FACTORS AFFECTING ENROLMENT OF COMMUNITY HEALTH FUND MEMBERS: A CASE OF KWIMBA DISTRICT

FACTORS AFFECTING ENROLMENT OF COMMUNITY HEALTH FUND MEMBERS: A CASE OF KWIMBA DISTRICT

By

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A Dissertation Submitted to the School of Public Administration and Management in Partial fulfillment of the Requirements for the Award of the Degree of Master in Health System Management of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation/thesis entitled ***FACTORS AFFECTING ENROLLMENT OF COMMUNITY HEALTH FUND MEMBERS,*** in partial/ fulfillment of the requirements for award of the Master of Health Systems Management of Mzumbe University.

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I, Benjamin Alto Simime, 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.

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DEDICATION

I dedicate this work to my beloved parents for the tireless efforts they put in raising me up to this stage. This too applies to my sister, who nourished me during all the time when doing the studies.

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I have special thanks to my supervisor Mr. Amani Paul for his ever-available guidance ,suggestion, criticism and encouragement throughout the time of my research production. He always had time and energy to provide support whenever I needed.

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LIST OF ABRIVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CDO	Community Development Officer
CHF	Community Health Fund
CHFA	Community Health Fund Association
CHMT	Council Health Management Team
DMO	District Medical Officer
DRF	Drug Revolving Fund
HF	Health Facility
HFGC	Health Facility Governing Committee
HSSP	Health Sector Strategic Plan
IMF	International Monetary Fund
KDC	Kwimba District Council
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MU	Mzumbe University
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
URT	Unite Republic of Tanzania
WHC	Ward Health Committee
WHO	World Health Organization

ABSTRACT

This study explored the factors affecting CHF enrollment in Kwimba District Council. It was set to explore the community's knowledge, perception, preferences participation or involvement in decision making. Cross sectional study design was employed in this study as research design. In line with this design, simple random sampling and purposive sampling techniques were used for sample selection, whose respondents were chosen from Ngudu and Wala Ward, particularly in four villages; Kakora, Welamasonga, Isaga, and Sumaha. Data were collected through questionnaire to key informants. These comprised both open ended and close ended questions. Findings of the study revealed that majority of population in Kwimba district were peasant. They preferred government health facilities as their primary health service provider due to its cheapness, availability and accessibility. Despite these facts, in favor of Community Health Fund, Kwimba district suffered from low enrollment. Only 3.2% were members (2120 households out of 64,720) mainly because the community had not received enough information on CHF. This has been due to low knowledge on existence and benefits of CHF among the community (especially nonmembers in remote areas). Other factors entailed poor quality of health services in terms of availability of drugs, medicine, medical equipment, supplies and diagnosis, referral systems, poor involvement of community on CHF management, and decisions. Study revealed that Community knowledge and perception towards CHF, community participation on CHF, and community preferences on health providers affected enrollment of CHF members. This study recommends for the following; that the district Management should increase efforts on sensitization of CHF benefits especially in remote areas at harvesting seasons. The district should also improve quality of health services by setting aside some amount of drugs for CHF in case they run out of drugs. There is a necessity too for the district to improve community participation in the local organization and implementation of the CHF scheme and lastly discourage user fee by increasing cost to encourage CHF enrollment

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CHAPTER ONE

BACKGROUND AND PROBLEM SETTING

1.1 Introduction and Background

With the introduction of the Arusha Declaration in 1967, Tanzania pursued a health policy that aimed at providing equal and free access to health facilities and services to the entire population. This was indeed a bold and revolutionary step stemmed from Mwalimu Nyerere's basic principle and conviction that improving the health and wellbeing of all Tanzanians was the way forward to sustainable development. Health care provision was reoriented to reach rural and urban communities include the poor who could not afford the costs of health care. Health services were provided free of charge by the government in all public health facilities, while voluntary agencies charged modest fees.

Hospitals were built in each region and there was also a shift on emphasis from curative to preventive services, hence increasing the range of interventions offered to the communities. These measures allowed the majority of Tanzanians to have access to health services and improve the quality of life. For instance, by 1992 about 72% of the population lived within 5 km of a health facility and 93% lived within 10 km. The life expectancy increased from 35 years in 1961 to 53 in 1983 (which latter on fell to below 50 years as a result of AIDS), (Ministry of Health 1994).

Following the world economic crisis in of the 1980's developing countries including Tanzania adopted the new economic reform prerequisite as the new condition for receiving loans from abroad (health sector reform), which Tanzania put in place several strategies to improve health services. Among the strategies was the introduction of cost sharing in health services through user fees, introduction of community health fund (CHF), introduction of drug revolving fund (DRF) and introduction of National health insurance fund (NHIF).

The introduction of user fees arrangements in health care services that were introduced in response to Structural Adjustment Programs in 1980s by the World Bank and IMF, marked the major health sector reforms in the history of Tanzania (as elsewhere in the developing countries). From the eyes of those who introduced such policies, they considered these reforms to be beautiful and suitable for the developing countries including Tanzania, (Ministry of Health 1994).

The consequences of these policies consists of what have been documented somewhere else and include increased inequalities. In Tanzania, Kenya and Cameroon for example, studies have shown that there were decline to utilization of health services of more than 50% contributed by introduction of cost sharing (Hussein, Mlangwa, & Hussein, 2005), despite the fact that transport cost was also one of the biggest burrier to utilization of health services, countries like Uganda for example showed the big health service utilization gap after the abolition of user fees where there were increase of health service utilization attendance from 44% to 77% at lower level health facilities on the first and second year (Nabyonga et al., 2005).

As in the year when this study was underway, Tanzania celebrated 16 years since establishment of community health fund (CHF) in all districts in Tanzania. The objectives of CHF, as stipulated in the Community Health Fund Act of 2001 has been: (i) To mobilize financial resources from the community for provision of health care services to its members; (ii) To provide quality and affordable health care services through sustainable financial mechanism; and (iii) To improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health(URT, 2001).

Evidence indicated that, the CHF scheme suffers from low enrollment rates in most of the districts with no viable strategies to increase the enrollment. The challenges include the availability of medicines in health facilities and lack of trust on the managers of the scheme or simply the community does not see that they own this scheme due to the bureaucratic procedures attached to management of funds and other procedures of the

scheme “is rather a government thing than a community thing”. These are issues that need to be addressed. CHF should be seen by policy makers, practitioners and beneficiaries as a stride forward to universal coverage for all citizens especially the poor. A call for high political will and leadership towards making it a reliable scheme in the Tanzanian district health system is advocated. Importantly, making CHF community driven might be a way forward to its success (Albin, 2011).

1.1.1 Community Health Fund

Community Health Insurance (CHI) is a general term for voluntary health insurance schemes organized at community level, that are alternatively known as mutual health organizations or micro-insurance schemes. They all share the following characteristics: being run on a not for profit basis, targeting informal sector and applying the basic principles of risk-sharing and members' participation in management. In Tanzania, families can join schemes as groups. A group is a set of people who are registered in the same household. Despite promotion of CHF schemes in Tanzania since the mid 90's, membership has remained persistently low.

Community Based Health Financing (CBHF) has emerged in developing countries as a response to the existing challenges in the health financing system which include low economic growth, constraints on the public sector and low organizational capacity. CBHF is a mechanism whereby community members (households) finance costs associated with health services, offering them greater involvement in the management of community financing scheme and organization of health services (Carrin, 2003).

Tanzania, like many countries in sub-Saharan Africa, faces the twin pressures of a tight public health care budget and the need to improve access to health services, especially for the poor and those working in the rural areas and/or the informal sector (Quijada & Comfort, 2002).

1.1.2 Community Health Fund in Tanzania

The CHF started in 1996 with a pilot scheme in Igunga district which was later expanded to other councils with the expectation of covering the whole country (MOH, 1999). The scheme was identified as a possible mechanism for granting access to basic health care services to populations in the rural areas and the informal sector in the country (Munishi, 2001).

According to the Community Health Fund Act of (2001) the objectives of the CHF are: (a) to mobilize financial resources from the community for provision of health care services to its members; (b) to provide quality and affordable health care services through sustainable financial mechanism; and (c) to improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health (URT, 2001)

1.1.3 Membership

Membership to the CHF is voluntary and each household within a district contributes the same amount of membership fee, as agreed by members of the community themselves, and is given a health card. The card entitles the household to a basic package of curative health services throughout the year. Normally, coverage is for the household head and other household members below the age of eighteen years. Households that do not participate in the CHF scheme are required to pay user fees on an individual basis at the health facilities at the point of use (URT, 2001).

1.2 Statement of the Problem

Kwimba Districts is located in northern part of Mwanza Region. It is one among the district with the smallest number of members that have joined community health fund scheme. The data for the overall membership toward 2015was only 3.2 % of the total number of households in the district.

Kwimba district health planning team (CHMT) in collaboration with National Health Insurance Fund (NHIF) had made several initiatives in advocating to the community on the existence and importance of community health fund on improving health and wellbeing of the community, as it improves the access to health care and to protect people against the financial cost of illness in an environment with shrinking budgets for the health sector. Several studies have shown that sick individuals in member households are more likely to get treatment than those in non-member households. Furthermore, being insured leads to an increase in the effective demand for health care, which results in to good health and social wellbeing. This indicated that members of the community health fund (CHF) were financially well-off protected against health shocks than non-members. This fact provided further evidence of the important role that micro insurance schemes (CHF) can play in the risk management of people in developing countries (Ministry of Health, 1999)

In the perspective of this study, there is a link between utilization on micro-health schemes (CHF) and social wellbeing. If community health funds services we reutilized effectively, this would bring about better and healthier community.

Despite the effort made on promotion and advocacy of community health fund the overall membership remained low, which indicated a gap on whether people did not have proper information on the usefulness and effectiveness of community health fund, or affordance to pay for premiums or community cannot access services at the time of their need. Thus this study aimed to investigate on the possible factors affecting low enrolment of Community health fund membership.

1.3 Objectives

The general objective of the study was to determine factors influencing enrolment of community health fund members towards community health promotion.

1.3.1 Specific Objective

(i) To examine knowledge of community towards community health fund.

(ii) To find on Perception of community towards community health fund.

(iii) To assess community participation or involvement CHF

(iv) To establish community preference on health service providers

1.4 Research Question

What are the factors influencing the enrollment of community health fund members toward community health promotion?

1.4.1 Specific research questions

(i) What is the knowledge level of the community on the effectiveness of CHF in promoting community health?

(ii) What is the perception of the community on the effectiveness of CHF in promoting community health?

(iii) Is the Kwimba community involved/participated in CHF decision making and management.

(iv) What preferences does the community have regarding the provider of health services?

1.5 Rationale for the Study

The study aimed at getting information from community health fund actors themselves. The rationale for the information obtained from this study was meant to serve the following;

(i) Introduce new knowledge on factors effecting enrollment of CHF perceived to the community

(i) Help decision makers to propose appropriate and effective intervention to increase CHF enrollment

1.6 Description of variables

S/N	VARIABLE	MEASUREMENT
1	Enrollment factors	Knowledge
		Perception
		Community involvement
		Community preferences
2	Knowledge	Education level
		Awareness of the scheme
3	Education	All Respondents with primary, secondary and higher education.
4	Awareness	Understanding of the insurance scheme
5	Perception	
6	Community Involvement	Transparency
		Decision making pertaining CHF matters
		Premium settings
7	Community Preference	Respondents interest on health service provider

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 introduction

In the 1970s, the African public health systems deteriorated parallel with the deepening economic crisis. Following this, Tanzania together with many other African countries banned the provision of free health care (Ministry of Health, 2003). In 1990s, the GoT introduced cost sharing and user fees as complementary methods of health financing. In 1994, a health sector reform together with other social reforms conducted in Tanzania. One of the health sector reforms was health financing, the reform directed to look for various health financing mechanisms to cover the gap that could have not been filled by the Government (Ministry of Health, 2003). Community health fund was the only insurance scheme to cover the poor rural majority of this country as it had been proved successful in Ghana among other countries. Establishment of the Community Health Insurance (CHI) in Africa must be seen in the context of large majorities within the population trapped in poverty and excluded from formal social security systems. The African CHI movement was started out of a concern to either improve access to healthcare for a greater proportion of the population, or to ensure a stable source of income for healthcare provision, or both (Soors & Devadasan, 2010).

Community Based Health Insurance (CBHI) has emerged in developing countries as a response to the existing challenges in the health financing system which include low economic growth, constraints on the public sector and low organizational capacity. CBHI is a mechanism whereby community members (households) finance or co-finance costs associated with health services, allow greater community involvement in the management of community financing scheme and organization of health services (Carrin & Guy, 2005)

CBHI schemes has been seen as a way forward for universal health coverage due to the recognized obstacle that prevail in the tax financing and social health insurance, particularly in the less developed countries (LDCs).

The problems with tax financing are thus, small tax base and large informal sector, weak income and dependence on donors. Also, social health Insurance particularly CHF insurance scheme as reported by various scholars, creates a number of challenges coming from the design, enrolment, servicing and sustainability (Medicus Mundi Schweiz, 2009). Despite these problems ,CHF insurance schemes are seen as an appropriate alternative for extending insurance coverage in low–income countries especially among rural people engaged in the informal sectors (Allegri, 2006).

2.2 The Concept of Community Heath Financing

Finding a way to finance and provide health care for the rural poor in African countries is one of the greatest challenges facing governments and other development partners. In Tanzania, health care is primarily financed through government taxation and donor support. Other financing mechanisms include the National Health Insurance Fund (NHIF), social health insurance benefits from the National Social Security Fund (NSSF), private health insurance, user fees (out of payment expenditures) and the Community Health Fund (CHF), (Community Health Fund Act, 2001).The Tanzanian health financing system and its mechanisms are addressed in detail in various government documents, such as the CHF Act 2001, the Health Sector Strategic Plan (HSSP) III 2009 – 2015 and the National Health Policy of 2007 (Ministry of Health and Social Welfare, 2010). The CHF Act of 2001 allows for community contributions in the health sector in order to achieve universal health coverage and address issues of equity in health care services by removing payment hardships.

In 1995, Tanzania introduced the voluntary Community Health Fund (CHF) with the aim of ensuring universal health coverage by increasing financial investment in the health sector.

The CHF is a pre-payment scheme where members make small payments at regular intervals to decrease the risk of large payments in healthcare fees if a household member becomes ill. The CHF Act of 2001 stipulates that each district sets premiums depending

on the local economy and benefits are limited to dispensaries, which are at the lowest level of care (Community Health Fund Act. 2001). Membership is voluntary and lasts for only one year, but can be renewed. The scheme is limited to 6 core family members. Since 2001, the Local government has been required by National Health Policy to take care of the vulnerable population segments such as those over the age of 60, the very poor, the disabled, the chronically ill and orphans (Ministry of Health and Social Welfare, 2003).

2.3 Objectives of CHF in Tanzania

Following the economic recession of 1970s and 1980s the Government of Tanzania experienced financial hardship in providing free health care services to all communities hence health services deteriorated, in addressing this shortfall, the government reformed the health care financing systems by introducing the user fees in 1993 (Ministry of Health and Social Welfare, 2003). Subsequent introduction of other health financing schemes resembling prepaid insurance for instance the National Health Insurance Fund (NHIF): the CHF and its urban equivalent TIKA (Ministry of Health and Social Welfare, 2003) and various Micro Health Insurance Schemes (MHIS) such as Umasida and Vibondo. More recently, the National Social Security Fund (NSSF) introduced a health care benefit package known as Social Health Insurance Benefit (WHO, 2010).

The CHF started in 1996 as a pilot scheme in Igunga district which was later expanded to other councils with the expectation of covering the whole country. The scheme endeavor raising supplementary funds and improve access to health care for the poor and vulnerable groups in the rural areas (Community Health Fund Act, 2001).

The CHF is a form of pre-payment scheme designed for rural people in Tanzania**;** community members who do not participate in the CHF scheme have to pay the out-of-pocket expenditure as user fees.

User fees have negative impact to the poor people as increases the burden of diseases especially when individuals fall sick and postpone to seek for health care because of the expenses of treatment (Lekashingo, 2012).

In addition, an individual can fall sick at a time when cash is unavailable and hence end up with severe suffering. Being a member of CHF poses the best alternative to keep the poor people to suffer from financial catastrophe. However, according to various studies conducted on CHF enrolment and implementation the results shown that the poor are excluded and suffer the consequences (Kamuzora and Gilson 2007).

CHF resource mobilization are based on the concept of risk sharing whereby members pay small contribution on a regular basis to offset the risk of needing to pay the larger amount in health care as user fees when they fall sick. According to the CHF Parliament act no.1 of 2001, the objectives of the CHF are; (a) to mobilize financial resources from the community for provision of health care services to its members. (b) To provide quality and affordable health care services through sustainable financial mechanism; and (c) to improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health (Ministry of Health and Social Welfare, 2003).

2.4 Operation of the Community Health Fund

The CHF is a voluntary prepayment scheme meant for rural people employed in the informal economic sector, all contributing members issued with a membership cards. The council consults with community members about the contribution to be paid by each household and each household pay the same amount of membership fee as agreed by members of the community themselves, and is given a health card which lasts within a year (Community Health Fund Act, 2001).

The card entitles the household to a basic package of curative health services throughout the year. Normally, coverage is for the household head and other household members up to 6 (*Allegri, 2008*). Households that do not participate in the CHF scheme are required to pay user fees on an individual basis at the health facilities at the point of use (Community Health Fund Act, 2001)

Tiba Kwa Kadi (TIKA) is an urban community based health insurance scheme equivalent to CHF and is similar in design. It is mainly intended for urban and peril-urban districts and membership to this scheme is on family or household, as well as socio-economic groupings. Members of the household pay flat rate contribution fees to the scheme, the intention of the scheme is to increase community participation through the generation of additional resources for health facilities (Oriakhi&Onemolease,2012).

Implementation of an improved CHF scheme "CHF iliyoboreshwa" (Improved CHF) which had purchaser–provider split, strong insurance management information system (IMIS), active enrolment at village level, portability of membership, and cross district reimbursement approaches proved successful (Medicus, 2009). The results showed that the enrolment has increased up to 20% by august 2013 but the increased enrolment might be because it was a new project as it was in Igunga. Likewise, CHF plus scheme in Tanga expressed different suggestion in the operation and management. Different stakeholders such as CHF promoters and CHF agents, had slightly related roles which lead to increasing community participation in the CHF scheme (Practitioners, 2006).

The issue of each family member being provided with a portable identity card is a priority which is well stipulated by the CHF act no 1 of 200(Community Health Fund Act, 2001). It is a task of WHC to sensitize the community members to join the CHF, However, the improved CHF project conducted in Dodoma came up with recommendation of employing special officers specifically who should be dealing with enrolment.

Still, there is no evidence whether the existing structural design fail due to absence of enrolment officers as the WHC among other things responsible with sensitizing community members to join CHF scheme.

Currently, CHF is managed by NHIF since 2009 under the Memorandum of understanding (MoU) for 3 years. The new management of CHF can be understood as practically not possible since the legislation is not yet modified to allow the NHIF to take control over the management of CHF in the whole country. NHIF not yet embedded within district

management structures as CHSB does not include NHIF staff (Community Health Fund Act, 2001,Medicus, 2009, Practitioners, 2006)

2.5 Enrolment and Coverage

Low enrolment is amongst the biggest problem facing CHF insurance scheme in the Sub-Saharan African countries , it was suggested that increasing enrolment needs strategic plan to involve the community to participate from the scheme design and implementation earlier from the beginning (Mulligan, 2007). The literature shown that, setting the premiums in accordance with the ability and willingness to pay has significance impact in raising enrolment coverage in the scheme (Basaza et al., 2007).

As the mandate of setting the premiums and exemptions are vested under the WHC at ward level, scholars has reported the importance of handling the premiums carefully as can have an impact to the community to participate in the CHF scheme (Community Health Fund Act, 2001)Contrary, some results showed that if the premiums are set according to the ability and willingness to pay as suggested among different researchers, may fail to reflect the reality of the services to be rendered to its members especially when premium set too low (Kuwawenaruwa, 2011).

As a results, poor/inadequate health care services and eventually disrupts the community from rejoining the scheme (9). Group enrolment in CHF and creation of buffer stock was among the local organizational initiatives carried out by Tanzania Germany programme to support health (TGPSH) in two regions Tanga and Lindi, For example, the Districts of Lindi and Tanga regions where this programme was implemented enrolment raised up 20% (Tanzania Germany Programme to Support Health, 2014). Despite that the existing structural design allowed different stakeholders to involve in management of CHF, enrolment has remained unpromising 7.9% (10) (Tanzania Germany Programme to Support Health, 2014). An author has concluded that reaching the target of 30 % by 2015 is unachievable. Little has been done to assess community members' perception to CHF

and participation in the local organization and implementation of the CHF insurance scheme, therefore this study will provide insight in enhancing enrolment coverage.

2.6 Factors Affecting Community Health Fund Enrollments

Different studies and reports have suggested the factors affecting enrollment in the community health fund at different levels. In 2003 the Ministry of Health and Social Welfare suggested possible factors at regional level to be lack of commitment by some regional and district officials, inadequate follow-up from MOH, lack of capital for initiation of schemes, lack of uniformity for premiums, inadequate of mechanism for continuation of membership and unclear referral mechanisms (MOH,, 2003).

Chee et al. (2002) in the evaluation of the Hanang CHF argue that there are some weaknesses in CHF financial management and information systems especially in the operation at the WHC. An important question is whether facility staffs (who are often left with the day to day management of the scheme) have the financial and management capacity to handle the fund in addition to delivering services to patients. Lack of knowledge, capacity and experience in community mobilization and financial management are among the factors that have hindered the implementation of CHF in other councils (MOH, 2006).

According to Later veer, et al (2004), districts are not clear on CHF management rules and procedures and they reported that there was mismanagement of CHF funds in about 27% of CHF implementers. In other instances they found CHF funds were not utilized and hence remained idle at the district level.

There also appear to be problems in conducting regular audits despite the CHF Act of 2001 insisting that schemes employ competent and qualified auditors to audit CHF accounts (URT, 2001). An assessment by the Ministry of Health showed that not all councils conducted regular audits or reported to community members (MOH, 2003).

A recent cross-sectional descriptive study conducted at Magu, found that the enrolment had fallen to 0.08 % since the establishment of CHF in 2003.Among the reasons provided by respondents include lack of information pertaining CHF and poor knowledge on the scheme (Marwa, 2012). Similarly, high membership fees set by some council are also were barrier to enrolment. For instance, the MOH, CHF Facilitative Supervision report noted that Karagwe had proposed an annual fee of 30,000 Tshs per household to those currently paying 15,000 Tshs, a figure already above the average in comparison to much other district council contributions.

A cross sectional exploratory study conducted in Bagamoyo had the objectives to explore the effects of coexistence of user fees and Community Health Fund scheme, quality of care and utilization of health services on CHF enrolment, non-enrollment and drop out. The results shown a direct association between poor referral mechanism and poor quality of services were the major factors for falling enrolment as it was reported that the enrolment was at 2.5% only(Lekashingo,2012).

Several scholars found that, low income and income unreliability has influenced low enrolment. For example, 60% of richer households in Igunga district joined the CHF scheme compared to 33% of the poorest households (Msuyaet al., 2007). Other reasons include inadequate information due to insufficient sensitization to the community; introduction of NHIF which took out public servants who were potential members of CHF, non-coverage of referral care; perceived poor quality of health care services at public health facilities. Similarly to what other reports which has reported poverty, limited coverage package of the scheme has made many individuals not to decide to join (Worfe, 2010).

Low out of pocket, user fees set to some of the district has also been reported as one of the factor for low enrollment, as it gives no incentive for community members to join. Mhina gives an example of Nzega district, where the user fee was set from 1,000 shillings per visit hence many members opted to pay user fee rather than higher CHF premiums (2005). But this was somehow contrary to the part of farmers where they usually receive

their income annually, it is better for them to pay premiums when they sell their crops at once for the whole year. For stance in Hanang district the average visit per CHF house hold members were 32 (Chee, Kapinga, 2002), whereby simple arithmetic shows payment of yearly premium of 10,000 Tanzanian shillings which is more beneficial than paying user fees over the counter.

A variety of factors influence people's decision to join the schemes given the voluntary character of CHI. Affordability of premiums contributions is often mentioned as one of the main determinants of membership. Some of the WHO studies had addressed the issue of affordability. For instance in the Nkoranza Scheme in Ghana ,the estimated cost of contributions varied from 5% to10% of annual house hold budgets (Atims, 1998).It was therefore recognized that such contributions could be a financial obstacle to membership.

The technical arrangements made by the scheme management may influence people's perception of personal benefits. One example is the unit of enrolment. In the WHO Study, almost half of the scheme surveyed had the family as the unit of membership, a measureintroducedtoavoidtheproblemofadverseselection.IntheRwandanProjectStudy, large households with more than five members had a greater probability enrolling the CHI than others did (Schneider, & Diop, 2001).

The explanation given is that contributions were kept flat, irrespective of households is up to seven members; the average contribution per household member was there for less than for smaller families, inducing greater enrolment.

An innovation study on CHF done in, 2009 revealed the strength owing to high enrolment was due to the commitment of decision-making bodies like CHSB and CHMT, dedicated and willing coordinator with ability to handle data and prepare claims for health facility level (HF) reimbursement. Also possessing ability to keep record of enrollees for quick settlements of claims raised by HFs the matching funds from the central government, district setting aside buffer stock to ensure continuous supply of medicines and drugs (Stoermer 2012). Perception on the organization and implementation of CHF scheme has significance impact in raising enrolment in the scheme or otherwise this could lead to drop

out rapidly if the quality of care does not reach their expectations (Marwa Kessy Mushi 2013).

To some other researchers finds that lack of information due to insufficient sensitization to the community has effect on the enrolment of community health fund (Mhina, 2005), but somehow contrary to what has been found in Hanang District, the knowledge of CHF program was relatively high but the enrolment was still low, (Chee, Smith , Kapinga,2002). In Songea also, despite the fact that CHF and user fee knowledge were almost the same (94.4% and 93.2% respectively) most respondents (81.4%) used user fee in financing their health care consumption and it was the most preferred health financing mechanism (38%) followed by CHF with 30.5% (Hussein et al., 2005).

Likewise, perceived poor quality of health care services at public facilities (drug availability and inadequate service provision) was another factor that affected enrollment of community health fund (Mtei, Mulligan, 2007). It is well known that most pubic owned facilities provide poor quality care, characterized by inadequate human resource, and lack of drugs and equipment.

Quality of care might not have a greater impact in the community health fund enrollment if district involved private for profit and mission facilities as service provider for CHF members as suggested in the CHF design document (Community Health Fund Act,2001)this can also create challenge for pubic heath facility in their quality of care. Some of the factors that influence enrollment of CHF are rapid recovery, good health personnel, good drugs and anice welcome at the health facility is also the most important features of quality. This was determined in evaluation of the Maliando scheme in Guinea Conakry (Criel&Waelkens,2003). When members and non-membership were asked about factors contributed to enrollment they highlighted lack of quality of care as the most important cause of non-enrolment.

According to Mhina (2005) introduction of NHIF which took out public servants as the reason for decline in the enrolment of CHF, although it's clear that NHIF (which is mandatory for public health servants to join) is a challenge for CHF due to large Number

of Civil Servants living in districts where CHF is implemented. However in Nzega where the author did his research, the attainment of the expected enrolment of (30%) was not possible (Shaw,2002) even before the introduction of NHIF.

In Hanang the CHF enrolment fell from 23% in 1999 to 4% in 2000, two years before NHIF enrolment started. This significance cannot be explained by introduction of NHIF. The challenges posed by the introduction of NHIF however, is worth mentioned because for instance by 2001 in Kilosa district, (48%) of the renewing member in the CHF were government employees, NHIF being a mandatory scheme for civil servants, CHF has to develop strategies to increase enrollment for non-government employees and those in the formal sector (Kihombo, 2004).

According to Sinha et al.(2006) and Ito and Kono(2010),Education level in developing countries context may be a an important determinant of uptake community health fund as insurance, that the level of understanding among the target members (which might be related to education) of insurance schemes have positive significant effect on uptake rates, also other researchers for stance Schneider and Diop(2001) and Chankova (2008) find that to the households that are headed by a person with formal education are a more likely to join insurance (CHF) than others.

Shaw (2002), argued on the reasons for low enrollment of community health fund members and came up with low user fees set in public facilities as these give little incentives of community members to join the alternative health financing systems like community health fund .User fee in some councils for instance Nzega are set at 1,000 shilling per visit at health center level and many of community members are willing to pay these small user fees amount rather than the higher CHF premium amount (Mhina 2005). Likewise, high membership amounts set by some of the councils in Tanzania are likely to be a barrier to enrollment, for example MOH CHF facility supervision report noted Karagwe is proposing an annual fee of 30000 per household to those currently paying 15,000 shillings a figure which already above the average in comparison to many other district councils contributions (MOH, 2006)

Recent quantitative research has shed more light on enrolment decisions: (a) knowing peers that claimed, an informal trust-building factor, is the most important in explaining uptake of micro insurance (Morsink &Guerts, 2011), (b) households having higher ratio of sick members are more likely to purchase insurance, explaining the existence of adverse selection and ex post moral hazard (Ito &Kono, 2010), (c) insurance literacy has no impact , but marketing treatment (that alleviate the potential financial barriers to entry) has a positive association with the take up decisions of households (Bonan et al., 2012).

Community participation is one of the key ingredients of an empowered health system (CHF), which leads to a successfully and sustainable operations (Allegri 2006, Reid 2000). Community participation is all about engaging the community to participate in the development of the policies that affect their life and the primary goal of CHF was to involve the community to participate in resource mobilization, allocation and utilization at the community level (CHF Act 2001, mohsw 2013).

The study conducted by Mubyazi showed that health programs which had less involvement of local communities from early stages ended up with failures. Also highly involvement of community in the program implementation has been acknowledged making programs sustainable and successful (Mubyazi, Hutton 2012). The author concluded that, the issue of accountability to the members representing the community was of great concern.

Similarly, lack of knowledge and experience in community mobilization and financial management was reported to be hindering the implementation of CHF scheme. District officials seemed to have limited awareness on fund management procedures as 27 % of the implementers of CHF scheme revealed so (Masau 2004, Mulligan 2007).

Some authors, found that members of the scheme had never been invited to meetings to discuss the benefits and management of the programme, or been informed about how the CHF funds were utilized (Steinwachs,2000). Similarly, other studies found that community participation can be facilitated through “Willingness to Pay” These studies help to provide an understanding of the willingness of the community to participate in

CHF scheme and how much they are able to contribute (Steinwachs 2000, Kuwawenaruwa 2011, Consultant 2011). This, in turn, may persuade higher enrolment as the contributions can be set in accordance with ability to pay.

However, some authors had contrary idea on the payment of premiums that rely on community members' ability to pay rather the author recommended that the payment of premiums be oriented from actual calculations (Stoermer 2012). Some efforts that have been done so far were to empower the community to participate in decision-making and implementation of the program in an efficient and sustainable way.

On the other hand community involvement in the management of any project builds a sense of ownership of a particular project to the people. CHF schemes should be potential means to empower communities in making health care decisions and promoting cost sharing with local participations (Meshack 2013).

The study which was conducted in Hanang where opposite to this idea where CHF members where in the ward visited had had never been invited or attended a meeting of CHF members and did not know how CHF was managed (Wilongela 2010). Failure to disclose expenditure of locally raised CHF funds raises doubts among the community confidence to the ward and district CHF managers, in this study Kamuzora quoted one of the community respondent in Focus Group Discussion explaining about the accountability problem by saying " we do not know what is happening. No financial report has ever been given to us" (Paper, Chuma, Mulupi ,Mcintyre 2013).

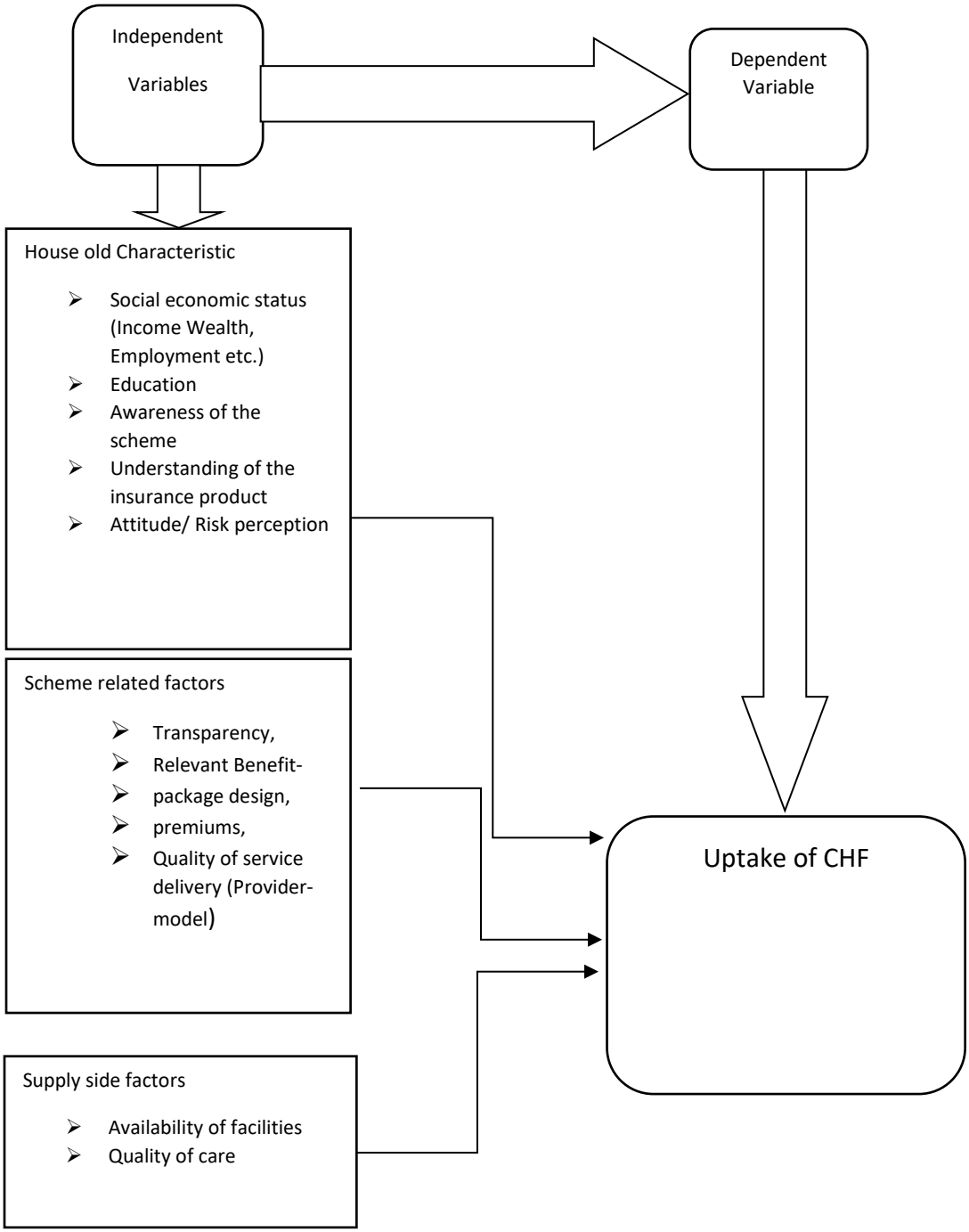
Last but not least, risk attitude of the households is another factor that influences households' enrolment in the Community Heath Fund (Kamuzora & Gilson, 2007) and (Preker, 2004). It is argued for the developing countries that, individuals and households have low attitude towards health risk and this led few of them to enroll in the micro health insurance schemes (CHF) in this case, in the meantime (Kiwara,2007) had a different view on the issue and argue that in various parts of developing countries, where appropriate mechanisms are available low income or rural households have joined micro health insurance schemes. This suggests that even the low income households can purchase

micro health insurance plans provided that appropriate arrangements for them are available.

A number of scholars have examined the effect of the supply factors, that is, the quality of health care services, the availability of health care facilities and waiting time on the demand for micro health insurance plans in developing countries. Other supply factors that scholars examined include the benefit packages, the insurance plans provide, the degree of freedom to choose providers and the extent of compensation provided by the insurance schemes. It is expected that the above mentioned supply factors also determine households' decisions to purchase micro health insurance plans in this case (CHF). In particular, factors such as the availability of health care services and the benefit packages have a bearing on the household spending on health services in the episodes of illness or injury. In this regard, they also influence the utilization of health care services and the decision to purchase health insurance plans ((Basaza, 2007) and (Johar, 2007).

Sinha (2005), investigated about supply-side barriers relate to schemes' design and management (for example, lack of clarity among scheme staff regarding the scheme's rules and processes and requirements that claimants submit documents to prove the validity of their claims) to accessing benefits in a community-based insurance scheme which affect take-up decision in the scheme

Figure 2.1: Conceptual framework



Source: Researcher's own construction 2014.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

In conducting this study, the researcher had to decide of what, where, when, how much, and by what means to inquire on factors affecting enrollment of CHF members. This is what constitutes a research design. A good research design includes; the nature of the problem, the objective of the study, the means of obtaining information, the availability and skills of the researcher, and resources availability. A cross section study design can be defined as the study of the existing cases at point in time .Ina cross section design, one set of observation is done for every unit in the study at a certain point in time regarding the length of time of the study as a whole (Kothari, 2004).

3.2 Research Design

Cross sectional design was carried out from July 2014 from the households in Kwimba district by using questionnaires and interviews which were translated in to Swahili language. The design was chosen due to its ability in determining the relationship of one variable and other in the study population at one point of time and also favorable as it was inexpensive in terms of financial and time effectiveness.

3.3 Area of the study

The study was conducted in Kwimba district Council. Kwimba District is one of the eight (8) districts in Mwanza Region, Tanzania. It is bordered to the West by the Misungwi District and to the North by the Magu District. The majority residents of Kwimba are Sukuma from the Sukuma tribe who actually speak Sukuma and Swahili languages. The main economic activity is subsistence farming of rice, sweet potatoes, cassava, maize and livestock keeping.

Kwimba district council was suitable for this study because; firstly, enrollment of CHF members in Kwimba district has been low. Secondly, such study had never been carried out before.

Thirdly, the researcher himself works in this council thus this study was less expensive in terms of accommodation, transportation and other costs.

3.4 Targeted population

The term population can be defined as large group of items or people from which the sample is taken. The term population is synonymous to universe (Kombo, 2002). In the process of inquiry, the researcher in this study involved; members of household who are CHF members and nonmembers, district CHF coordinator, the District medical officer, WHC's and facility health care providers.

3.5 Sample Size and Sampling Techniques

3.5.1 Sample Size

Sample size is a small group of respondents drawn from a population about which a researcher is interested in getting the information so as to arrive at a conclusion Kwimba district council has a population of 406,509 (National Bureau of Standard, 2012). It was difficult to involve the whole universe in this study because the larger the sample would have been employed the higher the cost would likely have been incurred.

A total of 203 respondents were included in this study, among them96 (47.3%) of 203 (100%) were CHF members and 96 (47.3%) respondents were non CHF members, which altogether formed a total of 192 (94.5%) of 203 (100%) people. 5 (2.4%) of 203 (100%) respondents were Ward health committee members, 4 (2%) of 203 (100%) health care providers, 2 (1 %) of 203 (100%) were the District medical officers and the District CHF coordinators respectively. The summary of the population sample size and composition is presented in Table 3.1

Table 3.1: Sample Size

NO	RESPONDENTS	NUMBER	PERCENTAGE
1	CHF Members	96	47.30%
2	Non CHF Members	96	47.30%
3	Ward Health Committee	5	2.40%
4	Health Care Providers	4	2%
5	DMO & DCHF Coordinator	2	1%
	TOTAL	**203**	**100%**

The researcher used formula designed for cross sectional studies to get minimum sample size for CHF members and non CHF members in the study which was 48, but then he multiplied the sample two times, the aim was to get participants twice the minimum sample size for each group to increase the power of the study which became 96 heads of the CHF household and 96 head of the non CHF household, the remained research groups were purposively selected as key informants.

3.4.2 Sampling technique

Two sampling techniques were used to select respondents in this study; firstly, Purposive sampling was used to select the District Medical Officer (DMO), District CHF coordinator, WHC's and health care providers. Secondly, multistage stage sampling employed to select 192 (47%) for household members and health care providers. The followings were steps used to enroll participants at household level.

a Stage one: From the district, wards were divided into urban and rural and the aim was to get participants from both urban and rural areas.

b Stage two: After division of the wards basing on rural and urban location, two wards one from urban Ngudu and the other one from rural Inala wards were randomly selected.

c Stage three: From each ward, two villages were randomly selected making a total of 4 villages. Within these villages house household were randomly selected basing on ones who were enrolled and non- enrolled ones, where 96 were head of CHF households and 96 were non CHF household making a total of 192 households.

3.5 Data collection methods

3.5.1 Questionnaire

This is defined as a set of questions that a researcher sends to the respondents to provide right information with an agreement of sending them back using a given address. A questionnaire comprises of either open questions or closed questions, or, both as used in this study (Kothari, 2004). By using a questionnaire, the researcher gathered information pertaining to social demographics, knowledge, perception, community participation and preference on CHF enrollment. Furthermore, information related to community perception on CHF servicing and sustainability strategies was collected through open questions.

3.5.2 Key informant (Personal interview)

The discussion was conducted between respondents and the researcher from which some experience were given out through open question by an interviewee and remarks are noted by the researcher for closed question (Kothari, 2004).In this study, the researcher conducted an interview with Ward Health Committee, CHF coordinator, the District Medical Officer, and the facility health care providers. These interviews aimed to gathering detailed information regarding to the community participation in the local organization and implementation of CHF scheme. The conversions were written down and transcribed soon after the end of interviews.

3.6. Data management and analysis

The principal investigator who is the author of this study was responsible for guiding and supervising the filling of questionnaire and checking of all interviews to ensure correctness. Data cleaning and editing was done in the field manually and by the use of computer. The analysis of the data was done by using SPSS version 13 computer programmer.

3.7 Validation and Reliability of Research Instruments

Validation of data collection instruments aimed at establishing indicators that provided evidence that information generated through selected instruments in the research is trustworthy and believable (Mertens, 1998). Mertens 1998) asserts that, validity (measuring the intended one) and reliability (accurate estimate of the target attribute) will be normally used in the quantitative approach. However, in qualitative research, validity stresses on internal consistency and a coherent logic across the study components and reliability focuses on dependability of the data (Punch, 2005). Thus, for the purpose of quality, the study instruments were refined through the comments from the research supervisor, and the researcher himself in the field. The purpose was to make the instruments focus on the purpose of the study.

Pilot testing to establish the reliability and validity of data gathering instruments was conducted in Kwimba district in Mwanza. The responses derived from the pilot study enabled the researcher to redesign some of the research questions for ambiguity clarification and making necessary adjustments. For validity purposes, the researcher used triangulation of the data. In the field, the researcher increased reliability of data by revealing the study purpose to the respondents. Confidentiality of respondents' information was highly regarded and ensured for respondents to freely express their views and uncover relevant information they will be aware of and or they will possess.

3.8 Ethical consideration

Ethical consideration is a condition established for adherence by the Research and Publication Committee of Mzumbe University (MU). The researcher obtained permission to collect data from Kwimba District Council office. Individual respondents were asked for their consent to participate in the study, they were required to sign consent to participate in the study. Respondents were informed that participation on voluntary basis and the right to withdrawal was upon respondent decisions. They were also informed about the purpose of the study and all the participants were assured of confidentiality of

information they provided to the interviewer. Anonymity was assured by not including the name of the respondents on the questionnaire and they were assured that there are no risks involved on participating in the study.

3.8 Limitation of the study

3.8.1 Language barriers

Some participants in the remote areas were unfamiliar with the Swahili language hence, the researcher employed local assistant researchers who were conversant with Sukuma language.

3.8.2 Recall bias

Some of the study participants had problems in recalling their past experiences during the interview; this lead to recall bias in this study. This study addressed these biases by limiting the recall to a maximum of two years. The researcher used prompting technique to make respondents think more about the issues in questions.

3.8.3 Lack of transport

Lack of transport and poor infrastructure especially in remote areas denied researcher and his team access to some areas which were included in the sample

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Sample size and their characteristics

This study had enrolled 203 respondents, from which; 65(32%) of 203 (100%) were female and 138 (68%) males. Respondents from two wards in Kwimba council were involved. Among 203 total respondents; 102(50.3%) were from Ngudu ward, and 101(49.7%) from Inala. Also, the respondents had different education level; 43(21%) did not have any formal education, 92(45.3%) had primary education, 58(29%) had secondary education, 10(5%) had university/college education level. The age of the respondents was been categorized into several age classifications; 21(9%) respondents agedbetween19–25; 96(47%) were between26 – 32, 52(26%) between 33 – 39, 20 (11%) between 40 – 47, and 14(7%) were between 48 – 54, as presented in the summary Table 4.1.

Table 4.1: Sample size and its characteristics

Variables		Frequency	Percentage
Sex	Female	65	32%
	Male	138	68%
	Total	**203**	**100%**
Ward	Ngudu	102	50.30%
	Inala	101	49.7. %
	Total	**203**	**100%**
Education level	Non	43	21.10%
	Primary	92	45.30%
	Secondary	58	29%
	University/college	10	5%
	Total	**203**	**100%**
Age	19-25	21	9%
	26-32	96	47%
	33-39	52	26%
	40-47	20	11%
	48-54	14	7%
	Total	**203**	**100%**
Main economic activity	Business	36	18%
	Peasants	137	67%
	Employed	12	6%
	Fisherperson	10	5%
	Other	8	4%
		203	100%

Source: Field study, 2015

Table 4.2: Trend of community enrollment scheme since Oct 2013 to march 2015

Year	2013	2014	2015
Enrollment	1836	2231	2120

Source: CHF Kwimba DC, 2014

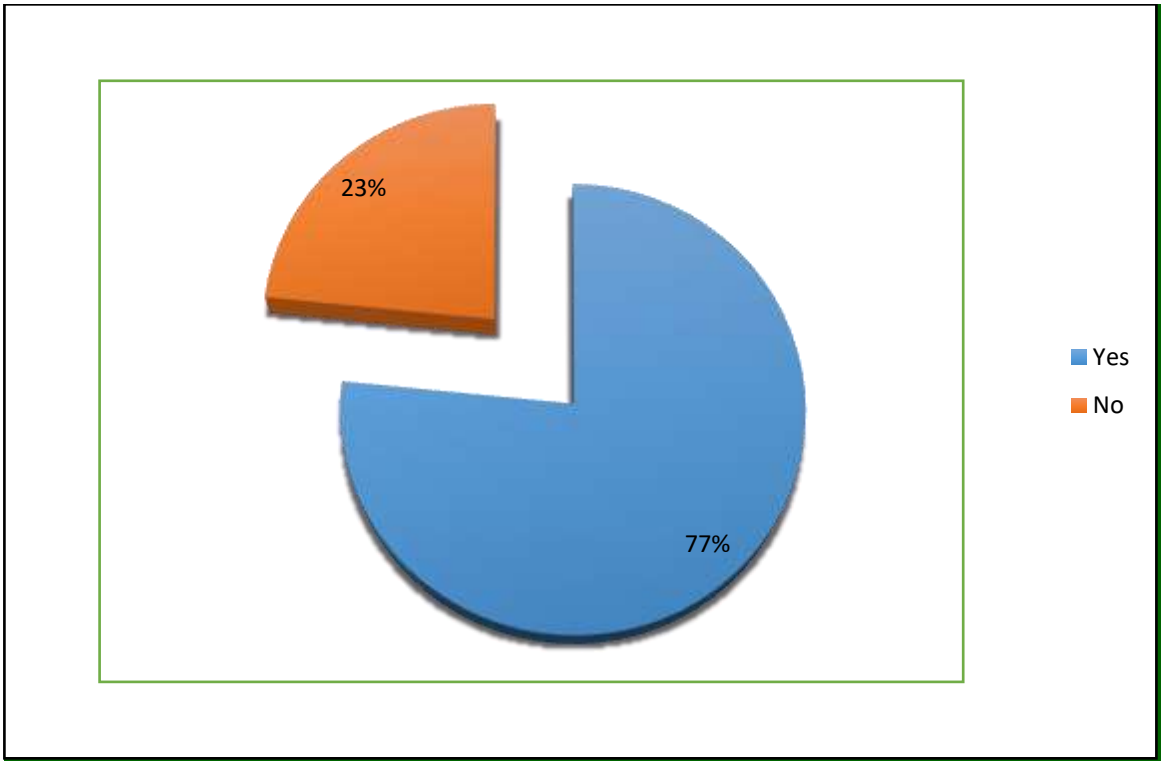
4.3 Research Findings

4.3 Knowledge of community towards CHF benefits

The question to whether the community had the knowledge on CHF was based on not only whether the household had come across the world CHF but also if they knew what CHF is by the list defining its meaning and the benefits of its members.

So then, in determining knowledge of community towards CHF benefits, several questions were asked to the respondents. The responses indicate that, 192 heads of households were tested to represent the community; from which 96 were CHF members and another half (96) were not members of CHF. They were firstly asked if they had heard of CHF. 76.6% (147) of the total households replied *Yes* and 23.4% (45) had never heard of CHF especially for those located in the interior areas. Up to 96 members of CHF and 51 Non-members of CHF replied *Yes* while the remaining 45 respondents who were not members of CHF said had never heard of CHF. Figure 4.1shows the response of all heads of households.

Figure 4.1: Community awareness of CHF existence



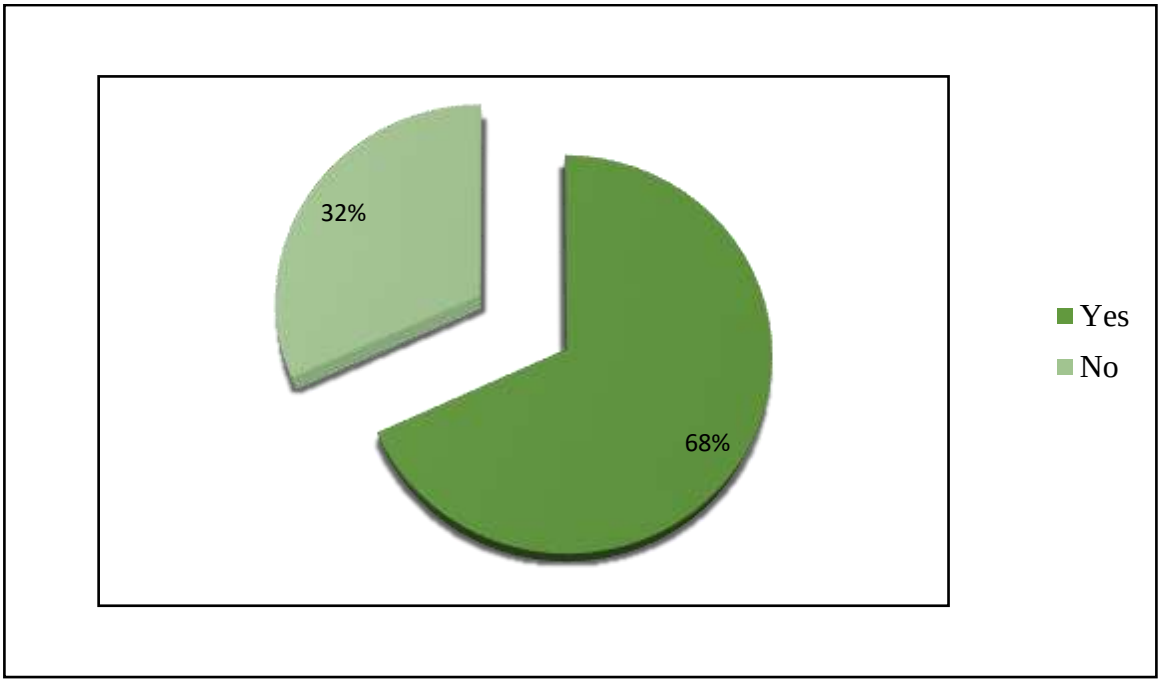
Source: Research data, 2015

However, regarding the knowledge of the community towards CHF, respondents were required to say if they knew the meaning of CHF. The findings revealed that 62.0% (119) heads of households understood the meaning of CHF as an insurance that allows its

members to be treated throughout the year after paying membership fee, 2.6 % (5) said CHF was a means of wastage of money and the rest 35.5 % (6)8 did not know its meaning. All members of CHF (96 heads of households) knew the meaning of CHF where by the other answers were replied by CHF non-members

On the other hand, as clarified in figure 4.2, all 192 (heads of household) respondents were asked to mention at least one or two advantages or benefits of being a CHF member would have compared to a non-members. Up to 61 (31.8%) of respondents said there is no benefit while 131 (68.2%) which most of them were members, admitted being a member has advantages such as being able to access health services (drugs medicine supplies and diagnostics) any time within the year compared to non-members where they might fail to pay for these services at times of bankruptcy, Figure 4.2 explains.

Figure 4.2: Knowledge of community towards CHF benefits

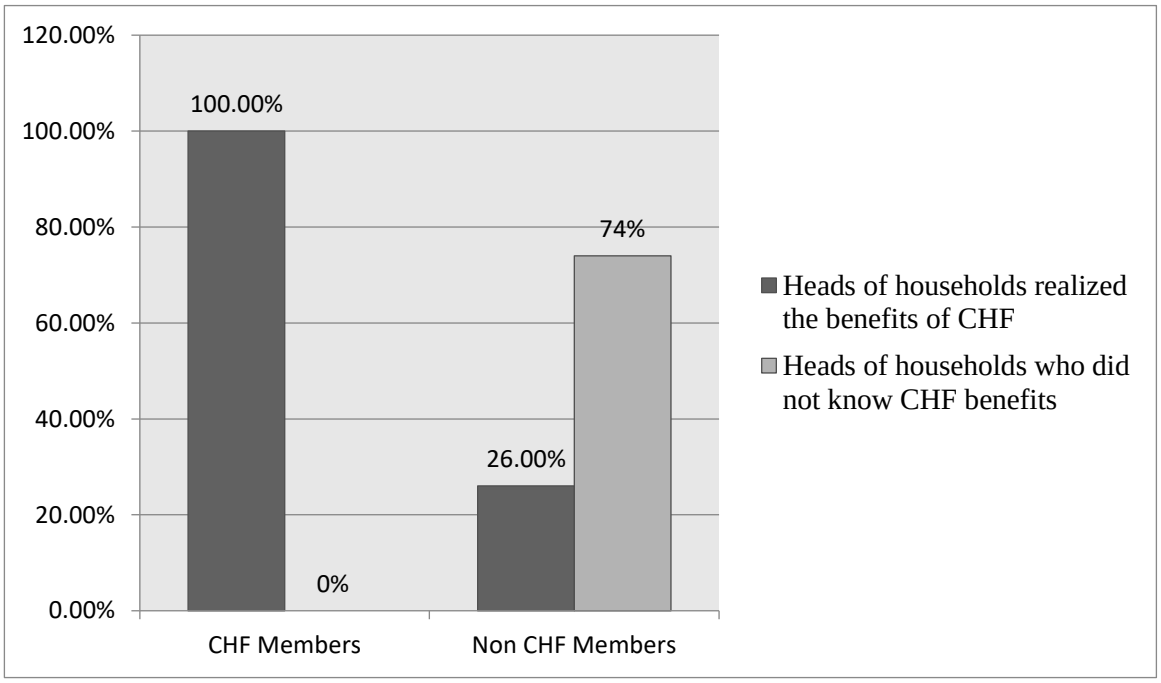


Source: Research data, 2015

From those 131 (68.2%) respondents who realized the benefits of CHF, 96 of the respondents which is about (100% of CHF household) were members of CHF and 35

[26.7% of CHF nonmembers] were not members of CHF. On the other hand non CHF members were also asked on where there are advantages or benefits of being a CHF Members and he answers were as follows, 71 respondents which is about (74%) believed being a member of CHF had no benefit while the remained 25 nonmembers (26 %)said there were advantages of being CHF member as clarified in the chart mind.

Figure 4.3: Community knowledge toward CHF benefits



Source: Research data, 2015

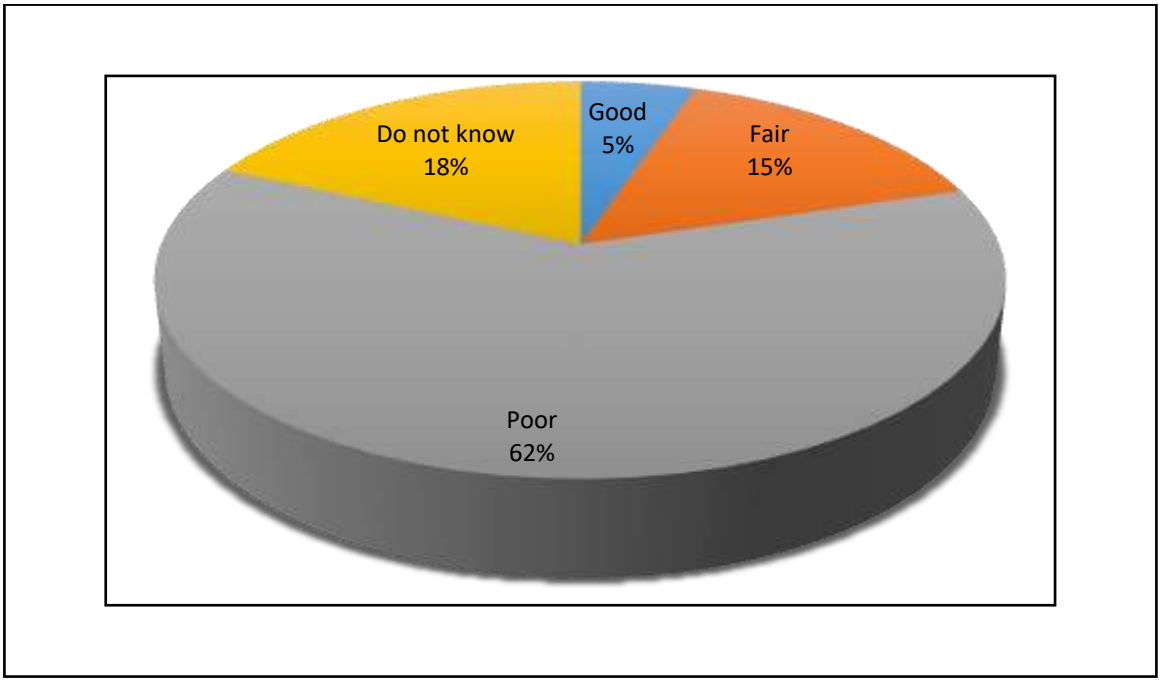
As it may be noted from previous responses, household members who recognized the CHF benefits were first alerted to acknowledge the benefits of the scheme or the gap between the member and non-member without considering the real situation on the ground. These were later on the called to answer more questions about the performance of CHF.

4.4 Perception of the community towards CHF services

The findings on perception of the 192 heads of household discovered that 10 (5.2%) head of the household respondents perceived that the quality of services offered by the CHF

insurance scheme as good, while 29 (15.1%) households leaders perceived as fair. However, 118 (61.5%) respondents perceived the quality of services offered by CHF as poor, whereas the other heads of the households 35 (18.2%) particularly CHF Non-members did not know anything about quality of CHF services. Figure 4.4 shows their responses.

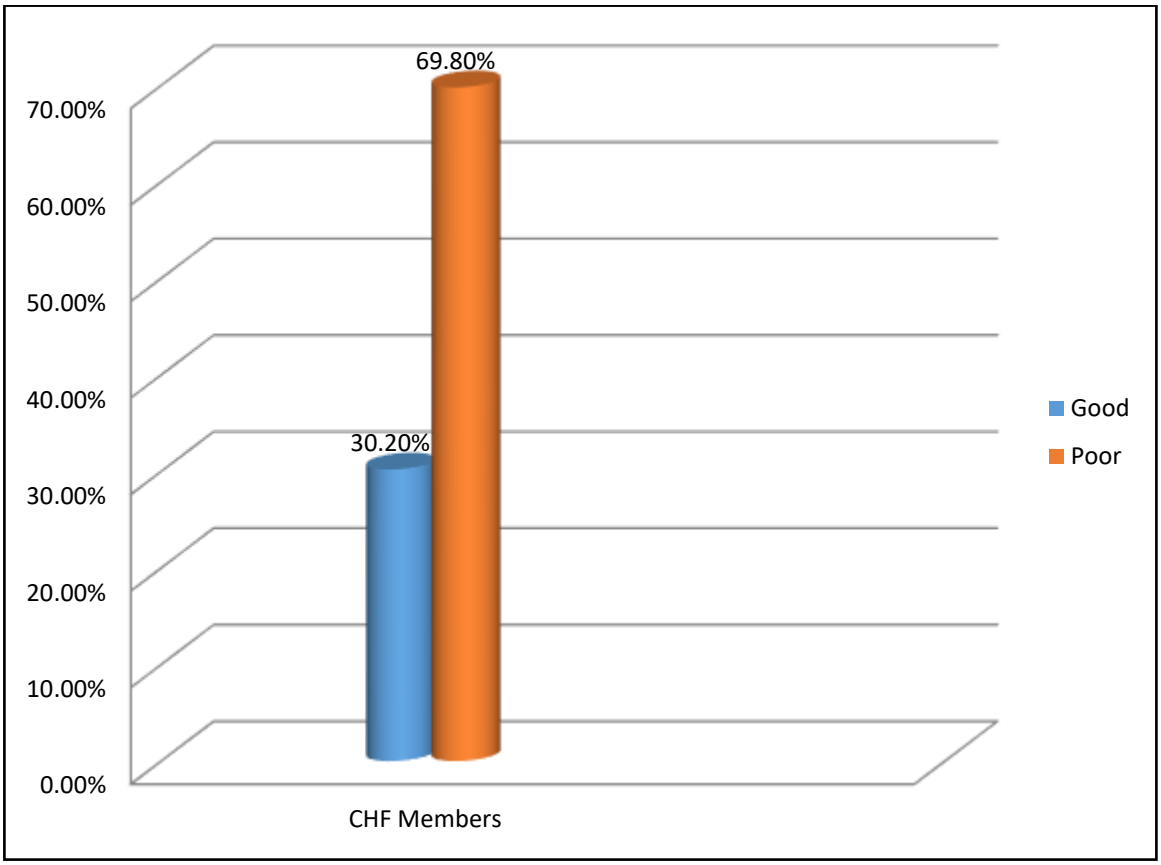
Figure 4.4: Perception of the community towards quality of CHF services



Source: Research data, 2015

Furthermore, 96 heads of households who were members of CHF were interrogated of their perception concerning availability of services offered by CHF such as drugs, medicine, medical supplies, diagnosis, equipment and referral systems; their response show that, 67 of the respondents which translates to 69.8% of the CHF members perceived the availability of services as poor; while 29 of the respondents which is 30.2% perceived the availability of services as sufficient (good) as shown in Figure 4.5.

Figure 4.5: CHF members' perception on availability of services



Source: Research data, 2015

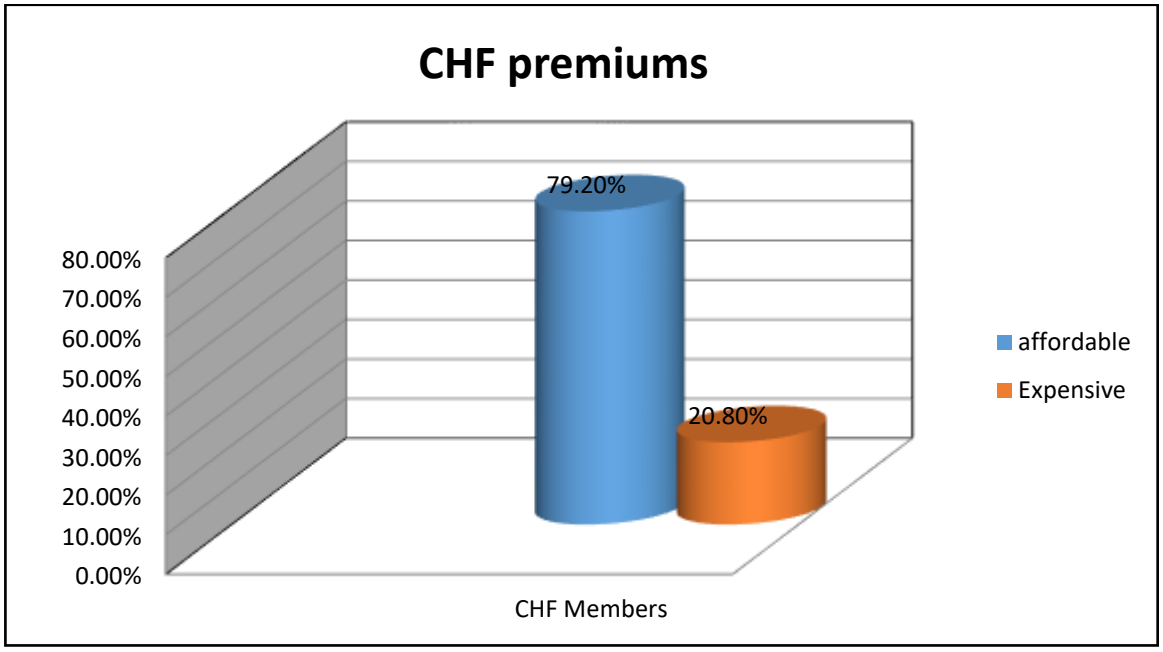
4.2.2.1 Perception of the community on affordability of CHF premiums

The study was set to investigate on the affordability of premiums. To achieve this, the CHF members were asked to respond toward their perception on the premiums. Majority (79.1%) of the CHF members which translates to 76 members said theCHF premiums are affordable. Only 20 members which translates to20.8% of all member claimed premiums were expensive. This is clearly indicated inFigure4.6. In the same view, affordability of premiums to nonmembers were also tasted and the results showed only 29 households members 30%denied they could not afford to pay premium as it was too high that it was worthy yearly harvest. However, the remaining 67 households (70%) agreed that the premiums were affordable.

Findings from interviews revealed the WHC which reported that they would like the amount of premiums be reduced as this would motivate number of people to join the Scheme. They explained the issue of poor harvest due to scarce rainfall which hindered individuals to pay ten thousands rather they commited their funds for procurement of food stuff. This was evidenced through a remark by one member, who said the following;.

> *"Payment of annual fees of 10,000 is very high especially during the year of crop failure most of people can not afford to pay that amount is better if reduced to 5,000 perhaps that could be at least affordable to many people.However, the amount of annual fees was organized without taking into consideration economic status of the community at large, one of the WHC respondent in the FGD confirms this*
>
> *The amount of CHF premiums at our district was set too high,the premiums did not consider the financial difficulties of the community"*

Figure 4.6: CHF members' perception on Premiums

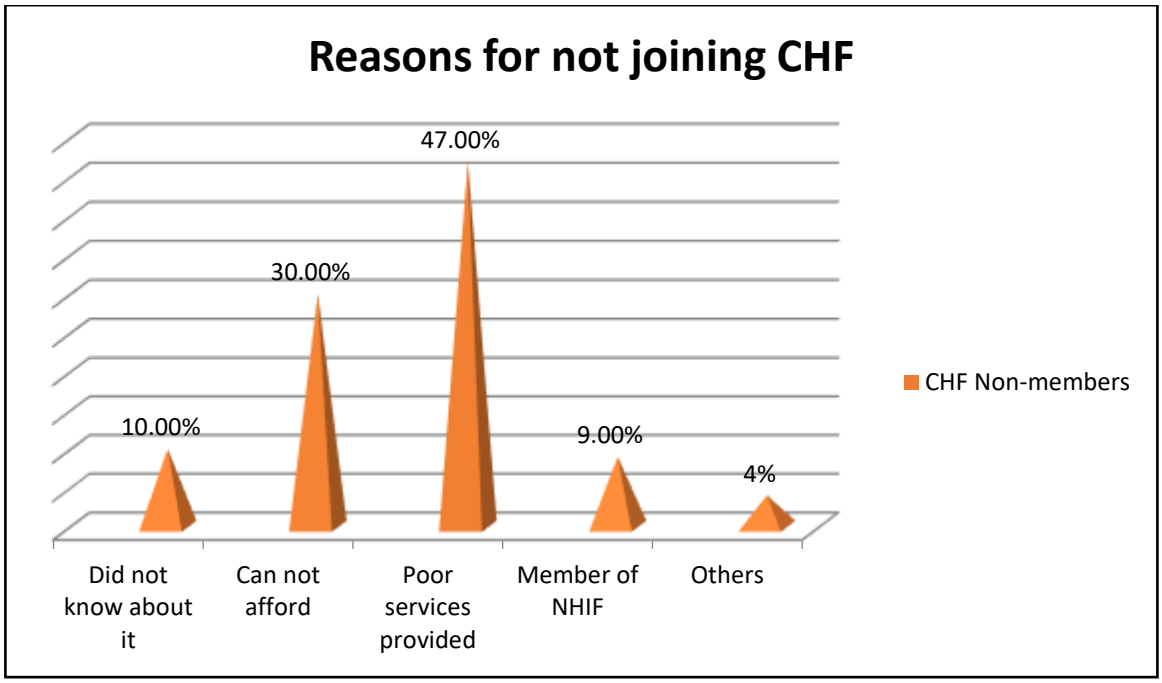


Source: Research data, 2015

4.2.2.2: Reasons for not joining the scheme

The study further sought to establish the reasons for not joining CHF. Up to 96 participants who were CHF non-members were asked to determine the reasons to why they had not joined CHF. The findings indicated that 30.2% (29 households' leaders) of the respondents did mentioned that they could not afford premiums set on CHF as the reason for not joining; 47% (45 heads of households) did mention that they could not join CHF because of the poor services provided (that comprises of shortage of drugs, medicine, medical supplies, medical equipment's, diagnosis and lack of referral services), 10% of the respondents which is about (10 respondents), said that they did not know about the existence of CHF as the reason for not joining, 9% which makes of (8 respondents) they mentioned being member of NHIF as the reason for not joining CHF and 4% of the total respondents which makes about (4 respondents) had other reasons for not joining. The summary for these details is given in Figure 4.8

Figure 4.7: Reasons for not joining CHF Scheme



Source: Research data, 2015

Most of the respondents from rural villages (i.e. Isaga land Sumaha) gave out reason for not joining that they could not afford CHF premiums and not knowing the existence of CHF unlike the respondents from Urban areas with greater percentages i.e. Kakora and Welamasonga where their major reason were poor services of the scheme and other reasons such as being a NHIF member as well as lack of community involvement in decision making.

However, unavailability of drugs, medicine, medical equipment, supplies and reagents, lack of knowledge on CHF benefits in the community, budget deficit for community health promotion in health budgets emerged to be reasons for non-enrolment to CHF. Others include absence of health facilities CHF bank accounts, economic status of the community, enrollment to CHF being a volunteered act and inadequate health staff was reported to be a key reason for the low enrolment in the CHF scheme WHC's and CHF officials (DMO and CHF Coordinator) and facility health providers.

Four major problems with quality of services emerged from the study: shortage of drugs and essential medical supplies; limited range of services provided, inappropriate diagnosis due to lack of diagnostic equipment, especially laboratory equipment and lack of possibility to use health facilities of members' choice and staff related problems.

Findings through the interview with CHF coordinator and DMO indicated the truth that shortage of drugs, medical equipment's and supplies is one of the major reasons for low enrollment of CHF. ,It became evident that the problem is most influenced by the fact that MSD is faced with huge amount credit from the government. With this big load of drugs supply coverage in the entire country yet MSD cannot supply all orders. The other problem is the government exemption policy , this is the policy which enables some community group to access health services for free regardless of the shortage, such groups are elderly people who are poor above the age of 60, mothers , children under five, and other typical disease groups such as TB ,HIV/AIDS and psychiatric. The supply of drugs and medical equipment's is very low and yet some groups access health services for free where it lead to even worth situation where the money paid for health insurance in schemes

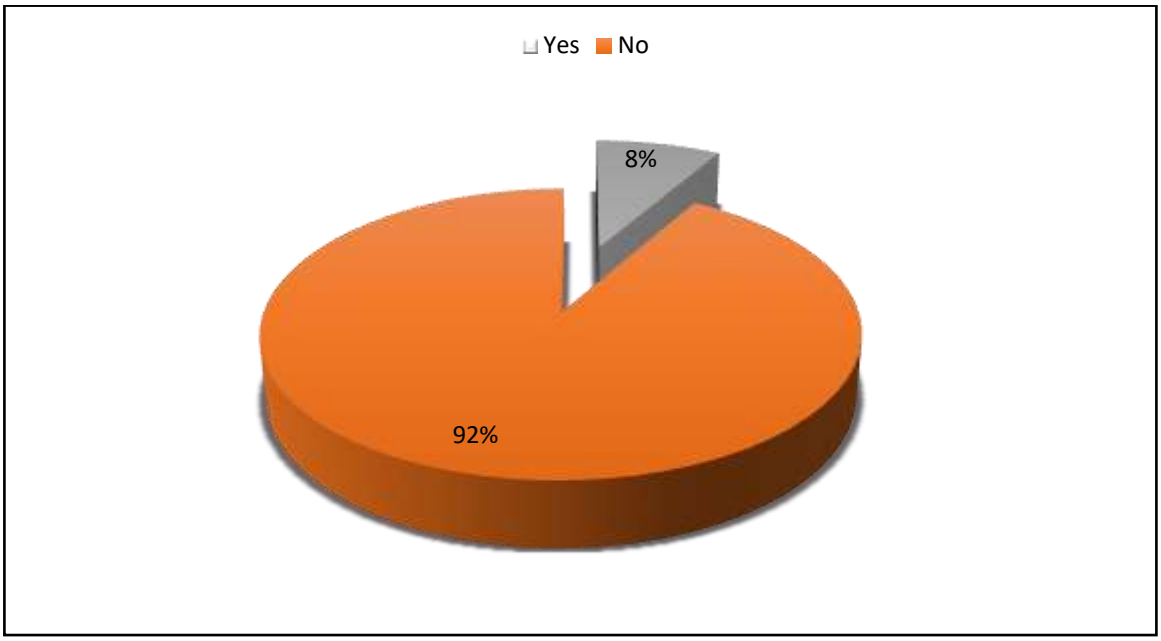
is being used for services for other community exempted groups who either cannot afford health care or belong to special groups as mentioned earlier.

The study observed the lack of referral services covered under CHF as another reason cited by majority members of the household. The results shows that lack of referral services within the district is an obstacle for community to enrollment in the CHF scheme, treatment is confined to one health facility where you have paid your premium, or otherwise you are limited to access health services. The households members discouraged this system where a member could not access healthcare on other facility rather than the only facility where one was enrolled, they suggested that CHF managers should change this system as people could catch sickness anywhere.

4.5 Community involvement/participation in CHF

192 heads of households were asked to respond on whether they thought CHF management involves community on CHF management and execution matters. The results were as follows, only 8.3% of the respondents (16 respondent)sreplied Yes(CHF involves community in management and decision making) while 92% of the total respondents which translates to176 respondents said No (that CHF management does not involve community in its decisions) [see figure 4.8]

Figure 4.8: Community involvement in CHF management and execution matters.



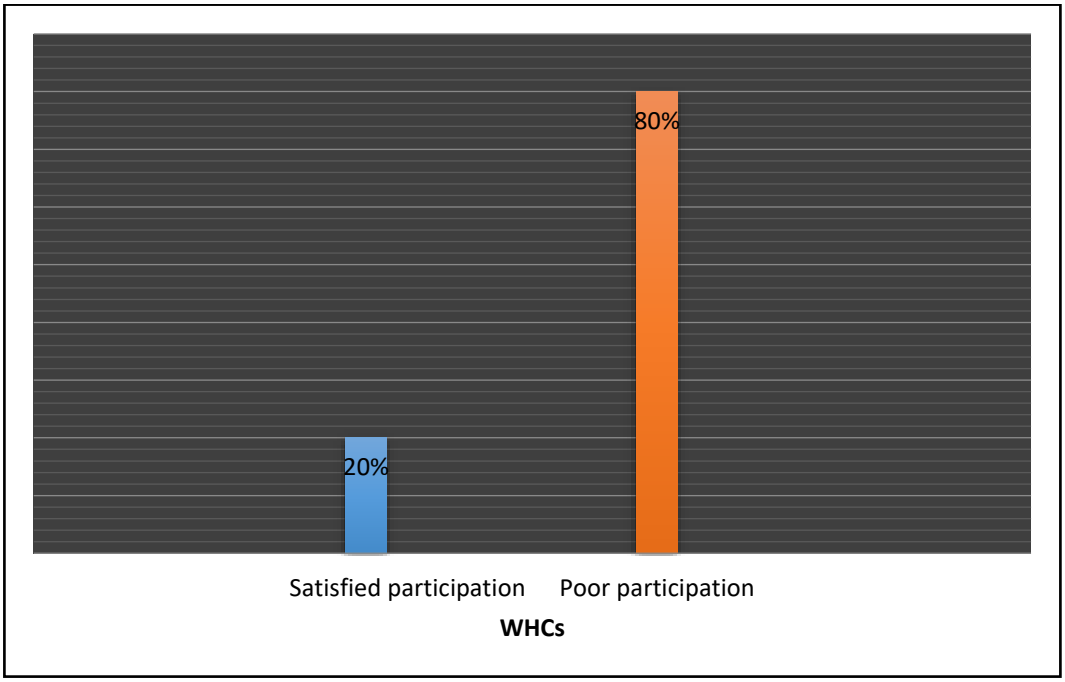
Source: Research data, 2015

The majority of WHC members were reportedly not involved in the local organization and management of the CHF scheme at ward level. Health Committee has been found as inactive in some wards, also reported not to carry out its responsibilities as required by CHF act of 2001. Failure to accomplish their responsibility has led to poor performance of the scheme.

Analysis from the interview shows that the majority of the respondents do not participate in the local organization structure of the CHF scheme at their ward level.

According to analysis from interviews conducted with five (5) WHCs, majority of the respondents (80%) argued that there is poor participation of community in the local organization structure of the CHF scheme at their ward level. On the other hand, 20% of WHCs were satisfied with the participation (Figure 4.9).

Figure 4.9: Participation of community in CHF by WHCs



Source: Research data, 2015

Findings indicated that committee members were not concerned with mobilizing and allocating of the resources at their ward. However, mobilizing the resources and allocating is a potential to improving the local organization structure of the CHF scheme. It is unfortunate in this study as majority (80%) of the members interviewed have been reportedly not involved in organizing this scheme.

Since the committee members were chosen they had never been sensitized of their responsibilities as committee members.

Basically, the CHF guideline addresses the issue of community participation in the local organization and implementation of CHF scheme that could be represented by WHC and HFGC as well as CHSB. Unfortunately, the members who were supposed to represent the community in mobilizing the resources for improvement of the scheme do not perform their functions as required by the guideline.

The interview analysis shows that the district did not promote and support community initiatives. This was revealed by the declaration stated by CHF coordinator of Kwimba district who reported that the district had not prepared any budget to run the WHCs; when one female respondent said; *"the Comprehensive Council Health Plan (CCHP) does not include activities to support the WHC at the ward"*

All (100%) interviewed respondents said that they had never been involved in the local improvement of CHF local structure at their wards. There were no local initiatives taken by the committees in the local organization of the CHF scheme at ward level. Mobilization of the resources through raising enrolment rate has been reported by all respondents that are not often done. Most of the committees' members were not happy with the existing CHF structure as it hindered community involvement in the scheme local organization and management at the ward level.

The study findings also indicated that the community had not been involved in implementation of the scheme. This is to say that, they had taken no efforts in ensuring servicing, enrolment and sustainability of the CHF scheme.

The findings also indicate that, challenges facing the CHF scheme varied among the respondents but majority expressed poor quality of care that was due to lack of drugs, and medical equipment, laboratory equipment, lack of referral services, membership is confined to one health facility.

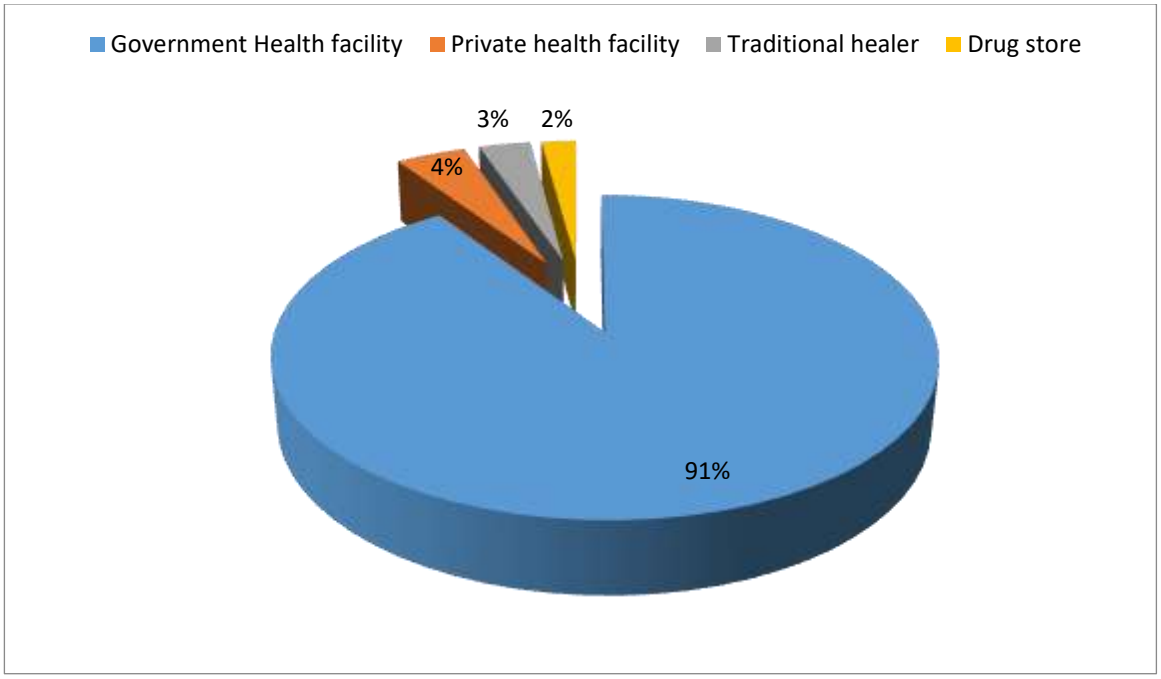
Since, committee members' core functions were not well known to themselves, the results shown that they had not taken any efforts to address them

In a course of interrogation the opinion of the respondents on what should be done to ensure a sustainable CHF, most of the respondent suggested the services be improved by increasing benefit packages, referral services, and members of the scheme be free to be treated anywhere within the district without being disturbed.

4.6 Community preferences on health service providers

Most people at the study area preferred a government health facility as their first choice when they got sick. 174 (90.6%) respondents mentioned government facilities as their most preferred health facilities, while 8 (4.2%) said they preferred to go to private health facility. At least 6 (3.1%) heads of households preferred traditional healers whereas Drug stores were the preference of 4 (2.1%) households' heads. The information is summarized in Figure 4.10

Figure 4.10: Health providers' preferences by heads of households



Source: Research data, 2015

For those who preferred to get their treatment at government facilities, most of them gave the reasons that they provide service at cheap price, the only available facility and that it is near the place they live .Provision of good services was not seen as attraction for many respondents to use government facilities. However, provision of good services was the main reasons for all those who prefer private facilities.

Those who preferred to go to drug stores indicated that they did so because of several reasons including, no drugs at government facilities, they can provide tailor made dose according to your money and there are many choices of drugs

Despite the common belief that the community in Lake Zone preferred more use of traditional medicines and witchcraft during their social and health problems, in this study only 3.1% of the total sample admitted to use traditional medicines as their most preferred service providers as indicated in Figure 4.3.

Table 4.3: Reasons for preferences

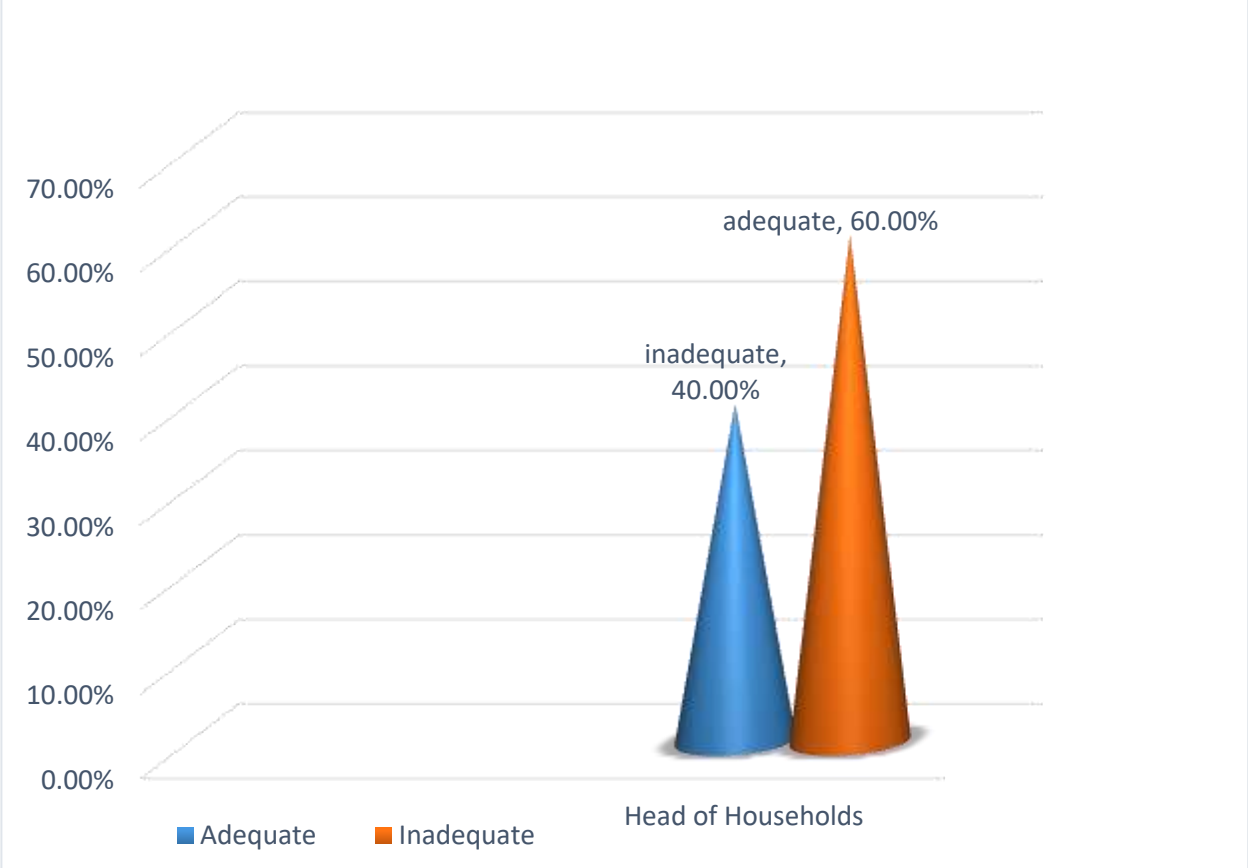
Most preferred health provider	**Reasons for preferences**						**Total**
	Only available facility	**Cheap**	**Near my place**	**Good service**	**Member of CHF**	**Others**	
Government facility	24 [13.8%]	132 [75.9%]	18 [10.3%]				174[100%]
Private for profit				8 [100%]			8 [100%]
Traditional healer						6 [100%]	6 [100%]
Drug store						4 [100]	4 [100%]
Others							
Total	24	132	18	8		10	192 [100%]

Source: Research data, 2015

4.2.4.1. Head of households' enrolment strategies in the CHF scheme

The findings from the current study revealed that few head of household respondents 77 (40 %) perceived the enrolment strategies of the CHF insurance scheme as adequate, while the majority of them, 115 (60 %) perceived that the enrolment strategies of the CHF scheme are inadequate. The summary is also presented in Figure 4.11).

Figure 4.11: Head of household on CHF enrollment strategies



Source: Research data, 2015

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Demographic Information

The respondents in this study had different levels of education for stance 43(21%) did not have any formal education, 92(45.3%) had primary education, 58(29%) had secondary education, 10(5%) had university/college education level. The age of the respondents were categorized into several age classifications as 21(9%) respondents were aged between19–25; 96 (47%) were between 26 – 32, 52 (26%) between 33 – 39, 20 (11%) between 40 – 47, and 14(7%) were between 48 – 54

5.2 Knowledge of community towards CHF Benefits

The findings of the study shows that 62.0% (119) heads of households understood the meaning of CHF as an insurance that allows its members to be treated throughout the year after paying membership fee, 2.6 % (5) said CHF was a means of wastage of money and the rest 35.5 % (6)8 did not know its meaning. All members of CHF (96 heads of households) knew the meaning of CHF where by the other answers were replied by CHF non-members

On the other hand, all 192 (heads of household) respondents were asked to mention at least one or two advantages or benefits of being a CHF member would have compared to a non-members. Up to 61 (31.8%) of respondents said there is no benefit while 131 (68.2%) which most of them were members, admitted being a member has advantages such as being able to access health services any time within the year compared to non-members where they might fail to pay for these services at times of bankruptcy. This reveals that the awareness of CHF benefits in Kwimba district id=s still low comparing to other district in Tabzania for example the study conducted in Iramba the level of awareness was 95.8% (Mwendo, 2001) while in Mufindi district it was found to be 98.7% (Ministry of Health, 2003)

5.3 Perception of the Community towards CHF services

In the current study, the result shows that 10 (5.2%) the heads of households perceived that the services provided by the CHF scheme as good, while 29 (15.1) % of the heads of households perceived that the services provided by the scheme fair. However, 118 (61.5%) respondents perceived the quality of services offered by CHF as poor, whereas the other heads of the households 35 (18.2%) particularly CHF Non-members did not know anything about quality of CHF services.

These findings relate with other many studies for community perception on the services that have direct impact to the individuals to participate in the CHF scheme (Wilongela 2010, Consultant HE 2003). Services that do not meet clients' expectations do hinder continual re-registering in the CHF scheme. This is manifested by a number of individuals dropping each year in the scheme to different places where the involuntary community health scheme operate Lekashingo (2003), Consultant (2003). The major concerns were the services provided to CHF clients that were very poor, lack of referral services and CHF members were limited to only one health facility where they were registered. Heads of household respondents claimed that it could be better if the scheme allow its members to be treated at any health facility within the district. In Ghana, dropouts of the national health insurance scheme gave poor experiences with the public health system as a major factor that contributed to their decisions of not renewing their membership Jehu, (2012). It is important that the concerns raised regarding poor quality of care in health facilities be addressed before implementation of the CHF scheme. Having done with those weaknesses found in this study, community members will appreciate the services rendered by the public health facilities through CHF scheme.

5.4 Reasons for not joining the Scheme

The results of this study has revealed that low quality of care in most of the health facilities is a key reason for the low enrolment in the CHF scheme. Major problems with quality of health care were; shortage of drugs and and essential medical supplies; limited range of services provided, inapropriate diagnosis due to lack of diagnostic equipment, especially

labaratory equipment and lack of possibility to use health facilities of members' choice and staff related poblems.

The issue of drugs were also reported by both CHF members and non CHF members as a major reason for low enrolment in the CHF scheme. CHF coordinator that one of the blame which the community poses is short duration of stay of drugs soon as they have arrived. For the services providers to be trusted with the community they are serving, health service providers should be accountable with the drugs entrusted to them.

Honest and trustworthy may build confidence to community over the health service providers and eventually raise community participation in the local organization and implementation of the CHF scheme.

The majority respondents from Questionaires demostrated that, unavailability of drugs and lack of referral services were main reasons for low enrolment in the CHF scheme. The enrolment in the CHF scheme requires optimal engagement of community in the organization and implementation of the scheme. These findings agree with results from studies done in Uganda where Out of 17 Ishaka scheme members interviewed, 14 pointed out that they do not have any role in the management of the scheme (Basaza, Criel, Van der Stuyft, 2007)

However, this findings are consistent with the results for the study done by Kamuzola where lack of community involvement stated as one of the major reason for low enrolment. For example the introduction of CHF were initiated by the Ministry of health and social welfare but the community did not participate on the design of the scheme (Kamuzora, 2007).

High premium of annual fees, respondents from rular areas in their Questionaires expressed their opinions that the scheme annual fees is relatively high and there is no choice of payment period. Community with seasonal earnings of income would like to

pay their annual fees during the time of harvesting crops that would simplify the payment be affordable to most of the majority of the rural poor individuals.

There was one similarly structured study on the CHF in Hanang district which also employed focus group discussions and semi-structured interviews, the study concluded that the explanation for low enrolment were the inability to pay the subscription fee, poor quality of care, poor education and limited mobilization of community members to join the scheme.

In this study, lack of drugs and referral services comes as the major reasons for failure to enroll into the CHF scheme. The points pertaining to drugs and lack of referral services were major concerns stated by all respondents from Questionnaires and interviews.

The implied meaning is that, to raise enrolment rate in the scheme the health services have to be improved as well as ensuring the community that have to benefit from the scheme should participate in the organization and management of the CHF scheme.

5.5 Community involvement/Participation in CHF

Overall, both Questionnaires and interviews data presented here revealed several that there is low community participation and organization in the CHF scheme. The findings identified for inadequate community participation in the CHF scheme organization and implementation are; lack of incentives, lack of ownership over the scheme, lack of awareness, lack of commitment to health service providers and frequent unavailability of drugs.

In the situation where the community does not fully participate in the organization of the CHF scheme, the possibility of the community to enroll in the scheme is little. However, the analyzed data indicated that majority of the respondents do not participate in the organization and implementation of the scheme. Committee members do not participate in, mobilizing, allocating and expenditure of the CHF funds. The Community could be participating in the scheme through ward committee members, but most of ward health

committees revealed to be inactive. Meetings to discuss issues of CHF scheme are seldom convened. For example, in some other wards in the district the WHC do not exist and those, which exist, are inactive, as they are not involved in any how to for improving CHF local structure at their wards.

Although, the district takes responsibility of managing the scheme, the results have shown that there is no budget is allocated to run the WHCs. For example, there were no funds to meet travel costs and other expenses for committee members to attend meetings. For lack of meetings, which were important in deciding matters concerning the local organization and implementation of the CHF scheme, district managers of the scheme have been practicing matters, which ought to be done by the WHC members.

The CHF guideline has clearly stipulated that WHC members should initiate, organize, and supervise the scheme members by making follow up for each quarter. The scheme, however have been not organized by the community members as most of the activities of the scheme are organized by the top authorities at district level, participation in ward and village level is insufficient.

The previous conducted study revealed that there is low community participation in the organization of the scheme particularly setting of the premiums. For example, the study conducted in Ghana revealed that most of the Community health based insurance scheme are top down driven, there is less community initiatives from the grass root levels (Jehu, 2012), likewise in this study, majority in the Questionnaires explained that they do not participate in the setting of the amount of fees.

5.6 Community preference on health service provider

Government health facilities were found to be more preferred in the area. This is the big favor to CHF since only government health facilities are being used as service providers. Affordability and accessibility were given as more reason for preferring government health facilities. 90% of the total respondents preferred using government health facilities whenever they feel sick only remained 9% mentioned other options when they are sick,

Despite the common belief that the community in Lake Zone preferred more use of traditional medicines and witchcraft during their social and health problems, in this study only 3.1% of the total sample admitted to use traditional medicines as their most preferred service providers. The government should put more effort on improving health service delivery such as availability of drugs medicine medical equipment supplies, reagents and referral services because of all these advantages only 30% of the total respondents perceived the availability of services by government facilities as good. Poor service by the government health facilities have een mentioned as reasons for low enrollment or drop out for CHF in Hanang, Iramba and Nzega (Ministry of health 2009, Wilongela 2010).

CHAPTER SIX

CONCLUSSION AND RECOMMENDATIONS

6.1 Introduction

The study was conducted at Kwimba district focusing on four villages of Kakora, Welamasonga, Isagala and Sumaha in two wards, Ngudu and Wala. The results showed that the majority of the heads of household's especially CHF members had enough knowledge on the advantage of CHF compared to the non-members. Most of the households perceived the quality of health services offered by CHF as poor. The assessment shows that, there is low participation of community in CHF management particularly WHC have been found inactive in resource mobilization, allocation and expenditure and finally the study determine that the community prefers to use health facility as their first choice whenever they get sick

6.2 Conclusion

In order to determine factors influencing enrolment of community health fund members, which formed the general objective of this study, the study specifically aimed at fulfilling four objectives; , to determine community knowledge towards CHF benefits, to determine Perception of community towards community health fund services, to assess community involvement in CHF, and to determine community preference on health service provision.The study found out that majority (68.23%) of the respondents admitted being a member had advantage or benefit compared to not being a member. This suggests that, the majority knows the benefits of being a CHF member compared to the remaining (31.8%), However in determining community perception towards CHF services, study findings indicated that 61.5% of households' leaders perceived the quality of CHF services as poor, 15.1% and 5.2% of the respondents whereby most of them were CHF members perceived the services as fair and good respectively.

On the other hand, 18.2% particularly CHF Non-members did not know anything about quality of CHF services.

However, among five (5) WHCs, majority of them (80%) argued that there was poor participation of community in the local organization structure of the CHF scheme at their ward level; whereas, only 20% of WHCs were satisfied with the participation. Low participation of community in CHF management particularly WHC discouraged enrollment of CHF hence community leaders had to play a vital role on mobilizing and implementation of community projects. The study finally determined the community preferably used health facility when in need of health services. Study findings found out that, most people (90.6%) at the study area preferred a government health facility as their first choice during sickness. Only 4.2% respondents preferred to go to private health facilities and3.1% of heads of households preferred traditional healer whereas. Besides this pattern, drugstores were preferred by 2.1% of households' heads.

Kwimba district suffer from very low enrollment CHF members and this is mainly due to the fact that large population especially in the remote areas has not received proper information about CHF benefits and also due to poor health services delivery especially on availability of drugs, medicine, medical equipment, supplies and reagents as evidenced in the study.

6.3 Recommendation

1. Management should increase efforts on sensitization on CHF benefits especially in remote areas because for there are still areas where people have not heard of CHF and even if they have, they still don't know what CHF benefits they would enjoy when they join.

2. Management should improve quality of services provided by government facilities by first reducing the cost of the premiums for CHF and members in order for the community to be able to access these services. The government should also raise

cost for user fee to discourage out of pocket payments as people will opt for CHF. In the same line, the CHF management should change the system of service delivery, particularly on dispensing drugs. It has to set aside some amount of drugs for CHF members in case they run out of drugs for cost sharing. Furthermore, the district should go further and let the facilities control their own resources and plan themselves on what to do with their money, as opposed to the current practices where the district centralizes that collection of the money. This requires the facilities to own their own bank accounts and keep their money so that they are in a position to control the availability of drugs, equipment's supplies reagents and other services.

3. The district should improve community participation in the local organization and implementation of the CHF scheme by empowering WHC and Health Facility Governing Committees. This can also be done by ensuring transparency on CHF performance, provide WHC and HFGC their functions and share ideas with them before taking actions in their community as for they are close and know their community better.

4. Since most of the people preferred government health facility as their means to access healthcare whenever they get sick, the district should increase strategies to enroll more people in CHF by frequently conducting sensitization programs especially in remote areas at reaping seasons because it is the only time where almost all the local people have money. Such scheme is vital to the community hence it avoids incurring out of pocket expenditure that may probably not be available at time of sickness.

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APPENDICES

Appendices I: Questionnaire English version

Questionnaire for determining factors influencing enrolment of community health fund members towards community health promotion.

SECTION A: IDENTIFICATION

Questionnaire Number……

District name……..

Street/village Name (health facility for exit questionnaire)……

Name of Interviewer ……...

Respondent id (name/sr #)…….

Date of Interview: Date……..Month…….Year……..

Section A: Personal characteristics

Please tic the right answer

1. Gender

A. Male

B. Female

2. Religion

A. Christian

B. Muslim

C Other (specify)……..

3. Tribe ……

4 Age (years)

5. Level of education

A. Not gone to school

B Completed primary school

C. Completed secondary education

D. Completed higher education

6 Major economic activity

A. Farmer

B. Employed

C. Business

D. Fishing

E. Others

Section B: knowledge of community towards community health fund benefits

7. Have you ever heard of CHF

A. Yes

B. No

8. What is health insurance?

A. Any means of guaranteeing against loss of money

Insurance provide protection against illness

C. Means for wastage of money

D. I do not

9. What is your understanding of the CHF scheme?

A. Members prepay specified amount of fees before they receive health care

B. Allow its members to be treated throughout the year after paying membership fee

C. CHF Purchases drugs for treatment of its community members

D. CHF collects community members' fees and fails to provide good services

E. I do not know

10. Do you know the advantages of being a CHF member?

A. Yes

B. No

11. If Yes, Mention Them?

……

……

……

Section C: Perception of community towards community health fund benefits

12. Do you think there are benefits from joining CHF?

A. Yes

B. No

13. If there are any, mention them

……

……

On your opinion, what is the quality of health services offered by CHF?

A. Good

B Fair

C. Poor

D. I do not know

14. How much do your pay for CHF premiums per year?

A. Tshs 5,000

B. Tsh 10,000

C. Tshs 15,000

D. I do not know

15. How do you feel about the premiums you pay per year?

A. Expensive

B. Fair

C. Too low

D. I do not know

16. On your opinion, what is the quality of health services offered by CHF?

A. Good

B. Fair

C. Poor

D. I do not know

17. If poor, can you explain why poor?

……

……

In your opinion .What are the challenges facing CHF?

……

……

Why didn't you join CHF

……

……

Section D: To assess community involvement in CHF

18. In your opinion. Do you think CHF management involves the community on CHF management and execution matters?

A. Yes

B. No

19. Have you ever attended a meeting in which CHF was among the agenda?

A. Yes

B. No

20. Do you know that there is a CHF committee in your village?

A. Yes

B. No

21. When was the last time you attended CHF meeting?

……

Section E Community preferences on health service providers

22. Where do you often go for health care whenever you get sick? And why do you choose so?

A. Health facility

B Private

C. Traditional healer

D. Drug store

E. Others

……

……

Section F Enrollment strategies

23. Do you think there are any efforts taken by districts to increasing enrolment into CHF?

A. Yes

B. No

C. I do not know

24. If yes, which ones?

……

……

……..

25. Are these efforts sufficient to increase enrolment?

A. Yes

B. No

26. What do you think of the District sensitization efforts about increasing the enrolment into CHF?

A. Completely acceptable
B. It is sufficient
C. It is very poor
D. Nothing has been done
E. I do not know

Kiambatisho I: Tafsiri ya Kiswahili

Dodoso la Kutathimini mtazamo wa jamii

SEHEMU A: UTAMBULISHO

Namba ya utambulisho_____

Kijiji_____

Kata_____

Tarafa_____

1 Jinsia:

a) Mwanaume
b) Mwanamke

2 Dini

a) Mkristo
b) Mwislamu
c) Nyingine (taja)……

3 Kabila ……..

4 Umri (Kwa miaka)……..

5 Kiwango cha Elimu

a) Hakwenda shule
b) Msingi
c) Sekondari
d) Elimuyajuu

6 Shughuli kuu ya kiuchumi

a) Mkulima
b) Mwajiriwa
c) Mfanyabiashara
d) Mvuvi
e) Nyinginezo (taja)_____

Sehemu B: Ufahamu wa jamii juu ya utekelezaji wa bima ya Mfuko wa afya wa jamii

7. Umekwisha wahi kusikia kuhusu CHF

a) Ndiyo
b) Hapana

8. Bima ya afya ni nini?

a) Njia ya kuokoa hela
b) Bima inasaidia kujikinga na kuweza kutibiwa wakati wa ugonjwa bila ya kutumia pesa
c) Ni njia ya kupoteza hela
d) Sina hakika

9 .Nini ufahamu wako juu ya mfuko wa afya ya jamii?

a) Mfumo wa Malipo ya ada kwa wanachama kabla hawajaugua
b) Inawezesha wanachama kupata matibabu baada ya kulipia ada ya uanachama.
c) Inasaidia kununua madawa kwa ajili ya kutibu wanachama wake.
d) Unakusanya ada za uanachama na hushindwa kutoa huduma bora kwa wanachama wake.
e) Sijui.

10.Unafahamu faida za kujiunga na mfuko wa afya wajamii ?

a) Ndiyo
b) Hapana

11. Kama unajua zitaje

……
……....

Kipengele C: Mtazamo wa jamii kuhusiana na faida za mfuko wa afya za jamii

12. Unafikiri kuna faida zozote za kujiunga na mfuko wa afya wa jamii ?

a. Ndiyo
b. Hapana

13. Kama zipo zitaje.

……
……..

Kwa maoni yako ,nini mtazamo wako juu ya ubora wa utoaji wahuduma wa mfuko wa afya wa jamii?

a) Nzuri
b) Zinaridhisha
c) Mbaya
d) 4.Sijui

14. Unalipia kiasi gani kwa mwaka katika mfuko.?

a) A.Tshs 5,000
b) B.Tsh 10,000
c) C.Tshs 15,000

1.5 Unaonaje gharama za mfuko wa afya wa jamii?

a. Ghari
b. Zinaridhisha
c. Za chini sana
d. Sijui

16. Kwa maoni yako ,nini mtazamo wako juu ya ubora wautoaji wa huduma wa mfuko wa afya wa jamii?

a) Nzuri
b) Zinaridhisha
c) Mbaya
d) Sijui

17. Kama ni mbaya . unaweza kuelezea ni kwasababu zipi?

.....

.....

.....

Kwa maoni yako ni changamoto zipi zinazoikabili CHF?

.....

.....

Ni sababu zipi zilizo kufanya usijiunge na CHF?

.....

.....

Kipengele D; Tathmini ya ushirikishwaji wa jamii katika mfuko wa afya wa jamii?

18 . Kwa maoni yako, unafikiri uongozi wa CHF unawahusisha jamii katika utekelezaji wa majukumu?

a) Ndiyo
b) Hapana

19 . Ulishawahi hudhulia kikao ambacho moja ya ajenda ilikuwa CHF?

a) Ndiyo
b) Hapana

20. Je unajua kama kuna kamati ya CHF katika kijiji chako?

a) Ndiyo
b) Hapana

21 . Ni lini mara ya mwisho kuhudhulia kikao cha CHF?

……

Kipengele E: Mapendeleo ya jamii katika utumiaji wa huduma za afya

22. Unapendelea kutumia kituo gani cha kutolea afya? Na Ni kwa sababu zipi?

a. Kituo cha serikali
b. Kituo binafsi
c. Waganga wa kienyeji
d. Duka la dawa
e. Nyinginezo

……
……
…….

Kipengle F: Mikakati ya uandikishaji

23. Kwa mtazamo wako unadhani kunajuhudi zinazofanywa na wilaya katikakuongeza wajumbe katika mfukowa CHF.

a. Ndiyo
b. Hapana

24. Kama Ndiyo zitaje unazozijua

……
…….

25. Kwa mtazamo wako juhudi hizi zinatosheleza

a. Ndiyo
b. Hapana

Appendices II: Interview English version

Interview questions on community members involvement in the organization and implementation of CHF scheme through WHC at Kwimba

SECTION A: IDENTIFICATION

Please tic the right answer.

1. Questionnaire Number……

District name……..

Street/village Name (health facility for exit questionnaire)……

Name of Interviewer ……...

Respondent id no…….

Date of Interview: Date……..Month…….Year……..

Section A: Personal characteristics

1. Gender

A. Male

B. Female

2. Religion

A. Christian

B. Muslim

C. Other (specify)……..

3. Tribe …….

4 Age (years)

5 Level of education

A. Not gone to school

B Completed primary school

C. Completed secondary education

D. Completed higher education

Section B

1. When was the scheme started in your District?

   …….

2. Do you know the core functions of WHC in CHF scheme? If Yes mention any;

   ……

   ……

3. How do you get involved in the scheme local organization? ……..

……..

4. Does the district CHF organization involve you in its decision and management issues?
   1. Yes
   2. No
5. If No .Why do you think there is insufficient WHCs members' participation in the local organization of the scheme?

   ……
6. When organizing CHF premium package for community members, how did you participate in setting the amount?

   ……

   ……
7. What are the challenges facing the implementation of CHF in your ward? What are the possible ways forward?

   ……

   ……
8. Why there is low enrolment in the CHF scheme? What are the possible ways forward?

   ……

   ……

Kiambatisho I: Tafsiri ya Kiswahili

Dodoso la Kutathimini mtazamo wa jamii

SEHEMU A: UTAMBULISHO

Namba ya utambulisho_____

Kijiji_____

Kata_____

Tarafa_____

1 Jinsia:

c) Mwanaume
d) Mwanamke

2 Dini

d) Mkristo
e) Mwislamu
f) Nyingine (taja)……

3 Kabila ……..

4 Umri (Kwa miaka)……..

5 Kiwango cha Elimu

e) Hakwenda shule
f) Msingi
g) Sekondari
h) Elimuyajuu

SEHEMU B

1. Ni Lini mpango wa afya ya jamii ulianza katika wilaya yako?

.....

.....

2. Je uanjua kazi za kamati za afya za kata? Klama ndio elezea

……

……..

3. Je serikali ya kata inahusishwaje katika udumishaji wa mpango wa afya ya jamii

   ……

   ……

4. Je uongozi wa wilaya unakushirikisha katika kufanya maaamuzi ya mpango wa afya ya jamii
   a) Ndio
   b) Hapana
5. Kama hapana. je unafikiri ni kwanini kuna ushirikishwaji mdogo wa uongozi wa kata katika shughuli zinazohusiana na mpango wa afya ya jamii.

   ……

   ……

6. Je umeshiriki vipi katika uandaaji wa ghrama za uchangiaji wa mfumo wa afya ya jamii

   ……

   ……

7. Je kuna changamoto zipi katika kutekeleza shughuli za mpango wa afya ya jamii katika kata yako? Je ni njia zipi zitumike katika kukabilana na changamoto hizo?

   ……

   ……

8. Je kwanini kuna uandikishwaji mdogo wa watu katika mapango wa afya aya jamii? Je ni njia zipi zitumike katika kukabilana na changamoto hizo
   ……
   ……

Appendices III: Interview English version

Interview questions on factors affecting enrollment of CHF members to key informants (DMO, CHF coordinator) and Facility Health Providers.

SECTION A: IDENTIFICATION

1. Questionnaire Number……

District name……..

Street/village Name (health facility for exit questionnaire)……

Name of Interviewer ……...

Respondent id no…….

Date of Interview: Date……..Month…….Year……..

Section A: Personal characteristics

Please tic the right answer

1. Gender

A. Male

B. Female

2. Religion

A. Christian

B. Muslim

C. Other (specify)……..

A Tribe …….

3. Age (years)……

4. Level of education

A. Not gone to school

B. Completed primary school

C. Completed secondary education

D. Completed higher education

Section B

1. Do you think the community knows the meaning and advantages of CHF?
    1. Yes
    2. No

If No WHY

……

…..……

……

2 Basing on the strategies you are currently using. Do you think the community have enough knowledge on CHF?
    1. Yes
    2. No

If Yes/No

WHY……

……..……

……

3. From your experience. What do you think is the perception of the community on CHF?

……

……

4. How often do you involve community local organization in management issues?

……

……

5. From what you are doing. Do you think the local community is satisfied?

……

……

6. In your opinion, what should be done to increase enrollment of CHF members?

……

……

7. What do you think could be the reason for low CHF enrollment in the district?

……

……

8. When you were setting CHF premiums, Did you….. local organization at ward level ?

   1. Yes……
   2. No……

If No Why

……

……

9. In your opinion .What are the challenges facing CHF enrollment?

……

……