ASSESSMENT OF FACTORS INFLUENCING COMMUNITY HEALTH FUND MEMBER'S SATISFACTION WITH TREATMENT SERVICES OFFERED THROUGH COMMUNITY HEALTH FUND

ASSESSMENT OF FACTORS INFLUENCING COMMUNITY HEALTH FUND MEMBER'S SATISFACTION WITH TREATMENT SERVICES OFFERED THROUGH COMMUNITY HEALTH FUND

By.

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An Evaluation Report Submitted to Mzumbe University as partial fulfilment for Masters in Health Monitoring and Evaluation

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a thesis entitled "**Assessment of factors influencing Community Health Fund member's satisfaction with treatment services offered through Community Health Fund"** in fulfilment of the requirements for award of the Masters of Science Health Monitoring and Evaluation.

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Accepted for the Board of School of Public Administration and Management

Signature ……..

DEAN/CHAIRPERSON

DECLARATION

AND

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I, Denis Swai, declare that this thesis is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

Signature……

Date……

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DEDICATION

I dedicate this work to my Mother Hulda DM Swai and my lovely daughter Hulda Alarice Swai

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
CBHF	Community Based Health Financing
CHF	Community Health Fund
CHSB	Council Health Services Board
GTZ	Germany Technical Assistance
HIV	Human Immune Virus
MHIS	Micro Health Insurance Schemes
HCP	Health Care Provider
IEC	Information Communication Material
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MPEE	Ministry of Planning, Economy and Empowerment
NHIF	National Health Insurance Fund
NHP	National Health Policy
NSGRP	National Strategy for Growth and Reduction of Poverty
NSSF	National Social Security Fund
RSTGA	Rungwe Small Tea Growers Association
SDC	Swiss Agency for Development and Cooperation
SHIB	Social Health Insurance Benefit
SSA	Sub – Saharan Africa
TIKA	Tiba Kwa Kadi
TNCHF	Tanzania Network of Community Health Funds
URT	United Republic of Tanzania
URT	United Republic of Tanzania
VDC	Village Development Committee
VHGC	Village Health Governing Commitee
WDC	Ward Development Committee
WHC	Ward Health Committee

DEFINITION OF TERMS

Structure:	The physical composition of health facility including Human Resource and their capacity (Knowledge, skill and attitude) and other medical supplies
Process	This includes all Time waiting for service, Language used, Clarity of information, Media of communication, Clarity of feedback, access to service
Outcome	In this study outcome has been applied to mean the treatment results after receiving treatment service
Time waiting for service	Time taken by clients waiting to receive service
Language	The extent to which language used is pleasant and accpeted by service users
Clarity of information	Is an atrribute that measure the extents to which health information communicate is clear and undestood by service user
Media of communication	Is a means of communication as used for communicating between client and service provider
Treatment feedback	Is the result communicated to the service user after laboratory dioagnosis and other diagnosis procedures
Access to service	The extent to which a service user can use receive service without any barrier
Treatment follow up	Is the communication that is made by the Health Care Provider to follow up for the progress of patient/client
Human Resource and their capacity (Knowledge, skill and attitude)	Is the characteristic of Human resource for health capacity interms of acquired knowledge from training and skills development
Medical facilities/supplies and medicines	Medical equipment in health facilities

Treatment outcome	Results of tretment as perceived by patients/state of being after treatment/feeling after tretment

ABSTRACT

Background: In Tanzania, Community Health Fund (CHF) was initiated in 1996 with the aim of implementing a community Based Health Financing Scheme through volunteer membership contribution as additional income to improve access to quality health care service for marginalized rural community. The evaluation was conducted to assess factors that influencing Community Health Fund member's satisfaction with treatment services offered through Community Health Fund membership.

Methods: A cross sectional study design was employed that involved 153 respondents for which allowed collection of data that provided a descriptive estimates of the population parameters. The study was guided by Donabedian conceptual framework where by questionnaires were designed to assess structures, process of service delivery and treatment outcome as attributes of satisfaction. A sample size of 153 respondents was calculated by statalcl 13 (64-bit) within the effect size of 0.7– 0.8 one sample (Alpha = CI=95%, α=0.05, two-sided). Two health facilities were involved in the exit interview where by respondents were selected and interviewed based on their inclusion criteria.

Results: A bigger proportional of female 55(60%) and 40(60%) in Likombe and Mikindani compared to male 37(40%) and 21(34%). A big proportional of respondents revealed that structures of health facility include availability of adequate Health Care Providers (HCPs) and medicines influence their satisfaction (p=0.05). Most of respondents were happy with the quality of available medical supplies and it was statistically significant at satisfaction level (p=0.02). The process of service delivery indicate that CHF members spend more than one hour to receive treatment service in health facility from their first contact and there was significant association between time spent and satisfaction(p=0.02). However, significance association was found between happiness with treatment and overall satisfaction level with services (p=0.03) though members do not feel much difference from being a CHF member and other patients.

Conclusions: All three attributes - Structure of the health facility, process and treatment outcomes significanly influence CHF members sutisfaction of treatment services provided through CHF membership.However, the availability of medicines ,.and qualified HCPs have great influence in the Satisfaction with structures, while there is a significant influence of time in satisfaction with process of services provision and treatment results have significant assoaciation with service provided.

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CHAPTER ONE

INTRODUCTION

1.1 Background

100 million people worldwide are every year fall into poverty because of high expenditure on health. 11% of this population comes from Sub-Saharan Africa (SSA). The population account for 24% of the global disease burden which takes an estimate of up to 44% of the world's communicable diseases. The world is highly challenged with the means to support the quality of health care services for its 1.3 billion people which mostly living in a poor setting. About half of the world's deaths of children under five take place in Africa because of number of compounded factors including poor quality of health care (Preethi 2012).

Major world challenges around quality of health care, includes how to finance health care in developing countries particularly Arica. Today only 1% of the global health expenditure is spent in Africa (Health Care in Africa journal, 2014).

During 1980, WHO executive board meeting and Common wealth Ministers Conference in 1986, It was realized that major health problem in developing countries is how to contain the cost of health care; these challenges health care development in terms of how to maintain health spending, improve the quality of health care to achieve “health for all” initiative and how the Community Based Health financing could contain (Preethi 2012).

Sub Saharan Africa is thought to be the most affected population because of its level of limited resource, fragile health care system and weak health insurance schemes that are not well instituted and functioning (WHO, 2005). The quality of health care has continuously been affected. Burden of disease has been increased while the number of unproductive population in terms of labour force has been escalating as a because of

prevailing illness results from poverty and poor quality of health care (Karen et al, 2005).

Again, SSA countries experience limited resources in financing health care which affects the quality of health care, Community Based Health Care Fund and other related schemes, plays a big role in improving and influencing the quality of health care Services in Africa though does not cater for the population. The history indicates that, health insurance schemes in Africa are mostly working among population employed in formal sector - public and private were quality health services are sought. The majority of the population access health services through out of pocket expenditure which limits their capacity in terms of attending quality health care services (shimeles, 2010).

It is evident that many low-income countries will have substantial difficulties in achieving MDGs. Lack of sufficient financial investment, fragmentation of the delivery of health services, and poor quality of health care and health services is considered to be major obstacles to the successful implementation of health programs.

Case studies conducted in Kenya, Uganda, Burundi, Guinea and Nigeria focused on looking for health issues that require much attention and how to address. The capacity to collect or raise revenue for health has been supported by combining effort generated by other areas such as community health financing (McPake, 1993).

Tanzania, like many developing countries is challenged with high requirement to increase its budget allocation in health so as to meet health requirements for its population, including to improve access to quality health services, especially for rural, hard to reach population and marginalized. This high demand affects the quality of care that is required by the population and hence discourages the utilization (Quijada and Comfort, 2002).

In Tanzania, the solution to challenges in financing health care is still in a vain shadow. Financing for quality of health care depends on external sources and out-of-pocket, which increases the burden to the government and force the population to extreme poverty. Available revenue cannot cover for equitable health care for the population, beside other development challenges await. Available health insurance only covers a portion of the population who are in formal sector through the National Health Insurance Fund, Community Based Health Fund and other private Health Insurance of which its utilization still questioned (WHO, 2012).

The 1996 initiated Community Health Fund, which is in the form of prepayment for health service which has partly been supporting health care services to the community in rural areas and other people work in the informal sector in the country. The core objective was to collect funds or sources of additional income to improve access to quality health care service for marginalized rural community and other disadvantage groups through resource pooling and risk sharing. For more than 17years CHF has been in action with the major focus in supporting health care in rural areas, yet the extent to which members of CHF members are satisfied with the quality of health care services have not been realized (Munishi, 2005).

In Abuja Declaration 2001, Tanzania agreed and committed to spend 15% of her budget on health, however, health budget has been decreasing from 17% of the total budget in 2005 to 11% in 2011. The budget has been steeply decreasing in recent years whereby 9% in 2011/12 and 8.5% in 2012/13. The decrease has doubled per person out-of-pocket spending from an estimate of Tshs 3919 in 2009 to 11822 in 2011. This has affected the access to health care and also the quality of health care services which forced the population to become part of health care financing through community based health financing which has not been fully utilized (Abuja Declaration, 2011)

From the initiation of CHF there have been a number of challenges in the implementation that are compounded by the difficulties in arriving at a national consensus for a scheme's. Weak governance and coordination mechanism and poor infrastructures have highly affected the enrollment rate and quality of services in health facilities which has been instantly thought to affect the level of utilization of services (Waelkens et al 2005).

This study has then assessed patient satisfaction with treatment services offered under the Community Health Fund. The study has explicitly tried to find out how members of community health fund are satisfied with quality of service offered under CHF. It has also tried to find a link between factors that influence member's satisfaction and level of utilization of service so as to provide recommendation to the responsible bodies. The evaluation explored the enrollment trend of CHF members, treatment services mechanism and procedures used by CHF, assess the quality of service and provide feedback and recommendation to where and how customer satisfaction can be improved.

1.2 Description of the program to be evaluated

1.2.1 Introduction:

In Tanzania, CHF was initiated in 1996 with a pilot scheme in one district of Igunga. The identified as a right move towards social health insurance and support to health financing in rural areas by involving the community in the planning and contribution in the implementation of plans through volunteer contribution through their CHF membership (URT, 2001).

1.2.2 Program objectives

According to the Community Health Fund Act of 2001 the aim of Community Health Fund was to collect funds or sources of additional income to improve access to quality health care service for marginalized rural community and other disadvantage groups through resource pooling and risk sharing.

Specifically the scheme aims at: (i) Involving community in the mobilization of financial resources for supporting health care service; (ii) To improve quality and provide affordable health care services; and (iii) To strengthen health care services management at community level by involving the community in the planning and management process to ensure full participation of community available resource people and structures created (URT, 2001).

This study has then focused on one of the objective of the program which is 'To improve quality and provide affordable health care services'. As part of quality and affordability assessment, the study assessed factors that influence CHF member satisfaction with health care services provided through CHF.

1.2.3 Structure of Community Health Fund

The scheme is autonomous with a management structure at different levels. At district level, the scheme is managed under by Council Health Service Board while at ward level the ward development committee is responsible and village level the health Facility Governing Committee (HFGC) has been mandated the management of the scheme as in URT by law 2001.

1.2.4 Operation of the Scheme (CHF)

The membership card for CHF provides members of the family with access and other members of the family who are of the age bellow 18. These services are for members only, in this case households which are not registered have to pay user fees at different rates depending on the health problem at the point of use. The membership fee is paid annually at different rates depending on the district plans, existing service challenges, the willingness of members, and affordability of members. Currently Mtwara Municipal charges a rate of 5,000/= Tshs per person per annual. This is different From Mtwara District Council and Tandahimba which charges 10,000/= Tshs annually per household.

1.2.5 Key Community Health Fund stakeholders

Key stakeholders in the scheme who also have interests in this study includes MoH, Council Health Management Team, Ward Development Committee, Village Development Comment, Village Health Committees, CBOs/CSOs, Voluntary groups, Private hospitals, Religious leaders.

These stakeholders have different levels of interests in the scheme, different levels of communications with CHF and they also have different levels of interest in the evaluation of the programme. The study used their potentiality and views so as to have their experience and feelings in the scheme operation which was very instrumental in developing this comprehensive report. The report will be disseminated to all involved stakeholders.

Table 1.1. Key Community Health Fund Stakeholders

S/n	Stakeholder	Role in the program	Interest or on evaluation	Role in evaluation	Level of importance
1	MoH	Supervision	Effectiveness	Development of key and result use	High
2	CHMT	Supervision	Effectiveness	Use of result	High
3	WDC	Implementation	Effectiveness	Interviewed/ result user	High
4	VDC	Implementation	Effectiveness	Interviewed/ result user	High
5	CBO/CSOs	Implementation	Effectiveness	Interviewed/ result user	Medium
7	Religious	Implementation	Effectiveness	Interviewed/ result user	Low
8	Community	Beneficiary	Better service	Interview	Medium.

1.2.6 Program strategies:

Different strategies are employed by CHF in reaching the community and providing entitled service. These include the identification of the needy population and introduce a waiver system. Identify elders and poor people who cannot access service ie. Physically/mentally handicapped persons, widows, orphans etc and involve them in the community fund scheme, Community mobilization to increase enrolment rate and continue compiling and maintaining pro-poor lists and realized the impact of the CHF intervention for the poor and hard to reach population.

Table 1.1. Activities and resource

Se. No.	Major program activities	Resources
1	Mobilization of community on CHF	Human resource Logistics ie. Transport, venue, stationary etc Guidelines
2	Follow up to ensure Adequate medical supplies and equipment at health facilities by CHF fund.	
3	Capacity building of HCPs for improved care services	
4	Distribute IEC/BCC materials on the Community Health Fund	
5	Conducting continuous supportive supervision to H/facilities	

Source: URT, 2001

Fig 1.1: Logic Model for Community Health Fund (CHF)-Tanzania

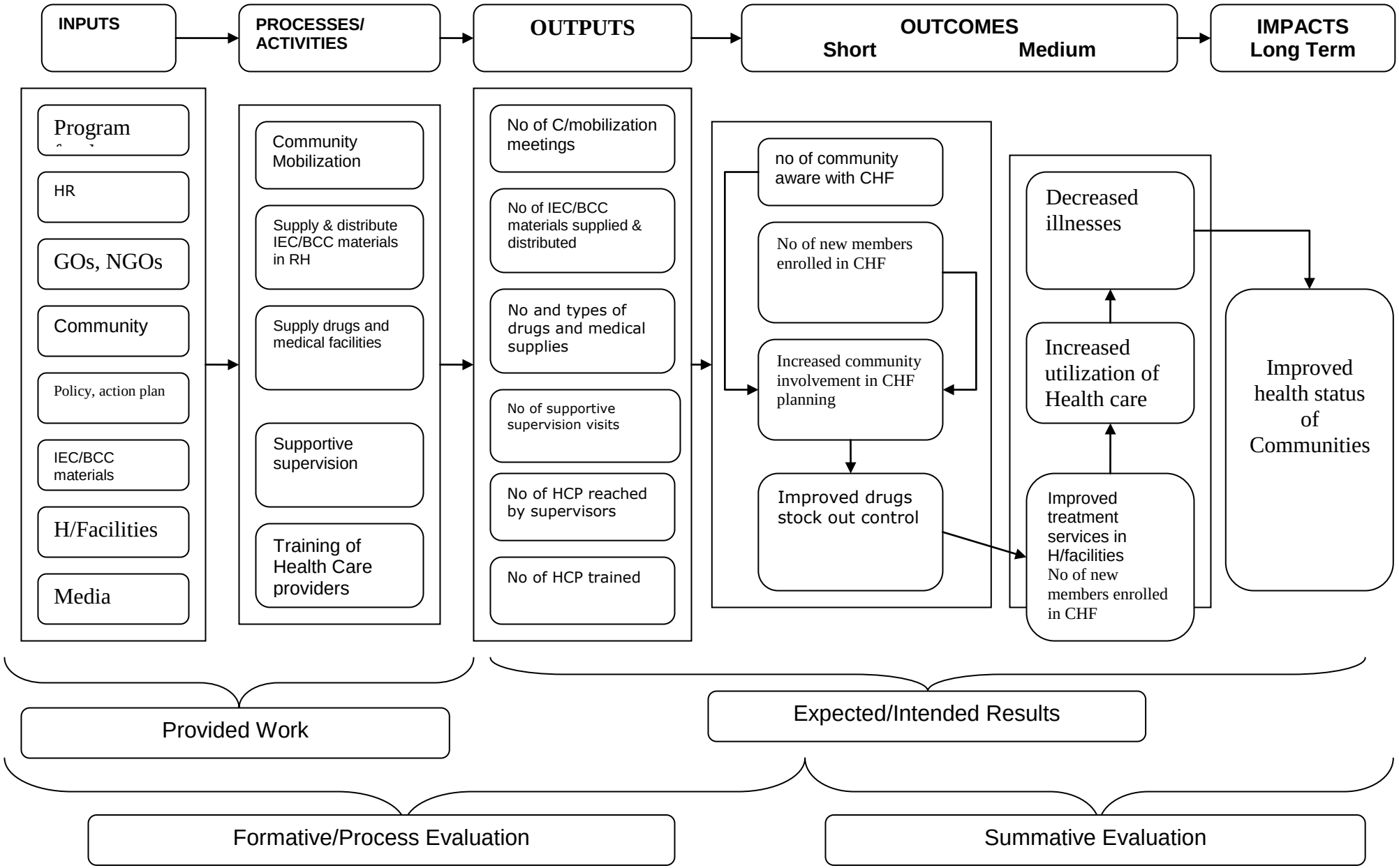


Figure 1.1. Logic Model for Community Health Fund Scheme

1.2.7 Statement of the problem

Tanzania faces many challenges in struggling to improve the health and health status of its population. In recent years, there has been serious commitment by government in trying to contain these challenges. Part of these efforts include her fully participation in the Abuja declaration 2001 with a commitment to increase health budget allocation to 15%, poverty reduction strategy (PRS), scaling up of the Community Health Fund (CHF), encouraging private Health Insurance Schemes and collaboration with other countries and International Agencies. (Ajiye, 2014)

As part of these initiatives, the government initiated CHF in 1996 which was thought to be a solution to the existing health care challenges in rural areas. The scheme has been operating as a partnership between the government and communities to ensure that communities contribute to their healthy development and not aimed to replace government grant.

In 17 years of CHF operation, CHF has encountered a number of challenges and setbacks that have contributed to the failure to attain its goal. Some of the areas that encountered challenges include fail to mobilize and increase enrolment rate of new members, low retention rate of members, Provision of quality and affordable health care services and improve health Care Management at community level.

As a result, CHF has continuously experienced decreases in proportional of member who are enrolled and utilizing service. The GIZ Tanzania CHF report 2012 indicate that, the scheme has not been able to sustain financial mechanism as it has been affected by low enrolment rate, sustained inadequate medical supplies and equipment at health facilities and low quality of health care services (GIZ, 2012) These factors are compounded by inadequate and unskilled health care providers and low participation of the community.

Despite of the general increase in the CHF enrolment rate, the proportional is still low compared to the projection. In some areas the increase has gone to beyond 20%, while in some district indicate below 4%. The question is to either these trends have been contributed by low awareness, poor quality of service at health facility level, low satisfaction with the services offered under CHF, Low awareness on the importance of enrolling to CHF or low ability to contribute for the membership fee (Kamuzora et al 2013).

This paper has provided results of the assessment of factors that influencing Community Health Fund member' satisfaction with treatment services offered through Community Health Fund and provided recommendations that will help to improve CHF operation and performance.

1.3 Evaluation questions:

i. Do the health facility structures (Human Resource, medicine and medical supplies) influence CHF member's satisfaction?
ii. Do the process of health service provision influence CHF members satisfaction with service?
iii. Do treatment outcome meets CHF member's expectations?

1.4 Evaluation Objectives

1.4.1 Broad Objective:

To assess factors that influencing Community Health Fund member's satisfaction with treatment services offered through Community Health Fund membership.

1.4.2 Specific Objectives:

Objective 1: To assess the level of satisfaction of CHF members with structure (Human Resource, medicine and medical supplies) in Health Facilities.

Objective 2: To assess Factors influence CHF members' satisfaction with health care service process/procedures in health facilities.

Objective 3: To explore the extent to which treatment outcome meets CHF member's expectations.

1.5 Scope of the study:

The study was conducted in two health facilities of Likombe and Mikindani involved 153 respondents who are the community health fund members attending these two health facilities for treatment service.

1.6 Rationale and Significance of the study

The study is designed to assess the extent to which CHF members are satisfied with treatment service offered through this scheme. As highlighted in the statement of the problem (1.2), results of the study provides answers to noted retarding trend in enrolments of CHF members. In getting clear and detailed justification, the study focused across three areas that was time factor in provision of service, sufficiency of medicines and other medical suppliers, and capacity of Health care Providers in the provision of service. Study findings would have impact in different levels of the CHF program which would positively contribute to the improvement of service delivery and increased enrolment rate of members and ultimately contribute to the development of the program. The results of the study will shared as evidence for improving planning and decision making in managing and implementation of CHF.

The study findings will be useful for replication or scale up of CHF in other areas of Tanzania and or other countries. As little has been researched in this area, particularly Community Based Health Fund, It will be a source of reference for further studies with regard to gaps that need to be realized in health development.

The study provided best and alternative options to the mobilization of financial resources from the community for providing quality and affordable health care services to its members.

On the other hand, the findings from this study provide means to how community involvement and participation would be sustained or improved for improved health care services management in the communities by empowering them in making decisions that would contribute on matters affecting their health and health development.

The findings are also expected to influence stakeholders to fully engage themselves in the program by increasing their level of interest. These include MoH, CHMT, WDC, VDC, Council Health Board, Health Facility Governing Committees, Village Health Committees, CBOs/CSOs, Voluntary groups, Private hospitals, and Religious leaders.

CHAPTER TWO

LITERATURE REVIEW

This chapter highlights on the different experience and literatures from different scholars on patients satisfaction with health care service, but more specifically services provided through health financing schemes ie Community Health Fund. Chapter is presented in two parts, Empirical part and theoretical part. The chapter has further more divided into sub titles to capture more detailed information on experiences on patient's satisfaction with health care service.

2.1 Empirical Part

2.1.1 Health financing system

Support and protecting health and health status is a very important aspect in human welfare and development. The Alma-Ata declaration made a turning point in health financing by explicitly put forward the Health for all commitment for all Nations, which would require all countries to review their health financing mechanisms (Evans et al, 2010).

Health financing is therefore essential as it portrays the ability of health systems to improve the health status and welfare of its population. Any health plan without financial resource will not be implementable. All material and human resources require funds to implement (WHO, 2010)

The most used types of health financing include general revenue also known as earmarked taxes, social insurance collections, private insurance premiums, community based health financing and direct out of pocket payments. The aim of health financing is to ensure equity and equality in the provision of health care services to improve social welfare of the population in need (Murray, C. J., & Frenk, J. 2000).

In developing countries, Health Financing changes and reforms are the most important central part and foundation for health development. Today's discussion and focus is how best countries can move from dependence on out-of-pocket system towards health insurance with has a greater advantage of risk pooling. This provides protection for the poor especially in rural (Gilson, 2001)

2.1.2 Community Health Fund and its Operation

Tanzania initiated the voluntary Community Health Fund (CHF) in 1996 with the goal of vent universal health coverage by escalating financial support in the health sector. In the initiation, the uptake of the CHF was low, with an enrolment of only 6% compared to the national target of 75%. Model for improving Community Health Financing has been developed that is expected to improve their enrolment rate, quality of care hence affects their satisfaction as a result, expedite their local contribution to improving health care financing (Boniphace, 1995).

The Community Health Fund Assessment Report (2013), provides that the Community Health Fund is acceptable in most of rural communities in Tanzania and that Community have shown great interested in enrolling themselves to the scheme provided that they are well involved and informed on the process, access quality of care they expect.

As per Community Health Fund Act 2001, enrolment into the fund is voluntary and has to be prepaid based on the mechanisms that is prepared by the council and should be at affordable cost that is determined by the community themselves. CHF is currently operating under NHIF after a long period of running under the MOHSW and PMO_RALG (Carme Baraldes 2003)

2.1.3 Enrolments, access and Service utilization of Community Health Fund

Access and utilization

The literatures on experience of CHF show that the implementation of CHF is based on household enrolment with the family size up to 6 members. One card is provided for a period of twelve month. The contribution varies from 5000 to 15000 Tshs and has to be agreed by members of the scheme in the specific district. The scheme is subsidized by the government as matching grants that complimenting the members' contributions with an equal amount from different sources. Household not enrolled will have to pay a user fee any time they want to access health services. (Bulletin of Medicus Mundi Switzerland No. 120, June 2011)

A study of the Social Capital and Willingness to Pay for Community Based Health Insurance conducted in rural Tanzania indicate that all social dimensions have positive contribution and influence on willingness to pay. Other factors include age, education for the scheme. Other social capital variables have a positive and significant impact on the WTP for the Community Health Fund (Tundu and Macha 2014).

Perception of members on service

Assessment of patient's satisfaction and acceptability with the quality of health care service has become a major area of health concern worldwide (Kravitz, 1998). The previous focus of Patient satisfaction assessment mainly concentrated around the extent to which patients are satisfied with medical care, health care providers, and health. However, Areas with regard to decision specifically involvement of patients in decision and choice and utilization of health care service of their interest have long been ignored (Rovner, 1996).

Patient satisfaction is highly influenced by the quality of service which is again determined by available strategy and health care financing mechanism; however a means to finance health care remains a big challenge is most of the African countries that

require special attention to address. In Tanzania, support in health care is mostly done through government taxing and donor support, which has not been able to cater for healthcare financial needs (Fjeldstad, 2001).

The assessment report of Community perceptions and factors influencing utilization of health Services in Uganda indicate that patient satisfaction is one of the barrier that is influenced by health seeking process, health service delivery, distance and available transport system, income of service users and perception of service users on the quality of service offered in public health facilities. Others include level of quality of service, availability of other facilities and medical equipments (Bakeera et al 2009). However, the study did not reveal the influence of other factors in the utilization of service users, which could also have an effect on the satisfaction and utilization level. These include Safety and security, fairness, facility layout, and time spent in service, medicine stock out control and skill, attitude and behaviours of health care providers. This study has hence focused on these particular areas.

The challenge of health care financing necessitated Tanzania to establish several financing mechanisms, thus includes the National Social Security Fund (NSSF), National Health Insurance Fund (NHIF), social health insurance benefits from the, private health insurance, user fees (out of payment expenditures) and Community Health Fund (CHF) Mills & Anne, 2012).

The Community Health Fund has been considered as a means that would ensure high involvement of communities in health care financing. In addressing the universal health coverage, the government insists on community contributions in the health sector in order to achieve health sector development (Marwa, Njau, Kessy, & Mushi, 2013). Etymologically, the Community Health Fund has emerged from the concept of Community-based health insurance. It is a new coming up concept that emerging and

promising concept which works for health care development bottlenecks, including the solution to poor quality of health care service. (Road, 2003)

Low satisfaction with health financing mechanisms and quality of services has continuously affecting the level of utilization of health care services, this due to low attention by government in this area. In long history, this has led to the continuing struggle of community and individuals within their poor setting to work tirelessly to cater for their health needs and seeking for health care service out of the formal health system (Carrin, Waelkens, & Criel, 2005).

The states in most developing countries have not been able to fulfil health care needs of their poor population. Continuous flinching in financial support from the government as necessitated the imposition of community user charges that has been defined as a public health, inability to meet community health care needs (Bennett, 2001).

2.1.4 Challenges of CHF operation

The aim of the Community Health Funds (CHFs) is to employ a risk pooling mechanism to assist the community with health problems that deteriorate their health and development. CHF seeks at employing a participatory approach to ensure that there are quality, affordable and accessible health service in rural communities that protecting the population, to contribute to improved quality of health care. From the initiation, CHF has been facing a number of challenges that has led to low percentage coverage of the program in terms of enrolment rate, utilization and general health outcome expected. (Stoermer et al, 2011)

In developing countries, health budgetary support from the public has continuously decreased while the community cannot fully contribute to their health plans that have led to the increasing imposition of user fees. This has increasingly burdened the community and proves the inability of the state to provide quality health care service to the community (Marchal, & Kegels, 2002).

The community health Fund was initiated with the aim of enabling the community to participate in financing for their health care services that will improve their health, however, the community have not really been able to see tangible changes in health care service delivery.

Services have continuously gone down including high stock out of medicines, poor IPD, OPD and lab equipment and supplies and high shortage of qualified health care workers. This has discouraged community initiatives and contributions hence declined the enrolment rate. (Marchal & Kegels, 2002)

The WHO health report 2006 states that, one of the reasons for declaining of performance of CHF of Community Health Fund including the mobilization of financial resource. This includes low participation of community members in financial mobilization. The scheme has also not been able to reach community members who are most vulnerable and cannot afford to pay for membership.

The scheme is based on the spirit of voluntarism engagement of the community, hence some found not necessary to engage themselves with the scheme hence opt the means that they found is best for their health facing problems. These weaken the capacity of the authority to engage all community members into the scheme; again, it weakens the capacity of the scheme itself in addressing the enrolment challenges. (Atim, 1998)

The community based health financing scheme faces challenges mostly being the availability of household data solely on qualitative methods of investigation. In addition, they mainly look at the impact of the schemes on the provider or the health existing health insurance scheme, largely neglecting the effects on the members (Johanes, 2003)

2.1.5 Achievements and Best practice

Community Based Health Financing has greatly contributed to health development of specific countries and highly contributing in Nations development both direct and indirect. Proponents advocate that CBHI schemes have been very important and potential mechanism to improve community health by involving the community and ensure that a large number of community member's access quality health services thus could otherwise realized. (Dror, 1999)

Moreover, McGuire highlights that, risk pooling is enhanced as more people participate in the scheme in this case the coverage of health care utilization increases (McGuire, 1989). Besides acting as an agency that expresses the interests and needs of its members, the CBHI tries to promote the use of preventive care and healthy behaviours" (Garba, 1998).

Experience from Uganda indicate that, In March 2001, In Uganda user fees were eliminated in all public sector facilities and remained only for patients with private health insurances and special cards. In place, there was an immediate, dramatic gush in the use of government health insurance that was provided to all. Utilization of health care services increased continuously (Bennett, Sara, and Gilson, 2001). An assessment of 78 health facilities in 10 districts review and compare data for 8 months before the initiation of insurance and compared 12 months after the after the elimination of user fees. Data for eight months before and 12 of user fees and found that an average of patients attending health facilities monthly rose by 53%. The increment went to 77% (Ridde, Valéry, and Morestin, 2011).

In South Africa, medical scheme utilization and contribution has continuously increased over the past two decades by two- to three folds. In the recent years, there has been decrease in number of members enrolled for the scheme as a result of inflation that has affected the price of membership has a large percentage of citizens fail to purchase. It

has also affected the quality of care as medicines and important medical supply have continuously been in stock out. This has highly affected the level of satisfaction with the service (McIntyre, J et al, 2007).

Ghana has made a gallant step far ahead of other African countries. While in most of African countries Community Health Insurance is considered to be optional, the Ghanaian government has made it compulsory health insurance and made clear the devotion to achieve Universal Coverage (Bennett, Sara, and Gilson, 2001). The assessment of National Health Insurance (NHI) indicates that Ghana will reach 60% of the population within ten years which will be the highest coverage, community members are highly motivated to paying the required contribution and the enrolment has been continuously increasing, however the assessment does not indicate the extent to which service users are satisfied with health care services and whether the increment in utilization of service contribute by quality (Agyepong & Adjei, 2008).

In Nigerian the scenario is different, less than 2% of annual national expenditure is committed to health. Out-of-pocket payments from citizens account for nearly 80% and no serious commitment to health insurance from the government. Mortality and morbidity have continually escalated as a result of ill health following low utilization of health care services. Poor health care service compounded by low commitment of government in a formal health care system widens the gap between community and formal health system. (Khemani & Stuti 2006).

Unlike Tanzania where Community Health Schemes are not mandatory, Costa Rica has made remarkable achievements in attaining universal coverage through mandatory managed to achieve near universal health care coverage through a combination of mandatory health insurance. Highly improved quality of service has contributed to increased service utilization which is higher at 90% among the general population and 95% elderly compared to other developed countries (Birdsall & Hecht, 1995).

In Tanzania Community Health Fund has been very successful over the past 10 years. The districts have absorbed CHF the centre of CHF activities with the Council Health Fund Board (CHSB) responsible for introducing the scheme and ensure it is well mobilized at local levels including Ward Development Committee (MOH 1999; MOH 2005). The challenges have remained to be less responsiveness of Healthcare Providers in the management of the scheme and inappropriate financial expenditures, including inadequate financial auditing which have generally affected the quality of service and utilization. (Mamdani et al 2004)

In 2006 Tanzania managed to develop and operationalise a guideline and CHF TRACK for the management of the fund were by 92 districts were already reached and sensitized. The contract has been signed between MoH and districts on expenditure framework of the matching grant that will assist in increase response of districts and responsible boards. (Sendoro, 2007)

2.2. Theoretical Literature review:

In assessing patient's satisfaction, it is important to look the frame work to which important factors associated with patient's satisfaction are well accommodated, This study is based on a Donabedian theoretical frame, which involves a chain of three components of health care which are structure, process and outcome, Structure assessment involved human resource including their knowledge, skill and attitude and other resource such as equipment and medicines. Process assessment involved feedback processes, time waiting for service, language used and communication process while the outcome defined as a treatment results which is the final attribute that determine patients satisfaction. (Donabedian, 1980:81)

The components of Donabedian Frame work are the standard and parameters through which quality of care can be improved with the expected results of increase health care user's satisfaction (Flippo 1984: 54) The model very useful in personal development,

development of policy and procedures, development of health care structures and system for quality improvement (Alspach 1995:276)

Table 2.1 Donabedian's frame work as applied in this assessment (Donabedian, 2003, pxxviii)

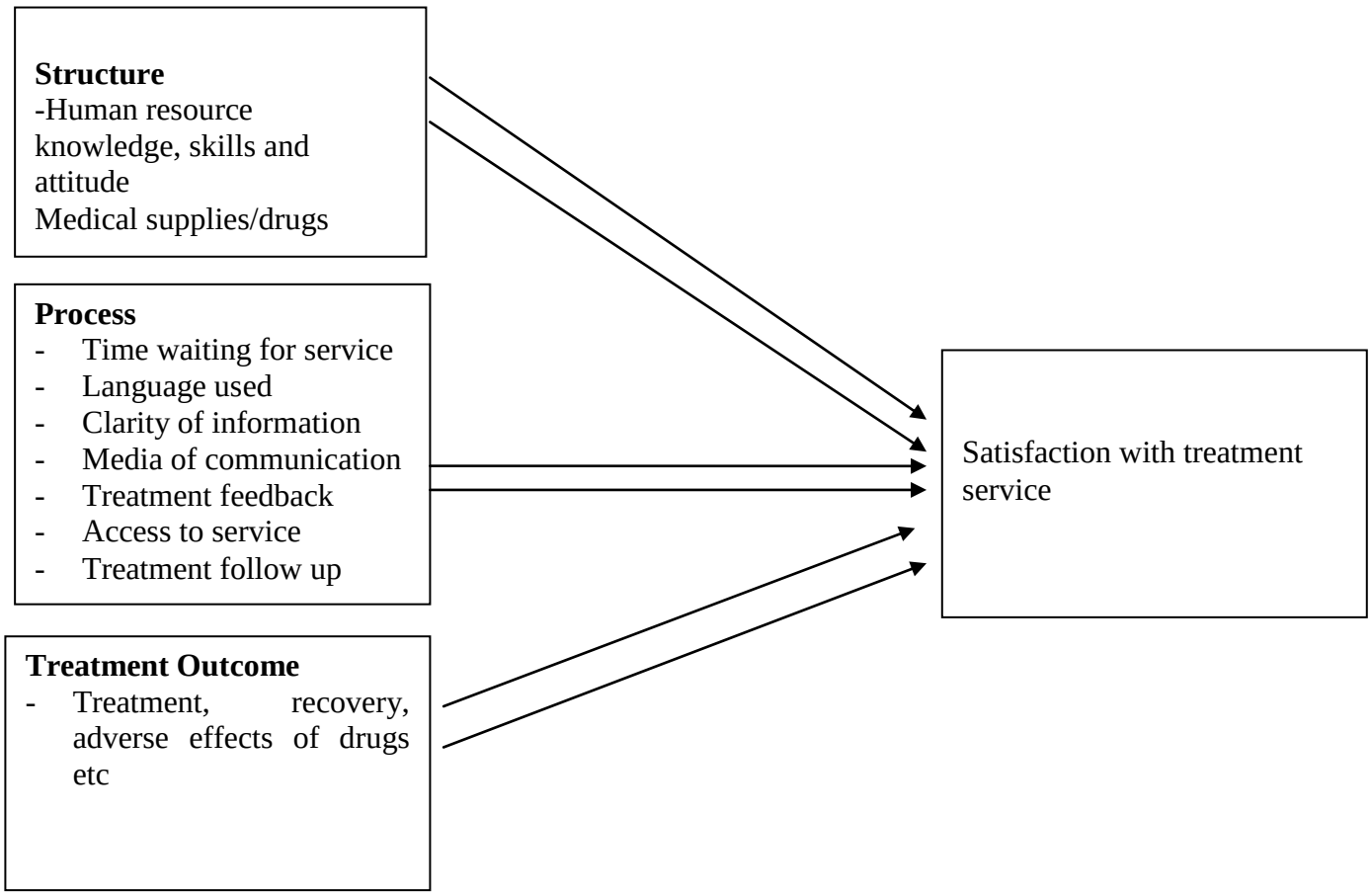
Structure of CHF	Process	Outcome
-Human Resource and their capacity (Knowledge, skill and attitude) - Medical facilities/supplies and medicines	-Time waiting for service -Language used -Clarity of information -Media of communication -Clarity of feedback -Access to service -Treatment follow up	Treatment outcome - Treated, adverse effects of medicines etc - Satisfied with the quality of service and treatment results

Source: Field Study

Conceptual Frame Work and Evaluation Model

The conceptual framework highlight a relationship between variables that influence the CHF members satisfaction with health care services provide through CHF membership as implied in this study. The model above explains a close relationship and influence of each component in the result of service. The structure of health facility including human resource capacity their skills and attitude can influence the process as. The process mostly depends on the available structures to enable provision of quality or required service which will result into certain level of outcome. However, the structures of service point have direct influence in the results or outcome of the service eg. If there are no sufficient medicines there should not be expected high quality treatment outcome.

Figure 2.1. Conceptual Frame Work and Evaluation Model for the study



Source: Donabedian, 1980

CHAPTER THREE

EVALUATION METHODOLOGY

3.1 Evaluation approach

This evaluation study employed formative evaluation that was specifically assessed the implementation process of CHF with a focus on members satisfaction with health care services provided through CHF membership. Evaluation employed a mixed approach to sequential exploratory approach in data collection, analysis and interpretation. Data was collected and analysed separately and then converging areas was identified where data can complement to produce more meaningful results.

Quantitative approach was applied to collect and analysed data and provide response with regards to Community Health Fund member's satisfaction with service from reception to exit.

3.2 Evaluation design

A cross sectional study design was employed that involved 153 respondents for which allowed collection of data that provided a descriptive estimates of the population parameters and answers on the current status of care (Olsen & St George, 2004).

The study was guided by Donabedian conceptual framework about satisfaction with health care that involved the structures of health facility and general health service systems, process assessment and outcome assessment (Donabedian, 1980)

3.3 Evaluation Period

Evaluation project was conducted between April and June 2015

3.4 Study area

The study was conducted in two health facilities of Likombe and Mikindani of Mtwara Municipal. Council Mtwara Municipal is one of the 5 districts of Mtwara region. The

district is bordered by (Lindi Region) to the North, by the Indian Ocean to the east, Republican of Mozambique to the south and the Mtwara District Council to the west.

Total population in 2012 is 38503 with a growth rate of 0.0161. The district has a total of 157 Villages, 11 wards and 7 divisions. The district is located 650 kms from Dar es Salaam. The main tribe is Makonde.

District health services

The district has 33 health facilities (HF) in public health system 30dispensaries and 3 health centres, no district hospital. Patients are referred to Mtwara regional hospital. There is also a mission health centre (HC) in Nanyamba. 85% of the population can reach a health facility within two hours on foot. The most common diseases are malaria, respiratory and gastro intestinal infections. They account for more than 50% of all morbidity cases. In addition, TB, leprosy, AIDS, schistosomiasis and Filariasis are endemic.

Community Health Fund (CHF) in Mtwara District Council

Currently, services at Public Health Facilities are provided free of charge. The district is in the implementation phase of the fund. The CHF card is for annual treatment of a household. In the Mtwara municipal definition of CHF includes father, mother and six children who are below the age of 18 years. In polygamous situation, each wife constitutes a separate household. A household deemed unable to pay, will be accepted from CHF or user fee payments. A user fee is per disease episode of 2 weeks.

3.5 Study population

The study population was the Community Health Fund members who attend the two public health facilities of Likombe and Mikindani.

3.6 Unity of analysis

The assessment used the community health fund members as a study unit.

Sampling units: The study focused on active Community Health Fund Members who from Mtwara Municipal who attend health care services in the two health facilities of **Likombe** and **Mikindani.**

Table 3.1. Variables and measurements

Independent variables	Dependent variable	Measurement and tests
-Time waiting for service -Language used -Clarity of information -Media of communication -Clarity of feedback -Access to service -Treatment follow up -Knowledge -Medicines and medical equipment	Satisfaction with treatments service provided service and treatment	Descriptive analysis and Logistic regression for testing strength of association

Source: Field Study

3.7 Sample size and sapling techniques

Sample was determined by using statistical package statalcl 13 (64-bit) whereby the effect size expected is 70 – 80. The power of the study, β and α error has also been determined by using stata commands.

. sampsi 0.7 0.80, power(0.8) one sample

Current status= 0.7

Target= 0.8

Power =0.8

A sample size is estimated from one-sample comparison of proportion

sampsi 0.7 0.80, power(0.8) one sample

Test Ho: p = 0.7000, where p is the proportion in the population

Assumptions: Alpha = 0.05 (two-sided), Power = 0.8, Alternative p = 0.8

In this case estimated required sample size: n = 153

3.8 Types and sources of data

The assessment based on primary data which were collected direct from clients (CHF members). Secondary data from CHF registers, vouchers books, and guidelines were used to complement primary data.

3.9 Data collection methods

Data were collected by using structured questionnaires which was developed and tested prio to data collection exercise.

3.10 Validity issues

All data collection tools were checked by the supervisor from Mzumbe University and CHF supervisor and tested before actual data collection exercise. Immediately corrections of data errors were done in the field. Anticipated data errors were made clear.

Sampling error: The study was conducted only in one district of Mtwara municipal which might not be the representative of all districts in Tanzania; however, it has been assumed that all districts have the same program structure, membership process and service and they also share some common challenges.

Recall bias: It is anticipated that study participants are likely to have quite sufficient memory to every response they provided, to minimize recall bias the study limit responses to a maximum of three months. Probing techniques was employed to assist participants to think and recall more issues.

Non response bias: Some respondents and participants expected in the sample size were not available during the interview day, while some refused to respond due to different reasons. Exclusion and inclusion criteria used as a limit in the selection of members to feel the gap. Drop out during interview was encountered. To avoid from affecting the

generalizability and representativeness (external validity) of the findings, re-sampling and selection based on the inclusion criteria was done so as to ensure high response rates of up to 90s%

3.11 Data management and analysis methods:

All quantitative data collected, was cleaned, coded and developed a data set which was imported in STATA software for further analysis. For some qualitative data, cleaning handled by reviewing findings and determines if there is difference, revise the coding scheme was also done where necessary. Respondents were involved in the analysis stage, consulted on the adequacy of the transcription of the interview (Member's validation), Field based cleaning was employed so that all inconsistencies are worked effectively in the field upon realization.

Data Analysis

The appropriate methods of data analysis were developed based on the nature of data, variables and nature of cases/events that were expected to be involved in the study. Different analysis of the same data set was done in different aspects of the underlying data structure. The study employed descriptive statistics for to summarize findings and describe the sample and inferential to draw conclusions.

Strength of association: **Since most of the variables described as independent variables which were most categorical with dichotomous responses with two levels nominal for dependent variable's outcomes, Logistic regression was therefore employed to test for the strength of association.**

3.12 Ethical issues

Ethical clearance: Mzumbe University was responsible for ethical clearance and other communication with relevant organizations and programs to ensure that ethical issues are well cleared before the study was conducted.

Informed consent: An introduction and supporting letters was provided by Mzumbe University and early communications was done by Mzumbe University to ensure that there is a well and informed consent. Respondents and other study participant were informed on the purpose of the study and requested for their consent before the interview.

Confidentiality: Name and other identifiers of respondents were recorded on the questionnaires. The filled documents were properly archived to ensure confidentiality.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents findings which are obtained from the point of recruitment of study respondents including their demographic characteristics, comparison of their characteristics and responses and proportion of their responses and other characteristics as per variables in each study objective.

4.2 Recruitment point of respondents:

A total of 153 CHF members and 25 HCPs were interviewed between April and May 2015. Participants were recruited based on the inclusion and exclusion criteria. All were interviewed at the point of service delivery of the two health facilities of Likombe Health center 92 (60%) and Mikindani 61(40%). The distribution of respondents based on the size of the health facility in terms of patient's attendance. The two health facilities receives an average of 1375 patients/week (196/day) were by Likombe has an average of 875 (60%) OPD/week and 125per day while Mikindani receives 550 (40%), patients OPD /week (79clients/day) (OPD register, February 2015). All HCP were interviewed based on their availability in their HFs during the time of evaluation, in this case sex was not a criterion.

Table 4.1. Recruitment point of respondents:

CHF members (n=153)			
Health facility	**No.**	**Frequency**	**Cf**
Likombe H/Centre	92	60%	60
MikindaniHealth Centre	61	40%	100
Total	**153**	**100%**	**160**

Source: Field Study, 2015

4.3 Demographic characteristics

Table 4.2: Demographic characteristics of respondents (CHF members)

Variable	Category of variable n=153	n (%)	p-value
Age	0-14 (	40 (26.14)	0.08
	15-35	64(41.85)	
	>35	49(32.03)	
Sex	Male	62(40)	0.06
	Female	91(60%)	
Occupation	Employed	30(19.61)	0.012
	Unemployed anywhere	59(38.56)	
	Self employed	64(41.83)	
Marital status	Married	85(56)	0.010
	Single	40(26)	
	Divorced	22 (14)	
	Widow	6(4)	
Education	Primary and no school	41(27)	0.43
	Secondary	89(58)	
	Tertiary	11(7)	
	Others	12(8)	

Source: Field Study, 2015

Sex: The distribution of sex of respondents also based on the inclusion and exclusion characteristics. Among respondents interviewed 91(60%) were females while 62(40) were males. It was noted that, a bigger proportional of female 55(60%) and 40(60%) in Likombe and Mikindani consecutively compared to male 37(40%) in Likombe and 21(34%) in Mikindani were available as respondents in the two health centres visited. The finding indicate that Females are more users of CHF service compared to males though associate between sex and satisfaction level was not statistically significant (p=0.06). To complete this information, 25HCPs were also interviewed among which 10 (40%) were males and 15(60%) were female.

Age: Results indicate that, 153 CHF members were interviewed where by 40(26.14%) aged between 0-14years who come to the facility during a day of interview, Majority of clients 64(41.85%) were aged between 15 -35 years who were found to be more utilisers of service compared to other age groups. However, association was found not statistically significant (p=0.08). 25HCPs were also interviewed to get useful information for complementing findings from CHF members. The age ranged 15-35 were 16(64%) and 35> only 9(36%).

Education: Majority of CHF members interviewed had gone to secondary education 89(58%) while 41(27%) primary education, the promotional included those who have not gone to formal education and 11(7.17) had gone to tertiary level and the rest 12(8%) had other forms of education. Findings suggest that community members with secondary school education in Mtwara are more users of CHF service compare to others tough association with satisfaction was not statistically significant (p=0.43). HCPs with different education and professional levels were also interviewed to get their views with regard to clients (CHF) satisfaction with service where by 20(80%) had at least a certificate or Diploma in different health professionals. The rest 5(20%) had higher level of education above diploma.

Occupation: Results indicates that that majority of the CHF members are frequent utilisers of service are self-employed people in different economic activities 64(41.83%) followed by those who are not employed 59(38%.56%) while employed were only 30(19.61%). The findings inform that, self-employed people are more users of CHFs service compared to other groups in the community and Statistical association was significant in satisfaction level (p= 0.012)

Marital status: Out of 153 respondents 85(56%) were married which is the biggest proportional of utilisers of CHF service compared to single 40(26%), divorced (22(14%)

and widow 6(4%). However, it was noted that, there is strong association between marriage and satisfaction level with CHF treatment services (p= 0.010)

Table 4.3: Demographic characters of respondents HCPs

	Parameter	Category of parameter	N(%)
	Age	0-14	0 (0)
		15-35	16(64)
		35>	99(36)
	Sex	Male	10(40)
		Female	15(60)
	Education	Only Secondary	0(0)
		Tertiary (Certificate and Diploma)	20(80)
		Others	5(20)
	Marital status	Married	19(76)
		Single	6(24)

Source: Field Study, 2015

4.4 Evaluation Findings

With reference to Donabedian's model of assessing patient's satisfaction, findings are tied to each of the three levels of the model as reflected in the objectives bellow and table 4.4.

4.4.1 Level of satisfaction of CHF members with structure (Human Resource, medicine and medical supplies) in Health Facilities.

As provided in the structure of CHF and defined in Donabedian' s frame work, the study focused on major highlighted issues of **"structure of service"** which includes Human Resource For health (their knowledge and skills and attitudes) and medical facilities/ supplies and medicines. The objectives attempted to assess whether the structure of HFs as an attribute for patients (CHF members 'satisfaction) influence their level of satisfaction with service.

A total of 153 CHF members were interviewed to get their responses and feelings with regard to Human resource available, their knowledge and skill, attitude, medicine and medical supplies available and their quality and general structures of health facility. 25HCPs were also interviewed so as get information with regard to service they provide their qualification and roles. The information was also assessed to see their sufficiency as compared to the Nation Minimum package for Health Centres in Tanzania.

Table 4.4: Results on Structure of health facilities

Variable	Variable category	n(%)	p-value
-Human Resource Knowledge, skill and)	Yes	105(68.63)	0.03
	No	48(31.37)	
Attitude	I trust them	123(80.39)	0.07
	Only trust some	24(15.69)	
	I don't trust	6(3.9)	
Medical supplies	Yes	91(59.48)	0.01
	No	62(40.52)	
Quality of medical supplies	Yes	80(52.29)	0.03
	No	73(47.71)	
Availability of Medicines	Yes	74(48.37)	0.02
	No	79(51.63)	
General facility structure	Yes	90(58.82)	0.22
	No	63(41.18)	

Source: Field Study, 2015

A: Human Resource: A total of 2 health facilities were evaluated on this (n=2), but the study unit was the health care providers (n=25).Two health facilities had different composition of Human resource. Respondents mentioned the available staff; a list of staff available was also displayed in Medical Officer in charge of each of the health facility. Main cadres which were assessed include Medical doctors (MD), Assistant Medical Officers (AMO), Clinical Officer (CO), Registered Nurse (RN), Nurse Midwives (NMW), Enrolled Nurse (EN), Medical Attendants and Data Clarks (DC). Each cadre provides services CHF members and none CHF members. No specific staff assigned for CHF member. However, all Health facilities had more that 100% of available HCPs which is more than the National Minimum package for health centres.

Table 4.5: Human resources providing health care services in the study sites

Health Facility	Cadre of staff									
	MD	AMO	CO	RN	NMW	EN	MA	DC	LAB	Total
Likombe Health Centre	1	7	2	8	11	4	18	2	1	53
Mikindani Health Centre	0	0	2	6	2	3	10	1	2	26
Nation standard	1	1	2	2	2	2	2	2	1	16
% HP in Likombe HC	100%	700%	100%	400%	550%	200%	900%	100%	100%	331%
% HP in Mikindani HC	0%	0%	100%	300%	100%	150%	500%	50%	200%	163%

Source: CCHP Report, 2014

B: Knowledge of Health care workers: In assessing the sufficiency of knowledge and skills of health care Providers, both CHF members (n=153) and Health Care Providers (n=25) were interviewed. 105(68.63%) of the CHF members accepted that HCPs have

sufficient knowledge and skills of treatment service they provide while 48(31.37) do not appreciate the knowledge and skills of HCPs. On the other hand, 5(20%) of Health care providers mentioned that they do not have sufficient knowledge and skills to provide health service while 20(80%) accepted that they have sufficient knowledge. However, association with satisfaction level was statistically significant (p=0.03)

C: Medical equipment and their quality: As one of the attribute of satisfaction with service both CHF members (n=153) and HCPs (n=25) were interviewed. Only 91(59.48%) of CHF members accepted that they are satisfied with medicines/medicines prescribed and their availability while 62(40.52) do not appreciate availability of required medical supplies for both OPD and IPD though association was statically significant (p=0.03). With regard to quality of available medical supplies majority 80(52.29) appreciate the quality while 73(47.71) mentioned they are not satisfied with the quality of these medical equipment's though the association with satisfaction was statistically significant (p=0.03). On the other hand, 9(36%) of HCPs did not accept that medical equipment are adequate while 16(64%) agreed that medical equipment available are adequate.

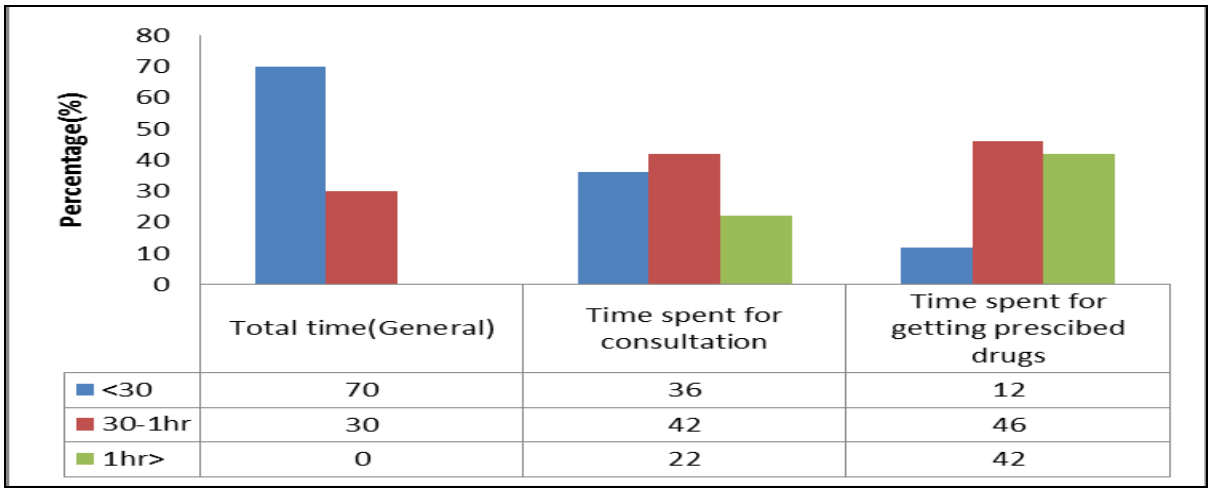
D: Medicines/Medicines: Of 153 CHF members interviewed only 74(48.37%) of CHF members accepted that they are satisfied with medicines/medicines prescribed and their availability while majority 79(51.63) do not appreciate availability of prescribed medicines in the health facilities. The association was also statistically significant (p=0.02). Inverse to this, majority of CHF members 80(52.29 accepted that medical equipment in the HFs are adequate while 73(47.71) did not accepted either available equipment meet their expectations. However, HCPs had different response where 10 (40%) mentioned that prescribed medicines are not sufficient and 15(60%) accepted that prescribed medicines are sufficient.

E: General Structure of the facility: The study shows a high proportion of CHF members 90(58.82) who are happy with the structure of health facility while 62(41.18) were not happy with the structure. It was noted that, there is no statistical significance in association with the satisfaction level (p=0.22)

4.4.2 Factors influence CHF members' satisfaction with health care service process/procedures in health facilities

As highlighted early, process of provision of health service is one of the determinants of patient's satisfaction with service. In this assessment, different attributes of Health service process as highlighted in Donabedian' s Model were assessed these includes Time spent for service, media of communication, clarity of feedback, access to service and treatment follow up.

Figure 3.1: % of response on waiting time



A: Total waiting time: Result indicate that majority of the CHF members 107(69.93) spend more than 30minitues to get service from reaching the HF to exit while

46(30.07%) stated spend less than 30minutes thought was not statistically significant (p=0.14. On assessment of time spent in different service delivery points, 18(11.76%) spend less than 30min to get prescribed medicines, 70(45.75%) spend more 30 to 60 minutes and 65(42.48%) spend more than 1 hour. Association with satisfaction was found statistically significant (p=0.006). when On time taken for consultation/waiting until one receive consultation service 55(35.95%) revealed that they spend less than 30 min while 64(41.83%) spend 30min to 1hour and 34(22.22%) spend more than one hour. Findings suggest that majority spend less than 30minutes. However association with satisfaction level was not statistically significant (p=0.71)

Table 4.6: Results on factors influencing process of treatment service

Variable	Category	n(%)	P-value
N=153			
Total waiting time	<30min	107(30)	
	>30min	46(70)	0.14
Time waiting for Consultation	<30min	55(36)	
	30min – 1hour	64(42)	0.71
	>1hour	34(22)	
Satisfied with Time taken at pharmacy	<30min	18(12)	0.006
	30min – 1hour	70(46)	
	>1hour	65(42)	
Satisfied with Clarity of information	Yes	120(78)	0.03
	No	33(22)	
Satisfied with Language used	Yes	58(38)	0.10
	No	95(62)	
Means of communication	Face to face	153(100)	NA
	Mobile	0(0)	
	Conference	0(0)	
Feedback after lab results	Yes	76(50)	0.93
	No	77(50)	
Accessibility to treatment	yes	102(66.67)	0.003

B: Clarity of information provided and language used: On the ability of HCPs to communicate health information effectively to patients it was found that 120(78.43) indicated that they receive clear information from HCPs while 33(21.57) responded that the health information provided by health care workers are not clear, this was justified by the strength of associated from the findings which was statistically significant (p=0.03). The language used was mentioned by 95(62.09%) to be very clear while 58 (37.91%) mentioned that the language used is not clear to them. Despite of clarity of language as responded by majority of clients, Association between the variables (Language and Satisfaction level) was not statistically significant (p=0.10)

C: Treatment follows up: Respondents were asked to mention the extent to which they receive treatment follow up during treatment as part of continue follow up for treatment as recommended. Only 62 (40.52) accepted that they receive follow up but they added that it is only when they are admitted. Majority 91(59.48) responded that they never receive any treatment follow up from health care providers.

D: Feedback after lab results: Results indicate that an almost half of patients attending health facility for treatment service receive their treatment feedback including lab results 76(50%) while the rest 77(50%) do not receive. The association test indicate that no statistical significance when assessed against satisfaction level.

E: Access to service: This aimed at assessing barriers in accessing service in health facility as CHF members who are different from other service users who pay user fees on service point. 102(66.67) admitted that they don't encounter any problem in accessing service while 51(33.33%) mentioned that they encounter different problems that arises as CHF members. The association with satisfaction level was statistically significant (0.03)

4.4.3 Extent to which treatment outcome meets CHF member's expectations.

Table 4.7 Response of treatment outcome

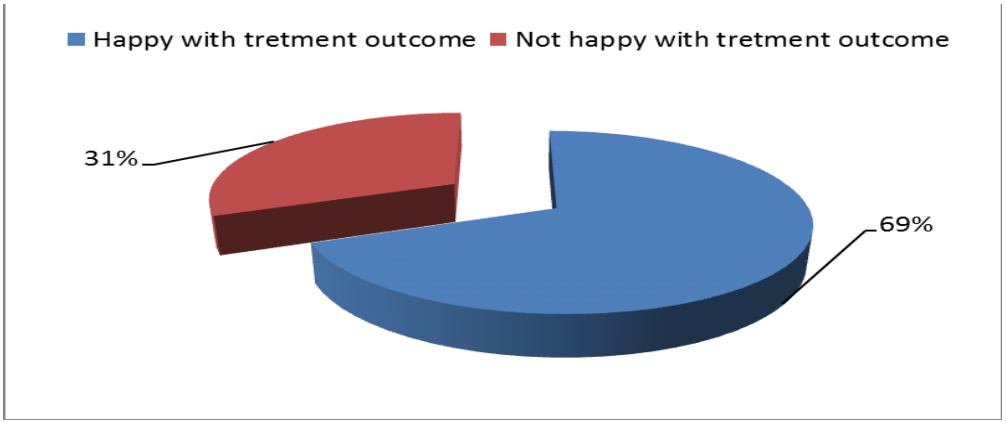
N=153			
		n(%)	p-value
Satisfaction with follow up after treatment	Yes	62(41)	0.5
	No	91(59)	
Satisfaction with treatment outcome	Yes	142(92.81)	0.112
	No	11(7.17)	

Source: Field Study, 2015

According to Donabedian Model, treatment outcome is the primary goal of health care and health interventions. CHF as an intervention aims at ensuring its service effect the health status of members in terms of recovering from disease, changes of behaviour and other physical and mental changes.

A: Satisfaction with treatment outcome: Respondents were asked how much they are happy with treatment outcomes after receive treatment service in health facility. Majority 142 (93%) mentioned that they are happy with treatment outcome as they become fine after treatment while 11(7%) they mentioned that they were not happy as their problems persists. However the association between treatment outcome and satisfaction with service was not statistically significant (p=0.11). In this case satisfaction level of CHF member is not influenced by the treatment outcome, but other factors.

Figure 4.2 % of responses on treatment outcome



Source: Field Study, 2015

B: Satisfaction with follow up after treatment: Out of 153 respondents, 91(59%) have never received any treatment follow up from health care providers while a small proportional 62(41%) of the CHF members have ever received treatment follow up. Association at a margin was found when tested with level of satisfaction with service (p=0.05)

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter follows up the findings presented in chapter four. The discussion based on the evaluation question and links them with the findings and interpretation. Each attribute in the evaluation question will be discussed and linked with outcome variable to produce a meaning and logic.

5.2 Level of satisfaction of CHF members with structure (Human Resource, medicine and medical supplies) in Health Facilities.

Mtwara has the history of high challenge of Human Resource for health (JICA, 2013), the recently plan and development of town might have attracted more health care workers in the district. Findings of the study indicate that Adequate of staffing has contributed to increased satisfaction of CHF members with service. Likombe Health Centre has more staff than the minimum standard of the ministry of health (MoH,2003) where there are adequate Medical doctors, Assistant medical offices, Clinical officers, Nurses of different cadres, lab personnel etc (Mtwara municipal CHP report, 2014). This is also reflected by the higher number of CHF members attend Likombe Health Centre compared to Mikindani where there are no higher level professionals like Medical doctors and Assistant Medical Offices (Ref 4.1). Human Resource capacity in the health facilities was to found to have strong association with level of satisfaction of CHF members, hence it is important for the district to build in these areas so as to improve satisfaction level, maintain retention rate and increase enrolment rate.

Findings of the assessment indicate a satisfaction with the availability of medicines and medical supply in health facilities. The existing challenges of inconsistence medicines supply form Medical Store Department (MSD), weak medicine management system

contribute to regular medicines stock out in public health facilities (PPRA, 2011). A tracer list in the medicine management assessment reports conducted in Mtwara indicate higher stock out for indicate that there is critical shortage of malaria medicines (Sulphadoxine-Pyrimethanine and Artemeter Lumefantrine) and other essential medicines of more than 44% (GIZ, 2013). Given that Mtwara is malaria endemic and malaria is the leading top ten diseases (Malaria) it is likely that the shortage has contributed to low satisfaction level, however the findings indicate a weak association (p=0.5). There was statistical significant association between mean score of the availability of medical supplies and satisfaction level (p=0.01), however, respondents are also happy with the quality of available medical supplies though they are insufficient (p=0.03).

5.3 Factors influence CHF members' satisfaction with health care service process/procedures in health facilities.

The process of provision of service cuts across different levels of service delivery in the health facility level includes treatment, preventive and health education. This may and may also involve the process of service the patient-client relation ie access to language, language used, treatment follow up, clarity of information and time spent for service to different levels. (Donabedian, 1988). As highlighted early, process of provision of health service is one of the determinants of patient's satisfaction with service. In this assessment, different attributes of Health service process as highlighted in Donabedian' s Model were assessed these includes Time spent for service, media of communication, clarity of feedback, access to service and treatment follow up.

Description of study findings reviles that, majority of CHF members spend more than one hour to receive treatment service in health facility from their first contact. In Tanzania, the issue of waiting time has not been well addressed due to complex challenge of other associated factors that contribute to increased waiting time these includes shortage of health care providers, and inadequate of medicine and medical

supplies. From this study findings, majority of HCPs spend more time (More than 1hour for waiting until they receive consultation). However, association between waiting time and satisfaction was found to be statistically significant (p=0.02). The association is justified by the influx of patients in Likombe health centre where there are more health care providers compared to Mikindani HC.

Due to shortage of health care providers, Most of the public health facilities have no waiting list to facilitate waiting time management. The assessment of the effect of waiting time in health outcome reviles that, sustained waiting time prolongs pains and affects the economy as time spent by patients and other relatives could counted in terms of loss of economy and productivity (Hirvonen J, 2007). The integration between service deliveries points has also been overlooked. In this case, waiting time has to be addressed so as to improve client's satisfaction with service.

The process of assessing patient's satisfaction involves the extent to which health information received by clients is clear, availability of treatment follow up and language used by HCPs (Patients-Provider relation). All respondents accepted that they receive clear information and the language used is clear and understood. As per MAT ethics booklet, Patients also have the right to receive the right information concerning their health (MAT, 1995). However, most of the patients do not understand their health information rights and benefits of receiving the right information on their health.

5.4 Extent to which treatment outcome meets CHF member's expectations.

As one of the important aspect in studying client's satisfaction, the study assessed the component of treatment outcome as provided in the Donabedian Model, Majority of study respondents mentioned that they are happy with treatment outcome. However it should be noted that, response are subjective to health problems of individual at hand or have ever encountered. It was realized that, Members with long time health problems like people living with HIV/AIDS, Diabetes etc were not happy compared to those with short term diseases like Malaria. The binary logistic regression indication a margin fit in

association between availability of prescribed medicines and happiness with treatment outcome (p=0.05). In this case no evidence of proof weather the noted happiness from findings is associated with medicines availability. However, significance association was found between happiness with treatment outcome and overall satisfaction level with services (p=0.03) though members do not feel much difference from being a CHF member and other patients. The growing of Mtwara town has made availability of private health facilities where most of none CHF members attend for service.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND IMPLICATIONS

6.1 Summary:

This chapter presents a summary of the findings that have been discussed in the previous pages. The summary presented as per each objective as in the findings and discussion part. The study sample size was very sufficient in getting enough respondents who produced meaningful results for the study. All variables of the study were statistically tested to see strength of association with outcome variable. Most of the variables were tested as binary where logistic regression was run to see their strength at 95CI and *p*-value of 0.05 as a standard. Odds ratios were included to see the protective effect within each of the variable's standard error so as to get clue for testing the Donabedian' s model as applied in this study. Number of demographic factors were tested chi2(2) to roll out for confounding factors and adjustment was made by running logistic regression across different variable.

Structures of the health facility influence clients satisfaction hence affect their general enrolment rate to the scheme, attendance and utilization of service. Likombe health Centre where there are more health care providers in number and qualifications experience influx of patients seeking for service while Likombe have an average of few patients attend. All assessed health facilities have more health care providers (>100%) compare to the National standard. It is therefore important for the district and Regional authority and MoH to plan for allocation of more health staff so as to improve utilization of health facilities and improve health outcomes.

It was noted that knowledge and skills of health workers have effect on client's satisfaction as it influences their ability to provide expected quality of service. Though majority of the respondents (68.63%) accepted that HCPs have sufficient knowledge and skills, it is important for concerned authority to provide continuous education so as to

keep updating and improving their knowledge to fit with dynamics in health. On the other hand, medicines and medical supplies also have great influence in CHF member's satisfaction with service as noted from this study, improving procurement and supply system for improving the quality of medical supplies and improve stock out control is of paramount important, the Ministry of Health, Medical Store Department have to put more strategies to improve on this. However, the use of CHF fund for procuring medicines should be accelerated as a backup.

Process of provision of health service is important attribute to the satisfaction level of clients (CHF members) in this assessment; longer time waiting for service prolongs pains to patients and has negative impact in their economy. It is then important for both health facilities and higher authorities to have strategies for reducing waiting time and queue management so as to improve CHF member's satisfaction with service and increase their general enrolment. Other associated attributes in process of service including clarity of information, treatment follow up and access to service. Though majority of respondent admitted that information provided are clear 120(78) it should be a continuous program to insisting on the positive effects of clear communication and customer language. Alongside, treatment follow up should be provided as it is not practiced, the member ship fee should be maintained as criteria for accessing service and there should not be any additional costs as per CHF policy. This will improve the member's satisfaction their positive feeling on the scheme.

Treatment outcome found to be a primary goal of health care and health interventions. All attributes discussed above can only be realized through treatment outcome, structures of the facilities, availability of medicines and quality of health care providers can only be appreciated if there are positive treatment outcome at service users level. The increased utilization of Likombe health Centre compared to Mikindani was associated with high expectation of more treatment outcomes. Findings from different studies as mentioned early indicate treatment outcome to be the most determinant of service utilization regardless of the distance. In this case, the government and other

stakeholders should work to develop and implement best strategies for increasing both human including specialists and material resources (Medicine and medical supplies) so as to improve treatment outcomes therefore improve CHF member's satisfaction.

Conclusion

From this study, it has been realized that CHF satisfaction with service depends on three aspects as per this assessment which includes structure of the health facility, process of service provision and treatment outcome. The three attributes of satisfactions have high influence in the health service user's satisfaction level. The linkage between structures (HCPs and their knowledge and skills, medical supplies and medicines), Process (waiting time, clarity of information, media of communication, clarity of feedback, access to service and treatment follow up) and general treatment outcome influence CHF members satisfaction with service and hence could be factor that influence the enrolment rate, retention and reduce drop out.

6.2 Recommendation:

The evaluator appreciate and appraisal for areas which CHF scheme have shown great performance especially in enrolment and retention. However the following recommendation should be considered as important areas for improvements:

Human resource knowledge and skills: There are high number of HCPs in the two health facilities studied but the number of patients attending in these health facilities is also very high, it is then recommended the District senior management team and Health Management Team (CHMT**)** should find mechanism to maintain and if possible increase the number of staff so as to reduce the waiting time for service especially in the medicine dispensing window where association with satisfaction has been very significant.

The regional Health Management Team (RHMT) and Office of Regional Secretary (RAS) should also support the implementation of CHF by advocating at the Ministry

level and involving other stakeholders in supporting the mobilization of CHF to increase enrolment, Provide technical support during planning to ensure that the comprehensive district plan includes CHF issues, include budget for CHF mobilization in their budget and involving other private sectors and local and international agencies in supporting the scheme.

Medical supplies and their quality: The number of medical supplies and their quality should be increased as it has been identified to be one of the factors that influence client satisfaction with service. It therefore recommended for the ministry of health and CHF committees to priorities issues of medical supplies so that the centres can be more satisfactory to users. This include replenishing the outdated and out of use equipment and equip with more modern facilities. However, health facilities should ensure proper utilization of available equipment.

Availability of medicine: The CHMT should work close with Medical store department and CHF board put a strategy to ensure that that there is stock control mechanism for medicines so as to avoid frequent out of stock that has been found to a major factor that affect enrolment of CHF members and retention but also affect the general utilization of health services at facility level.

Clarity of information: Training and continuous capacity building to Health care providers is very important for continue updating HCPS on guidelines and Medical ethics on different areas so that they are able and willing to communicate clear health information to clients which will effect and influence their attendance and utilization of services.

Access to treatment service: At health facility level, Medical Officers In charge should put mechanism to ensure that all clients CHF and none CHF members receive equal attention in service as most of CHF members claimed that those who pays in cash

receive more attention compared to the members who only come with their membership cards. On other hand there should be a suggestion box or regular client satisfaction survey to get clients feelings and suggestion on services they receive.

The CHF committees should work in collaboration with other sector (Multisector collaboration) in planning and implementation of its plans as issues of health cuts across all sectors. Community health workers at community level should also effectively use in sensitization and awareness creation on important of CHF and enrolment process so as to increase enrolment rate and retention.

6.3 Policy Implication

Based on the findings of this study, initiation of the improvement of performance of CHF and implementation of the recommendation of this study will have impacts across number of health indicators. The current HCP/Patients ratio 0.4 for physician and 2.8 for nurses per 10,00people require serious efforts to increase so as to increase service utilization. The improvement of structures, process of provision of service and general treatment outcomes will contribute to the reduction of maternal Mortality rate (MMR) from 454/1000, 000 to the target of 265/1000000 and 30% reduction of Global Health Initiative target and reduction of Home deliveries which is currently 49% of all annual deliveries.

The assessment recommend for improvement of HCPs language and health information sharing at health facility level. If well implemented this will contribute to increase CHF enrolment rate and health service utilization which will impact into increase of Intermittent Preventive Treatment (IPT2) coverage to above the current 27% as a result MMR, Under 5 Mortality Rate (currently 81/1000), Post neonatal death (25/1000) and Infant Mortality Rate(51/1000) will be reduced.

Currently, Tanzania has the population Growth Rate of 2.9% with Life Expectancy at Birth 54 for males and 56 for females. The growth rate is high compared to ongoing

improvement on health services. Tanzania is required to increase family planning to above 27% which will ultimately reduce the growth rate. This can be realized through increase health service utilization through improved structures, processes of provision of service and treatment outcomes of which in any case will increase enrolment rate of CHF members hence increase proportional of people utilize health care service hence reduce the burden of disease and other poor health outcomes.

Mtwara is one of the regions with poor health indicators, the findings of this study will be shared with the MOH and other heal development stakeholders working in Mtwara and studied sites for improving services as highlighted in this paper.

It is also a high time for the MoH to develop and implement a circular for recruiting Monitoring and Evaluation Officer who will be responsible for continuous monitoring and Evaluation of Health Programs at the ministry, Regional and District levels. Data and reports on CHF and other other programs will be available under one pool

6.4 Programmatic implications:

Finding s of these reports will be useful in programming at different levels. It is expected that The relevant district will use for improve CHF program at district level including developing strategies for improving enrolment and retention rate, waiting time management, improving planning for medicines stock out control other medical supplies. The report will also provide evidence for training and capacity building for HCPs for improving their knowledge and skills for improving their performance and increase patients satisfaction with service.

Ministry of Health and other programs will use the findings to affect their plans and decision on issues pertaining to health programming. The report has produced baseline data for further researches in the same or related areas, in this case research institutions are expected to use the findings for their reference and base line findings for further research within their programs

6.5 Findings for strategic planning:

Strategic planning require enough evidence, this report has provided over sight on strength, weaknesses, opportunities and threats that encounter health CHF as a program. It is then expected the identified gaps and challenges will provide a good ground and evidence for CHF strategic plan. Other health development stakeholders will also use as part of important tool and input in their strategic plan.

6.6 Limitations:

The evaluation was conducted in urban health facilities of Mtwara municipal involved mostly member who reside from urban areas. It might not be appropriate for replicating rural areas where the nature of life and other demographic characteristics differ from the study area.

6.7 Areas for further evaluation/research

A qualitative research is required to determine factors that influence CHF member utilization.

This will be useful in complementing quantitative information from this study.

The assessment of the effect of private health sector on CHF enrolment rate. This provides answers to increased rate of drop out from CHF either Private sector is an alternative or there are other factors.

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APPENDICES

Annex 1: Questionnaire for CHF members

Demographic information

Information	Response	Information
Date		Name of the facility
District		Code of the interviewer
Ward		Time interview started
Village		
Age in years		
Educational	1	Primary
	2	Secondary
	3	Tertiary
	4	Others (specify)
Occupation	1	Employed
	2	Unemployed
	3	Self employed
	4	Others (Specify)
Marital Status	1	Married
	2	Single
	3	Widow
	4	Divorce

Main variables	specific area for measurement	Code	Measurement

Objective 1: To assess the level of satisfaction of CHF members with structure (Human Resource, medicine and medical supplies) in Health Facilities.			
Skills and knowledge	Are you satisfied with number of HCPs available?	0	No
		1	Yes
	Do you think HCP have enough knowledge?	0	No
		1	Yes
Availability of prescribed medicine	Do you always get medicine which you're prescribed at the health facility?	0	No
		1	Yes
Availability of medical supplies	Do the quality of other medical suppliers e.g. Beds, treatment equipment's etc. meet your expectations?	0	No
		1	Yes
	Are you happy with medical facilities available?	0	No
		1	Yes
Objective 2: Factors influence CHF members' satisfaction with health care service process/procedures in health facilities.			
Access to service	Do you get any problem to access service by using CHF card?	0	No
		1	Yes
Time	How long do you wait for service from reception to the exit?	1	Less than
		2	30 min
		3	30 min to 1 hour
		4	More than 1
	How long do you wait to see HCP for consultation?	1	Less than
		2	30 min
		3	30 min to 1 hour
		4	More than 1

	How long do you wait to get prescribed medicines in the dispensing window?	1	Less than
		2	30 min
		3	30 min to 1 hour
		4	More than 1
Client-provider relation	How is the information you receive from HCPs?	1	Very clear
		2	Clear
		3	Not clear
	How clear, simple, friendly and understood is the language used by HCPs? (Please rate)	1	Very good
		2	Good
		3	Not good
	How is the Media of communication for you when you seek for service?	1	Face to face
		2	Mobile call
		3	Conferences
	Do you get clear feedback on your health problem (diagnosis, referral and treatment feedback)?	0	No
		1	Yes
	If yes, how often?	1	Very often
		2	Rarely
		3	Never received
	How would you classify the benefits received by being a member of CHF in health facility?	1	Very good
		2	Good
		3	Somewhat good
		4	Poor / bad
		99	N/A

Objective 3: To explore the extent to which treatment outcome meets CHF member's expectations.			
End results/Treatment outcome	Did you feel better after treatment?	0	No
		1	Yes
	Did you get any treatment follow up?	0	No
		1	Yes
	We are you satisfied with treatment outcome?	0	No
		1	Yes

Annex 2: Questionnaire for Health Care Providers

Main variables	specific area for measurement	Code	Measurement
Objective 1: To assess the level of satisfaction of CHF members with structure (Human Resource, medicine and medical supplies) in Health Facilities.			
Skills and knowledge	Do you have sufficient skills and knowledge to provide required service?	0	No
		1	Yes
	Do you think HCP have enough knowledge?	0	No
		1	Yes
Availability of prescribed medicine	Are medicines you prescribed available at the health facility?	0	No
		1	Yes
Availability of medical supplies	Do the quality of other medical suppliers e.g. Beds, treatment equipment's etc. adequate?	0	No
		1	Yes
	Are you happy with medical facilities available?	0	No
		1	Yes
Objective 2: Factors influence CHF members' satisfaction with health care service process/procedures in health facilities.			
Access to service	Do you get any problem providing service to CHF members?	0	No
		1	Yes
Time	How long does it take to provide service from reception to the exit?	1	Less than
		2	30 min
		3	30 min to 1 hour
		4	More than 1

	How long does it take to provider consultation service?	1	Less than
		2	30 min
		3	30 min to 1 hour
		4	More than 1
	How long does it take you to provide prescribed medicines?	1	Less than
		2	30 min
		3	30 min to 1 hour
		4	More than 1
	How the Media of communication for you when you seek for service?	1	Face to face
		2	Mobile call
		3	Conferences
	Do you provide feedback to CHF members on health problem (diagnosis, referral and treatment feedback)?	0	No
		1	Yes
	If yes, how often?	1	Very often
		2	Rarely
		3	Never received
	How would you classify the benefits received by CHF members compared to others?	1	Very good
		2	Good
		3	Somewhat good

		4	Poor / bad
		99	N/A

Objective 3: To explore the extent to which treatment outcome meets CHF member's expectations.

End `results/Treatment outcome	Do your feel better after treatment?	0	No
		1	Yes
	Do you provide any treatment follow up?	0	No
		1	Yes
	Are you satisfied with your client's treatment outcome?	0	No
		1	Yes

Annex 3: HCPs check list

Health Facility	Cadre of staff									
	MD	AMO	CO	RN	NMW	EN	MA	DC	LAB	Total
Likombe Health Centre										
Mikindani Health Centre										
Nation standard										
% HP in Likombe HC										
% HP in Mikindani HC										