as estimate of frequencies, percentages and correlation coefficients of some variables like availability of drugs and service package were analyzed by using scientific package for social science (SPSS) data analysis program.

3.6.3 Data Presentation

Presentation of data was achieved using different descriptive statistics such as pie charts, tables and charts. However, statements were used to clarify the statistical data from charts and pie charts.

3.7 Limitations of the study

During data collection some limitations were observed. These include hesitation of some of the CHF members to respond for fear that, their views would probably be reported to the authorized health personnel. Therefore, the researcher was obliged to devote some time making clarifications and hence convince them to respond.
CHAPTER FOUR

4.0 DATA ANALYSIS AND DISCUSSION

This chapter, deals with data analysis and discussion obtained from research findings from the study on challenges encountered by community health fund in provision of health care services in Dodoma Municipal Council.

The general objective of the study was to explore the challenges encountered by community health fund in provision of health care services in Dodoma Municipality. Specific Objectives were to examine the availability of the essential drugs when accessing health services through CHF initiatives at health facility, to assess the time spent by CHF members to access health services in health facility, to assess the availability of the health professionals in the health facility to render health services under CHF program and to assess awareness on the importance of CHF among the community members.
During the study research questions were: What is the status of the availability of essential drugs provided through CHF initiative in the health facility? How long does the CHF member spend to access health services in the health facility? Does the health facility have enough staff to render the health services? Is the community around aware on the importance of CHF?

This chapter is divided into five parts which include characteristics of the respondents, availability of essential drugs in the health facility, to measure time spent by CHF members at health facilities to access health services, availability of health staff and community awareness on the importance of CHF with their relationship on enrollment to CHF membership.

4.1 Characteristics of Respondents

This study consists of respondents comprising characteristics based on sex, education level, income level, marital status and CHF enrolment status. The characteristics were important to examine their relation to their CHF membership enrolment.

Table 1: Demographic Characteristics of the respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Status</th>
<th>Frequency</th>
<th>Percentage(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>72</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Average income per Month</td>
<td>Less than 100,000</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>100,000 – 400,000</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>500,000 and above</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>63</td>
<td>63</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Education Level</td>
<td>Formal</td>
<td>96</td>
<td>96</td>
</tr>
</tbody>
</table>
4.2 Respondents sex distribution

Most of the respondents involved in this study were female who were found attending health services at the visited health facilities. This indicates that, female are more prone to health problems compared to their male counterparts. Also health facility records indicates women have better attendance rate at health facilities compared to men. However, despite sensitization conducted not all women attending health facilities are enrolled in the CHF insurance scheme. During the study among 72 women interviewed only 20 were CHF members and the researcher was interested to examine the reason as to why those not joining the scheme did so. Some of the respondents said they were reluctant to join the scheme because of unreliable health services provided at the health facility. Another reason is the majority of the women are dependent their husbands in accessing health services as men are their to support them with financial assistance for health services.

In one of the interviews conducted one respondent argued:

"So often we access health services at our nearby dispensary we are not sure of the availability of drugs. Not all the time but health care providers sometimes tell us to buy drugs from local pharmacies around. As so people are reluctant to join CHF scheme."

4.3 Relationship between the level of income and CHF challenges in provision of health services.

During the study the researcher was interested to examine whether there is any relationship between the level income and challenges encountered by CHF in provision of health services. 60% of the respondents said "Yes" while 40% said "No". This implies that the level of income is directly proportional to CHF enrolment, meaning that most people with a reliable source of income could access health services easily compared to those without. Moreover, respondents were interviewed on their average monthly income where 56% argued to have an average of Tshs. 100,000.00 and 44% argued to have less. This implies that respondents could be able to pay for their insurance scheme with reliable source of income. This is another challenge encountered by CHF in provision of health services.
4.4 Relationship between marital status and Challenges encountered by CHF in the provision of health services

During the study the researcher was interested to know whether there is any relation between married couples and challenges related to provision of health services through CHF scheme, as most of the respondents involved in the study were married couples representing amounting 63% of the respondents who participated in the study. Through conducted interview and questionnaire provided, 74% of the respondents agreed on CHF contribution in improving their access to health services at anytime they fall sick while 26% did not agree. Some argued that households who are CHF members are sure of accessing health services even when they have no money compared to those who are not members. This implies that they need insured health services in their families to cover health expenses. Marriage leads to increase in the number of people in the family who will be in need of access to health services despite income level. The households who are CHF members have great security to access health services compared to those who are not insured. However, enrollment is still minimum.

4.4.1 Relationship between level of education with CHF awareness in provision of health services

During the study it was observed that 96% of the respondents interviewed and to whom questionnaires were provided had formal education level and 4% had informal education. This implies that most of them understand the importance of community health insurance. Some studies conducted show that, education can change people health behavior from negative to positive mind and regarding CHF enrollment an educated man can easily change his health behavior if he educates himself and knows importance of the Community Health Insurance to improve his health. For example, Health Belief Model Theory argues that there is a relationship between the level of education and behavioral change. People with lower level of education tend to be at late stage of change regarding their health related matter compared with educated ones (Rosenstock1966).
4.4.2 Relationship between respondents occupation and CHF challenges in provision of health services

During the study the researcher observed that 47% of respondents participate in the study engaged in small and large scale business activities, 24% were employed in either formal or informal sector with the remaining 18% participate in small scale farming and livestock keeping. This implies that more room is available among those involved in business to join CHF insurance scheme in order to access health services. Those who are employed could have their health services access through National Health Insurance Funds and other insurance schemes provided for those employed in a private sector. However, the number of CHF members among those involved in business is low, because they find no importance of joining the scheme because of their ability to pay for services when they fall sick. They can buy drugs from local pharmacies or visit private health facilities with improved health services where they are sure of getting treatment. This is another challenge to the CHF scheme which commonly operates in public health facilities.

4.5 Awareness Creation

4.5.1 Community awareness about CHF

One of the most important factors to increase CHF enrolment in any society is the creation of community awareness which is achieved through advertisement when conducting village meetings, radio and television broadcast. During the study it was observed that 86% of the respondents were aware of the importance of CHF scheme in the provision of health services while 14% were not. However, continuous campaigns on CHF enrolment is important to create more awareness on the importance of the scheme leading to more enrollment. CHF enrollment should be one among permanent agenda in all village government meetings. Despite awareness creation on the importance of CHF scheme only 20% of population in Dodoma are enrolled for CHF scheme (CHF Report 2016).

This study was related to the study conducted by Mtei and Mulligan (2007) which shows that, most of the respondents had limited knowledge and benefit of CHF due to poor source of information. Changing people towards the positive health behavior takes a long time and more emphasis should be taken to make people to change towards positive way to good health behavior (Matarazzo. 1984). In the transtheoretical model of health behavior change, it explains that people to change to the positive health behavior should pass in into four stages,
pre contemplation, contemplation, preparation and action. A person may change to positive health behavior if he believes that, disease in question can affect them, the cost he will incur if he contacted with disease will be high, fatality time of disease, and benefits of his change in economic and social status. Therefore the community sensitization to the CHF it should be day to day activities.

**Figure 2: Community awareness about CHF**

![Pie chart showing community awareness about CHF](chart.png)

Source: Field Data 2017

### 4.5.2 Benefits of the CHF scheme

The CHF scheme has several benefits to members. One of the main important benefits is to alert people that it is important to join the scheme prior falling sick. If the community members know the benefits of CHF insurance scheme they can join it. The study shows only 41% of respondents know the benefit of CHF with the remaining 59% not knowing the benefit of it. The community should also be sensitized to join CHF insurance scheme. Fig. 3 below shows community awareness regarding the benefit of CHF. People still do not join CHF insurance scheme because they don’t know the benefit of the CHF.
4.5.4 Other reasons for not joining CHF scheme

The study shows that most of respondents don’t know the contents of the CHF, its benefits, its package and its advantages and disadvantages of CHF because they are not well informed. In this study the respondents when asked why they don’t join CHF, 90% responded that they don’t know about CHF package in provision of health services, while 6% responded that the scheme provides poor services and only 4% of the respondent argued that they joined other health insurance schemes. However, sensitization and creation of awareness among community members can make more people to join CHF insurance scheme.
Figure 5: Reasons for not joining CHF

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor service</td>
<td>50%</td>
</tr>
<tr>
<td>Do not know the content</td>
<td>20%</td>
</tr>
<tr>
<td>Joining other insurance</td>
<td>10%</td>
</tr>
</tbody>
</table>

4.5.5 Relationship between knowledge of essential drugs and CHF enrolment

The essential drug is the list of the drugs which will be available at the certain Health facility according to the level of the health facility. The essential drugs list are divided into five category of level as follow.

A - Medicine used at dispensary level
B - Medicine used at health center level
C - Medicine used at district hospital level
D - Medicine use at regional referral Hospital
S - Medicine used at zone referral Hospital national and special hospital

During the study it was observed that about 83% of respondent they did not know about the essential medicine found at various levels of health facilities from the dispensary level. That is why, they used to complain no medicine at health facility. For example, a patient can access health services at say regional hospital and receive all necessary medical prescriptions. However, when the same person visits another health facility for health services and finds no prescribed drugs are available he may start complaining and becomes reluctant to join CHF insurance scheme. without knowing that, the prescribed drugs are not recommended to be found at that level. The scheme should educate their CHF members about the levels of health facilities and drugs found at each level. This will reduce the complains among CHF member about the drugs. Also some of the clinicians have tendency of prescribing certain drugs to patients. For example, One may prefer to prescribe only amoxicillin drugs but and forgets the
alternative drugs for amoxicillin which is cloxacillin. Knowing the level of facility and types of drugs found at each level can reduce the complaints among CHF members.

**Figure 6: Respondents’ knowledge about Essential drugs**

![Bar chart showing respondents' knowledge about essential drugs.]

4.5.6 Drug supply by MSD and Prime Vendors to health facilities

Health facilities order the drugs Quarterly a year from the Medical Store Department (MSD). The Ministry of Health Community Development Gender Elderly and Children sends the money to the MSD and the health facilities order drugs from MSD. Most often when facilities order drugs from MSD they receive some drugs and most of other drugs may be missing (Out of the Stock-OS). This factor causes the health facilities to run shortage of drugs and medical supplies and unable to provide services properly.

From the study it was observed that only 24% of the patients receive prescribed drugs when they are at health facility and 76% don’t get the drugs from the health facility due to out of stock of such drugs. However, the drugs may be purchased from verified prime vendor to curb drugs shortage at the health facility.
4.5.7 Missing prescribed drugs

According to the National Health Insurance Fund (NHIF) scheme when the patient misses the prescribed drugs from the health facility, the health facility in charge fills Form Number 2 provided by NHIF to enable the patient get the prescribed drugs to the selected private pharmacies to get the missing drugs. This is contrary to what is done among CHF members. When they miss prescribed drugs they have to go on their own to the private pharmacies and buy drugs. If the patient doesn’t have money he will remain untreated. This is the factor which makes some of the community members not to join the CHF scheme. In one of the discussion conducted through interview most of the members argued:

“This is double payment. We are encouraged and sensitized to join CHF scheme but on arrival for at the facilities we are told that there are not drugs and that we have to go to local pharmacy and buy while we have paid for the services through CHF scheme.”

The study findings show that 97.6% of CHF members bought drugs from private local pharmacies when they missed them from the government health facilities.
4.5.8 Waiting time to receive services at health facility

In actual circumstance people need quick services when in demand for it. However, nowadays when one goes to the Government Health facilities one may find a large group of people waiting for the health services. The waiting time is among major challenges in attracting the community to join in CHF scheme.

During the study the respondents were asked about the time spending in waiting for services. 22% of them argued that it takes about an hour to access the services while 40% of the respondents said it is more than two hours and 38% said it is about an hour. The quality of health services provided through the scheme can also be measured in terms of waiting time.

If waiting time in receiving health service in health facility is minimized, it will be among the major factors for the community to join the CHF. Inadequate distribution of health facility in the country, is one of the factors which contribute congestion of people health facilities. Waiting time in rural areas health facilities is one of the major challenges facing the health sector towards improving the quality of health services. Unequal distribution of health facilities cause prolonged waiting time to receive health services among patients visiting the facilities including CHF members for CHF memberships. Reduced waiting time at the health facilities will influencing the community to join the CHF.
4.5.9 Challenges encountered by CHF members when receiving services

The CHF scheme is like many other health insurance schemes in the world. The CHF implementation scheme in Dodoma Municipal faces many challenges on its day to day activities. Respondents were asked whether they were aware of the challenges they face in the implementation of CHF scheme. 70% of them said "Yes" and while 30% said "No" In one of the interview discussions conducted one of the respondents argued: "If you want to become the CHF member, you are supposed to register yourself at your village office. There, they take your particulars and send to the CHF manager to the district and they put your information in the website. After that, you are recognized as CHF member. This process it takes almost one month" And during all this time one cannot access health services as a CHF member until registration is full. This is one of the factors the community not joining CHF insurance scheme because of the duration of the time between CHF contribution and the time your card are registered, whenever you fall sick you can’t get any treatment."
4.5.10 Establishment of the CHF

The CHF was first introduced in Igungu District in 1998 as the pilot study. The aims of this scheme are risk polling of the community in health related matter. The schemes works as voluntary and prepayment insurance designed to improve financial sustainability in health sector and increase access to health services especially for poor people most of them living in rural areas (Shirima 2006).

The council of the respective district has mandate to set the amount of CHF contribution to his people. Since CHF was first introduced in Igungu in 1998 up to date the contribution of CHF still remains at the between Tsh. 5,000-40,000 for the one household no matter the running costs of the scheme is high.

Improved CHF started at the first time in Dodoma region in 2007, by community sensitization in all villages and council accepted and signed. The amount of contribution
remains Tsh. 10,000.00 even if the price of drugs at the market is high and running cost of the scheme is high. That’s why the scheme failed to provide the quality health services to his members. The stakeholders and The Ministry of Health Community Development Gender Elderly and Children should look for reasonable amount of contribution for the scheme in order the scheme to provide better and improved services to the CHF members.

4.5.11 Community acceptance to CHF

At the beginning of the programme, the community accepted after being sensitized by councilors through village meetings and DMO/CHMT through public announcement and more efforts was put on it. But as days went on members started to drop out from the CHF scheme. This caused shortage of drugs and members are not respected by health providers, lack of feedback mechanism to the CHF members, long spending time at health facility and shortage of health staff to provide the services. All of these factors discourage the CHF members not to pay their contributions each year. The respect of the health providers to the CHF members is one of the factors to make them join the scheme each year.

CHF members, complain that “no special care between CHF members and non-members in the provision of health services. Also health workers are used to ignore the CHF members as if they receive the services free of charge.”

It is revealed as in the report from national health insurance fund in September 2016 that only 9,463 of households were enrolled in CHF in Dodoma Municipal Council. This is only 8% of the total population joining the CHF from population of 410,956 and 89,514 households.

**Figure 10 Households joining CHF**

![Households joining CHF chart]

- 2011/2012: 1,265
- 2012/2013: 1,107
- 2013/2014: 1,374
- 2014/2015: 6,768
- 2015/2016: 6,814

Household CHF member
4.5.12 The obstacles encountered by CHF scheme

When interviewing the CHF coordinator on the problems facing the CHF on the provision of services to the CHF members, she responded;

“We have three problems in provision of the health services regarding CHF members. The biggest one is the shortage of the drugs. Another one is shortage of the staff, and the other is lack of enough information among CHF members regarding CHF enrollment”.

“The shortage of drugs is caused by amount of contribution of CHF, the supplier of the medicine are found in Dar es Salaam and we are living in Dodoma”. When you make the order of drugs, it takes 2 months to receive the ordered drugs. “The price of medicine we bought from MSD is high when compared to the selling price of medicine to the CHF members. Example one of the drug is amoxicillin”.

The price charged to the members of NHIF is Tshs. 2,400 per dose while the price charged to CHF members is tsh1,200, so we provide the service at lose”.

Health facility in charge of Kikuyu when asked about the price of drugs and the amount of money claimed she responded that, “We claim a lot of money from CHF manager but she pays us only Tsh. 1,000 per form and not actual amount you have claimed for. This causes the facilities to run big shortage of drugs”.

The shortage of the health professionals in the health facility causes the problem of members to spend a lot of the times in health facility to wait for services. This brings problems to the CHF members. In the community awareness, “most of our CHF members don’t know the CHF health package, that is why they demand the services which is not in the CHF package.

4.5.13 CHF contribution

According to the CHF act of 2001, each district through the councilors have mandate to set the amount of contribution to his people depending on the economic activities of his people.

Since 1998 when CHF was introduced for the first time in Igunga up to date, the amount of contribution remains the same that is Tsh 10,000 per household per year. The oldest district in operating CHF is Igunga which started in 1998 to date with 40.8% enrollment rate in the month of September 2016.
The amount of contribution is not enough to run the scheme. The government, through the
councilors in Tanzania should review the price of the Drugs in market and amount of
ctribution does it cater the provision of the service to the CHF members.

4.5.14 Package of the service rendered by CHF scheme

When the CHF coordinators were asked whether CHF scheme has package it provides they
responded that it provides the package according to the levels of the health facility. The CHF
scheme provides, (a) out-patient services, inpatient services and main surgery and medicine
provided by the schemes at levels set by Ministry of the Health Community Development
Gender Elderly and Children. Most of the CHF members have no knowledge on the levels of
health services delivery and health package provided by CHF scheme to its members. This is
because the members are not well informed about health package they suppose to receive
from the scheme.

This causes the confusion between health providers and CHF members about services and
drugs offered by the CHF schemes. The level of drugs and category of facility are.
A. Is the drug found at dispensary level.
B. Is the drugs found in health centre
C. Is the drugs found in district hospital
D. Is the drugs found in regional referral hospital
E. Is the drugs found in specialized hospital

The community should be given an education about the package of services provided by CHF
scheme in order to reduce the confusion between two parties. Ghana community health
insurance scheme is only the scheme which provides good package among the insurance in
Africa. The following is the health package provided by Ghana community health
insurance. In the out–patient department- general and specialized consultation, diagnosis, x-
rays ultrasound scanning, surgical operation and physiotherapy. In the inpatient department
the services which are given include, general and specialized patient care, diagnostic test,
blood and blood products, surgical operation, accommodation and food.

In dental department service provided are;– extraction ,incision and drainage and dental
restoration whereas in the maternity unit they provide – antenatal care, normal delivery,
assisted delivery and post-natal care. In the emergence department they provide with medical emergencies, surgical emergencies, pediatric emergencies and obstetric emergencies (Blanchet N, et al 2012).
CHAPTER FIVE
CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The aim of this research was to explore the challenges encountered by CHF in the provision of health care services in Dodoma Municipal. The findings would enable the responsible people to take appropriate measures regarding issues raised, so that the goal intended by CHF scheme could be met. Therefore, different findings obtained from different respondents of different groups drove the researcher to draw a conclusion and put down some recommendations.

During the study the researcher found that one of the challenges in providing health services through CHF scheme is the availability of essential drugs at the health facilities due to the fact that, health facilities are equipped with serious drugs and medicine shortage forcing the clients attending the service to buy drugs from local pharmacies. The buying price is not equal to the selling price to CHF members. The buying price of medicine and medical supplies from Medical Store Department (MSD) is higher compared to the selling price to the clients. The two schemes National health insurance (NHIF) and Community Health Fund (CHF) have two different selling prices of the drugs to their members. The selling price of some drugs for example amoxillin to the NHIF members is high than Selling price of CHF members. The drug is sold to NHIF member at Tshs. 2400 a dose, but for CHF member it is Tshs. 1,200. This can make the facility to run out of stock of the medicine. Selling of drugs to CHF members when receiving services creates a big challenge since the clients may not have money to contribute regarding they are CHF members.

The second challenge is the lack of community awareness among CHF members. When asked about monthly income earning most of respondents argued to receive between 100,000- 400,000 per month. This implies that the community has capacity of joining CHF by 44%. Community members have capacity of paying CHF membership premium cards but
they lack awareness. The scheme should make and create awareness to the community about the CHF.

Not only that, but also the waiting time for CHF members to receive health services takes more than two hours where members spend more time at the health facility for to get services. This is due to the shortage of the health worker staffs where some of them were removed from the public service having discovered that they possessed fake certificates.

5.2 Recommendations

Based on the above discussion, it should be recommended that, in order to address the challenges encountered by CHF in provision of health service the following measures should be taken:

All those implementing CHF scheme should make sure that drugs and medical supplies are all the time available at the health facilities. The scheme should look for the additional drugs suppliers within Dodoma region and not depending on only those who are from Dar es Salaam. This is because often ordered drugs not reach at the health facility on time and always cause the shortage of drugs and other medical supplies required to provide services to CHF members.

The government through the local government authorities and councils should make review on CHF contribution in order to meet the price of the drugs at the market place. The amount of Tsh 5000 contributed premium is not enough in actual sense. There is a need to make modification by sensitizing the community to contribute more.

The government through the Ministry of Health and Local Government Authorities should employ health professionals to minimize health staff shortage. If the government employs adequate number of health staffs, time spending at the health facility will be reduced and quality of health service provided will be improved to the community.

The government through the Ministry of Health and Local Government Authorities should make CHF as mandatory to all community members and not a voluntary practice. This will make many people to join the scheme and this can reduce the burden of the disease among the community members and the government per se.
A CHF member is the one who pays his contributions for the CHF Scheme. The amount of contribution is as per the respective council prescribed amount according to the council by by-laws. Every district council has a mandate to set the amount of contribution to their people depending their economic activity. The average amount it lies between Tshs. 5,000.00 to Tshs.40,000.00. However, the amount contributed is smaller compared to services provided at the health facility. That is why the scheme fails to run properly due to the increase in health service expenses. Stakeholders, Ministry of Health Community Development Gender, Elderly and Children under President’s Office Regional Administration and Local Government Authorities should therefore conduct a review on the amount of CHF contributed by its members. On the other hand, the Government should enact laws that every Tanzanians join in one of the health insurance either through Government or Private Health Insurance scheme as government of China made big revolution to improve health among people of China where all people are covered by health insurance either under the government or private authorities.

As some of the health staffs are not faithful in drug management, regular drugs audit should be conducted to the health facilities to minimize drug and medical supply fraud.

Also the scheme should pay back funds to the health facility the moment they claim after providing the service to CHF members. This will enable the health facilities to buy drugs and hence reduce the shortage of drugs and medical supplies in the health facility.

The CHF scheme should create mechanism of making community sensitization on CHF enrolment and also create community awareness, by making community meetings at the from the village level and ward meeting. The municipal council put CHF a permanent agenda in their Council meetings. Also, the scheme should provide feedback mechanism to the CHF members and health facility in charges about the operation of the CHF. The feedback information to the CHF members and health facility in charge avoid possible conflict between health providers, CHF members and CHF scheme implementers.
REFERENCES


Kihombo, A. (2004), health insurance in Tanzania: enrolment determinants in the community health Fund (CHF), the case of Kilosa District. PhD. Dissertation Brabdeis University, College of Health Science.


Munishi, G. (2001), Constraints to Scaling Up health Interventions: Country Case study; Tanzania CMH Working paper Series No WG5; 16


www.repoa.or.tz/documents/equity-implication-user-fee-health-pdfnovember cited on 22/December,2016. Manday 11.00:pm
INTRODUCTION
May name is Hinju Nestory, a student from Mzumbe University pursuing master of Health system management. I Humbly Request your assistance in answering question by giving your view regarding challenges encountered by CHF in the provision of Health care service to the member.

I assure you that your option will be treated with high degree of confidentiality and will be Applicable for intended objective.

Party 1. Personal Information
Name of street…………………………………………………..
Name of respondent…………………………………………….
1. Sex (Tick one)
   a) Male  (  )
   b) Female (  )

2. Marital status (Tick one)
   a) Single (  )
   b) Married (  )
   c) Widow (  )
   d) Widowed (  )
3. Education Level (Tick one)
   a) Formal education (  )
   b) Informal education (  )

4. What are the source of your income?
   a) Small business (  )
   b) Farming (  )
   c) Salary (  )
   d) Others (Mention).................................

5. What is your average income per month?..........................

PART 2: Membership and service provided by CHF

6. Have you heard about CHF?........
   a) YES (  )
   b) NO (  )

7. Do you know the benefits of CHF?........
   a) Yes (  )
   b) No (  )

8. Are you member of CHF?
   a) Yes (  )
   b) No (  )

9. If no, Why?..................
   a) High amount of contribution (  )
   b) Poor service (  )
   c) Others (specify).................................

10. Do you know essential drugs
    a) Yes (  )
    b) No (  )

11. When you go for health service do you get all drug prescribe by doctor?
    a) Yes (  )
    b) No (  )

12. When you miss drugs where do you get the missing prescribed drugs
    i. Next visit (  )
13. What time do you spend from time you arrive at health facility tile you get the service.
   i. One hour
   ii. Two hour
   iii. More than two hour

14. What is the challenges facing CHF scheme in your area
   i. ....................................................
   ii. ....................................................
   iii. ....................................................

15. What to do to remark those challenge
   i. ....................................................
   ii. ....................................................
   iii. ....................................................
   iv. ....................................................

16. What is status of health service provision in the scheme
   (Tick as appropriate)

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>GOOD</th>
<th>AVERAGE</th>
<th>POOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short waiting time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Package of service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of staff</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2: INTERVIEW GUIDE FOR CHF CORDINATOR, WARDS, HAMLETS, EXECUTIVE OFFICERS AND HEALTH WORKERS

1. When did CHF start in your region, ward and mtaa streets?
2. Do you think the community accepts CHF programme?
3. What are trends of people joining CHF since it was established. Do members increase or decrease?
4. Which factor causes people joining or not joining CHF?
5. What are the challenges encountered by CHF in the provision of the health care services?
6. Which measures do you think you can take to overcome those challenges?
7. What is your opinion on amount contributed by the community?
8. Can you give your suggestion to the government, stakeholders and Ministry, about CHF?
9. Do the scheme have package of the service to the CHF members?