



EVALUATION OF FACTORS AFFECTING COMMUNITY HEALTH FUND GROWTH IN TANZANIA: A CASE OF ILALA DISTRICT.

Marketing

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ABSTRACT

The purpose of the study was to examine the factors affecting community health fund (CHF) growth in Tanzania. The study objectives were to assess the socio-demographic, socio-economic as well as socio-cultural factors affecting CHF scheme growth in Ilala district. The sample size of study was 400 members and non-members of CHF scheme, staff members of CHF institutions and local government officials from four wards (including Ilala, Kisutu, East and West Upanga). Respondents were selected using random sampling processes. The study used a cross-sectional design. Data were collected using questionnaires. Data was analysed using descriptive statistic while multiple linear regression was carried out to determine the general relationship between independent and dependent variable. The findings showed that majority of the surveyed households had sufficient education level and with ages more than 50 years. A higher number of the households had unreliable jobs that gave them no option to join CHF scheme. The majority of the surveyed households mentioned traditional healing to be the most appropriate way to treat their health implications. Based on the study findings, the researcher recommends that households have to be categorized by authorities into strata of different income levels and geographical locations premiums determined according to their ability to pay. Timings for revenue collection to be designed in such a way to suit the situation of different members. Revenue from alternative sources must be collected from Central or local government.

KEYWORDS

Community Health Fund, Tanzania

INTRODUCTION

In recent years, community based health financing reforms in many developing countries, as a mechanism for raising additional funds for essential public health services, enhancing access to care and reducing out-of-pocket payments (Diop & Ba, 2010). According to the study conducted by Macha *et al.*, (2014), community based health insurance is usually organized and managed by local government institutions, local health facilities, or non-government organizations, with significant community involvement. Despite the proven effects of community based health insurance schemes in enhancing access to services and financial protection, in many developing countries there has been limited population enrollment in such schemes (Abel, 1992).

In many developing countries, initiatives are underway to implement community based health insurance as a means of expanding access to affordable care among the informal sector (Normand and Weber, 1994). However, increasing coverage with voluntary health insurance in low income settings can prove challenging. In the United Republic of Tanzania, user fees have progressively replaced financing from general taxation since 1993. From 1996 on, the Tanzania government introduced Community Health Fund (CHF) schemes, essentially a district-based Community Health Insurance (CHI) arrangement (Mtei and Mulligan, 2007).

A number of studies have examined and reviewed the constraints to increasing enrollment. Ndomba & Maluka (2019) assert that among the potential barriers to enrolment in Tanzania are affordability of premiums, poor quality of health care services offered to members and limited referral services. Poor management (unfavorable scheme design) and lack of trust were also reported in some studies to affect the coverage of community based insurance schemes (Kamuzora & Gilson, 2007). Concerns about the lack of inclusion of referral care and associated transport costs in the benefit package have also been reported elsewhere. Recent moves in Tanzania to promote engagement with the private sectors in the provision of quality health services in areas with the limited public facilities through service agreements (or contracts) should facilitate a widening of the benefit package (Catherine, 1998)

CHF was developed among many reasons to help the community members to access quality and affordable health care services. According to the CHF Act of 2001, the objectives of the CHF included: mobilizing financial resources from the community for provision of health care services to its members; (ii) providing quality and affordable health care services through sustainable financial

mechanism and (iii) improving 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).

However despite the government effort in insuring the health scheme succeed among majority of its citizens, there has been low enrollment rate of the community members into the CHF and high rate of dropout among the registered members. Moreover, even in the areas that where there was once high enrollment in the scheme, they have recorded tremendous decrease in enrollments. Kamuzora and Gilson (2007) investigated the causes of low enrollments and came up with findings that poor inability to pay membership contributions was the most important barrier, whereas poor quality of care, non-acceptance of the need to protect themselves against the risk of sickness and lack of trust in CHF managers mattered more to average and wealthy community members.

The success of the CHF is expected to increase enrollments of the community members in the non-formal sector as well as those in the rural areas in accessing the affordable and quality health services from up to referral hospitals depending on their subscription package. Therefore this study intends to evaluate the factors affecting community health fund (CHF) growth in Tanzania.

Literature Review

Community Health Fund

The Community Health Fund (CHF) is a type of Community-Based Health Insurance (CBHI) scheme which is being implemented in Tanzania (Macha & Maluka, 2019). CHF is a voluntary health insurance scheme mainly targeting informal and rural population; and it was first piloted in Tanzania in 1996. Later, the government made CHF a voluntary prepayment health financing mechanism by 2001 CHF (URT, 2001). The CHF membership is for the entire household members. At the district level, the CHF is overseen by the Council Health Services Board (CHSB) which comprises representatives from the district authorities, public health care providers, private healthcare providers and the community at the ward level, the Ward Development Committee and the Health Facility Committee are responsible for mobilizing people to join the CHF, tracking the membership base, overseeing premium collections, evaluating CHF operations, providing recommendations and granting exemptions (URT, 2016).

Health Care Services

Health care is the maintenance or improvement of health via the

prevention, diagnosis, treatment and cure of diseases, illness, injury or other physical and mental impairment in people. Health care services are delivered by health professionals and allied health fields. Access to health care may vary across countries, communities and individuals influenced by social and economic conditions as well as health policies. Healthcare services mean the medical and related healthcare services provided by physician to patients. CBHI schemes are usually voluntary and characterized by community members pooling funds to offset the cost of healthcare.

Theories Used

The Health Belief Model (HBM)

The Health Belief Model was developed in the 1950's by social psychologist Hochbaum Rosenstock who was working in the US Public Health Services to explain the failure of people participating in programs to prevent and detect diseases. The Health Belief Model has provided a useful framework for investigating health behaviors and identifying key health beliefs and it has been widely used and has met with moderate success in predicting and changing a range of health behaviors (McLeroy, 1988).

According to McLeroy (1988), the Health Belief Model is an extensively researched model of health behavior attempting to predict health-related behavior in terms of certain belief patterns. A person's motivation to undertake a health behavior can be divided into three categories: individual perceptions, modifying factors and the likelihood of action. Individual perceptions are factors that affect the perception of illness and with the importance of health to the individual, perceived severity and perceived susceptibility. Modifying factors include demographic variables, perceived threats and cues to actions. The likelihood of action is the perceived benefits minus the perceived barriers of taking the recommended health action. The combination of these factors cause a response that often manifests into the likelihood of that behavior occurring (DiClemente, 2002). The HBM theorizes that people's beliefs about whether or not they are at risk for a disease or health problem, and their perceptions of the benefits of taking action to avoid it, influence their readiness to take action (Abel, 1992).

The key strength of Health Belief Model lies in the fact that it was developed by researchers directly working with health behaviors and so many of the concepts possess face-validity to those working in health behavior. However, compared to other similar social cognitive models of health behaviors, the Health Belief Model suffers from a number of weaknesses. The way in which the variables in the Health Belief Model combine to produce behavior has not been precisely specified and, as a result, it is frequently tested as six independent predictors of behavior (DiClemente, 2002). The relevancy of Health Belief Model to this study lies upon the fact that community's knowledge, perception, preferences participation or involvement in decision making to join CHF scheme depends upon many factors that, this study intends to explore in order to achieve the universal coverage of CHF scheme in Tanzania, specifically Ilala district.

Empirical Studies

Socio-demographic factors affecting CHF scheme

The socio-demographic characteristics of clients and their perception of quality of care play a major part in people's decision making process especially in service utilization. Policy makers need to recognize community perceptions as potential enablers and barriers to enrolment, and to invest in understanding and addressing them in the design of interventions to stimulate enrolment (Appiah et al., 2012).

Mulupi et al. (2013) conducted a study in Kenya to examine the effects of socio demographic factors on CHF scheme. The results showed that perceived poor quality of care in public health system can be a major hindrance of Universal Health Coverage. Good quality services, particularly related to drug availability and interpersonal relationship between clients and health provider can boost trust in the public system and in so doing encourage people to belong to health insurance. Moreover, the study included the following other factors: demographic variables such as age was assumed that middle aged people enroll more compared to other groups; on sex it was assumed that females enroll more on CHF than males; in occupation, marital status, level of education, size of the household influence CHF enrolment.

Mtei & Mulligan (2017) conducted a study in Tanzania to examine the

effects of socio demographic factors on CHF scheme. Findings indicated that if members are more involved, the potential for membership fees to be set at an affordable rate is much higher and the benefit package will be clear to all members, avoiding the possibility of over expectations of the benefits package

Socio-economic factors affecting CHF scheme

Madhukumar & Gaikwad (2012) conducted a study in India. It was observed that the main barriers for the subscription of health insurance were low income or uncertainty of income, not adequate knowledge regarding its benefits and do not feel the Also, for economic variables that involve distance to health services and availability of transport are related with joining or not joining CHF. Another study was conducted in Tanzania by Msuya et al. (2014) and reveal that more than 60% of the households that were considered to be either rich or normal had joined the scheme compared to only about 33% of the poor ones; also village of residence was one of the significant variables that affect the decision of households to join the CHF scheme.

Macha et al., (2014) conducted a study at Igunga in Tanzania and their findings indicated that the three middle income quintiles were more likely to enroll in CHF than the poorest and the richest. CHF members were more likely to be big, and headed by a male than uninsured households from the same area. Also poorest were more likely to join as were large families and of greater risk of illness with disabilities or persons with chronic diseases.

Socio-cultural factors affecting CHF scheme

On socio cultural variable that include attitudes and practice of the people towards CHF and health insurance in general were assumed that people have positive attitude towards CHF enrolment as it will help them to access improved health services. Furthermore, the communities perceive CBHI as a crucial healthcare services which is relevant to use at a later point in time during the time of illness or any physical impairment. In the study conducted by Kishole & Nalini (2019), it was concluded that, in order to facilitate local health planning, implementation and monitoring, the role of both the local elected bodies and civil society has been critical. The success of participatory planning platforms globally depends upon the central role of civil society organizations and upon adequate investment of time and resources in capacity building. NGOs play critical roles in handholding and training and as interlocutors between communities and governments (URT, 2001).

Kishole & Nalini (2019) indicated that community engagement and participation have the same goal- i.e. improving public health service deliveries and policy projects. However, both are not initiated by the same actors. According to Olushayo & Pamela (2019), community engagement is a *top-down* initiative. Hence, it is implemented by a governmental body such as a city /town/ village. The government officials are the ones encouraging citizens/communities to discuss, assess policies and contribute to the projects. On the contrary, citizens implement community/citizen participation which is a *bottom-up* initiative.

Research hypothesis

The following research hypotheses are used to test the specific objectives. They are based on the reviewed theories and empirical findings above

- H₁: Socio-demographic factors affect positively CHF scheme growth
- H₂: Socio-economic factors affect positively CHF scheme growth
- H₃: Socio-cultural factors affect positively CHF scheme growth

Independent variables

Dependent Variable

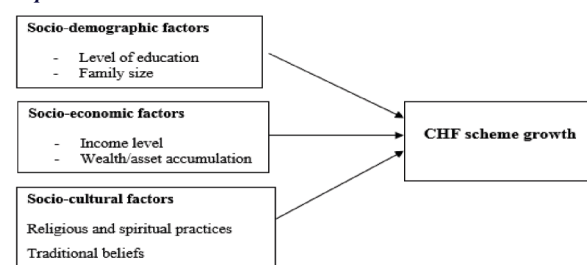


Figure 1: Conceptual framework

Source: Authors construction from literature review (2023)

Methodology

Research Design.

A research design, according to Kothari (2004), is a conceptual framework for how a study is carried out; it serves as a guide for gathering, measuring, and analyzing data. This study used a cross-sectional design, where by quantitative data was collected at a single point in time. Cross sectional design take the form of questionnaire survey, with participants selected using random sampling processes (Matthews & Ross, 2010). The study was conducted at Ilala municipal council is one of the four municipalities of Dar es Salaam city; other municipal councils include Temeke, Kinondoni and Dar es Salaam city council. Simple random sampling was used select 400 respondents of the study. The procedure involved listing clients of CHF scheme and writing them on pieces of paper which amounted to the population of study. The papers were tossed and selected randomly to amount to a sample size of 400 respondents. Those selected were corresponded with names in the list and were picked for the study. Sample size was calculated by the following formula;

$$n = N / (1 + N \cdot e^2)$$

$$n = 64,034 / (1 + 64,034 \times 0.05^2)$$

$$n = 400$$

Sources of Data.

Primary and secondary sources of information were both used by the researcher. Kothari (2004) argues that the most recent and original primary data are those that have just been gathered. Interviews and the questionnaire were therefore employed as the main data sources in this study. While secondary data are those that are not brand new because they have already been compiled by others and are typically acquired through books and online sources. Books and online sources were employed in this investigation, along with public and unpublished records.

Data Collection Methods

Kothari (2004) states that there are two fundamental types of research methods: quantitative and qualitative. Data Collection Methods In quantitative research, an element is explained by means of the collection of numerical data that are then examined using mathematically based methods. On the other hand, qualitative research methods focus primarily on observing and evaluating behavior, attitudes, and views.

Qualitative Method

Research in this purposive sampling was used in this study, and six employees (senior executive officials) in the banking industry were interviewed. kind of situation is a feature of the researcher's perceptions and insights To find out what factors affect employee satisfaction levels in the bank, interview questions were developed for this study.

Quantitative Method

The researcher used a descriptive analytic strategy for this investigation. Creating Samples: A sample of 60 non-directorate employees was chosen using a straightforward random selection procedure. Because it is convenient and affordable, the simple random sampling method was chosen (Higgins, 2009; cited by Abdullah, 2013). As a result, a huge number of responders could react for a relatively low price. Create a questionnaire To verify the accuracy of the data, the location and the targeted respondents are first identified. From NMB Head Office, a total of 60 respondents were chosen for the main quantitative investigation. This study's data were collected via self-administered questionnaires. In this case, the researcher created a set of questions that bank employees without director positions answered.

Documentary review

A documentary review is an examination of documents that contain the information we need (Milanzi, 2009; cited by Kimaro, 2015). Using this technique, the researcher was able to evaluate the accuracy of the information obtained from a primary source, such as surveys. It included examining journals and reports on the level of job satisfaction among employees.

Data Analysis and Interpretation

Data were analyzed for this study using the computer program SPSS and descriptive statistics. While descriptive statistics were employed

to evaluate data quantitatively, SPSS was used to analyze the data and produce frequencies, percentages, and numbers. Because of this, the study tried to address the suggested research issues by using both quantitative and qualitative data analysis techniques. Due to the fact that some data were presented as numbers and others as descriptions (words). The research results were presented using tables, figures, and words following analysis.

Validity and Reliability

Validity is the accuracy and dependability of the findings; to ensure data validity, the researcher discussed the questionnaire's content with her supervisor before heading out into the field to make sure the findings would be trustworthy and able to be generalized. When consistency is shown over multiple measures, it is said to be reliable, according to Carmines and Zeller (1979). Reliability is the ability of an instrument to produce consistent results when measured repeatedly. Reliability was assessed using Cronbach Alpha

Ethical Issues

In the entire conduct of the research, the researcher also took moral principles and ethical concerns into consideration. Also, the researcher took into account the research value of the respondents' voluntary participation; any respondent who was not ready to participate in the study was not pushed. Anonymity, honesty, informed permission, fraud, and secrecy were a few of the ethical concerns that were taken into account.

FINDINGS AND DISCUSSION

Table 1: Demographic Characteristics

Demographic characteristics of respondents

Gender	Frequency	Percentage (%)
Male	138	34.5
Female	262	65.5
Age		
20-29	43	10.75
30-39	57	14.25
40-49	194	48.5
50 and above	106	26.5
Educational Level		
Non-formal education	23	5.75
Primary education	77	19.25
Secondary education	205	51.25
College	67	16.75
University/Degree level	28	7
Occupation		
Peasant	68	17
Employed	20	5
Entrepreneur	194	48.5
Jobless	118	29.5

The purpose of obtaining data on the basis of sex was to gain the insights to determine the participation in CHF between male and female participants. The findings in (Table 1) show that 138 (34.5%) respondents were males and 262 (65.5%) were females. These findings suggest that the membership of females to CHF was somewhat higher (65.5%) than that of males (34.5%). This result is not surprising given the reality that the number of female members tends to be higher than males due to the fact that female household specifically mothers are the one with the responsibility to take care of the family hence forcing them to seek for health insurance back up.

The age of respondents was divided into four age groups; 20-29, 30-39, 40-49 and 50-and-above. The findings (See Table 1) indicated that majority of the respondents were aged between 40 and 49 which constituted 194 respondents (48.5%), followed by 106 respondents aged 50 and above (26.5%). About 57 respondents were aged between 30 and 39 (14.25%) while 43 (10.75%) respondents had the age limit of 20-29. The findings in Table 1 suggest that most of the respondents (75%) were adults (ranging from 40-49 and above 50 years) and were capable of expressing their experiences with regard to access to health care under CHF scheme in Ilala district. It is also a case that adults are likely to take health care matters particularly accessing quality health care for their own sake and of their families.

The level of education of respondents was categorized into five levels; college (certificate and diploma level), degree level (including bachelor, masters and PhD), Primary and secondary education level as

well as non-formal education. Findings (See Table 1) show that 67 respondents (16.75%) had attained college (certificate and diploma level), 28 (7%) had attained degree level, 77 (19.25%) had attained primary education and 205 (51.25%) attained secondary education (o-level and high level education) while the rest 23 (5.75%) had non-formal education.

The findings suggest that the respondents were sufficiently educated and therefore they were in a position to assess performance of CHF against their expectations including whether they adequately accessed health care services under CHF considering their level of understanding. The findings suggest that the respondents were sufficiently educated and therefore they were in a position to assess performance of CHF against their expectations including whether they adequately accessed health care services under CHF considering their level of understanding.

Most of the respondents were jobless and entrepreneurs while others are peasants. This implies that the level of income is directly proportional to CHF scheme growth, meaning that most people without a reliable source of income could not access health services easily compared to those with reliable income. Those who are employed could have their health services access through National Health Insurance Funds and other insurance schemes provided for those employed in a private sector. According to the study conducted by Stephen (2015), people who are richer in rural areas are those who engage in multiple occupations like small business/trade owners of small shops, keeping animals as well as farming can easily afford to pay for the CHF membership fee.

Findings according to specific objectives

Socio-demographic factors affecting CHF scheme growth

Table 2: Number of dependent children and Family Size

Number of dependent children	Frequency	Percentage (%)
1-3	31	7.75
3-5	69	17.25
5-8	185	46.25
8-above	115	28.75
Family size		
1-3	45	11.25
3-5	81	20.25
5-8	156	39
8 and above	118	29.5

Respondents were also asked to indicate their highest number of dependent children. About 31 respondents (7.75%) indicated 1-3, 69 respondents (17.25%) indicated that their highest number was 3-5, 185 respondents (46.25%) recorded that their highest number of dependent children was 5-8, while 115 (28.75%) respondents recorded to have 8-above dependent children.

Furthermore, respondents were asked to indicate their family size (the size of their households). The results showed that respondents (11.25%) indicated that the number was 1-3, 81 respondents (20.25%) indicated that their highest number was 3-5, 156 respondents (39%) recorded that their highest number of dependent children was 5-8, while 118 (29.5%) respondents recorded to have 8 and above household size.

Socio-economic factors affecting CHF scheme growth

Table 3: Occupation and Income Level of the respondents

Occupation	Frequency	Percentage (%)
Peasant	68	17
Employed	20	5
Entrepreneur	194	48.5
Income levels of respondents		
Less than 30,000	185	46.25
30,000-100,000	125	31.25
100,000-300,000	64	16
More than 300,000	26	6.5
Jobless	118	29.5
TOTAL	400	100

Respondents were asked to record their job categories. Out of 400 respondents surveyed, 68 (17%) recorded that they were peasants, 20 (5%) recorded that they were employed (either civil servants or private

institutions' workers), 194 (48.5%) recorded that they were entrepreneurs, while 118 (29.5%) recorded that they were jobless. Results showed that most of the respondents were jobless and entrepreneurs while others are peasants. This implies that the level of income is directly proportional to CHF scheme growth, meaning that most people without a reliable source of income could not access health services easily compared to those with reliable income. Those who are employed could have their health services access through National Health Insurance Funds and other insurance schemes provided for those employed in a private sector. These results suggest that the majority 310 (77.5%) did not get reasonable good income and one would expect the majorities of the household to have little chance to afford CHF scheme payment. In India it was observed that the main barriers for the subscription of health insurance were low income or uncertainty of income, not adequate knowledge regarding its benefits and do not feel the need (Madhukumar & Gaikwad, 2012).

Socio-cultural factors affecting CHF scheme growth

Table 4: Beliefs on traditional healing

Extent of traditional healing beliefs	Frequency	Percentage (%)
Very much	178	44.5
Rarely	130	32.5
Not at all	92	23
TOTAL	400	100

Respondents were asked to indicate the extent to which they believe on traditional healings. The majority, 178 (44.5%) indicated the highest beliefs on traditional healing followed by 130 (32.5%) who indicated that they rarely rely on traditional healing while 92 (23%) indicated to not believe on traditional healing at all. The majority of the respondents mentioned traditional healing to be the most appropriate way to treat their health implications due to various reasons including uncaring attitudes of most of the healthcare personnel while others reported that they have been bewitched hence thinking that traditional healing were the better option. Some respondents also mentioned commercially available remedies including "forever living" health products as the alternative medicine to treat their health problems. A recent study in the Hai district conducted by Hindley (2017) found that most people with dementia had visited Christian faith healers and traditional healers for diagnosis and treatments. In rural Tanzania, where most people live far from health centers often rely on traditional healers to treat their various health problems. Unfortunately, patients only turn to modern health care services only when traditional healing treatments fail.

Regression analysis

Multicollinearity Test

Before multiple regression was performed multicollinearity test was carried out. Multiple regression model normally faces multicollinearity problem for independent variables. Tolerance and Variance Inflation Factor (VIF) were used for testing multicollinearity in the model (Table 4.3.1). Gujarati (2007) asserted that when the VIF value is less than 5 it indicates no multicollinearity in the model. Since all VIF results of all variables under this study were less than 5, it is concluded that there was no multicollinearity problem.

Table 5: Multicollinearity Test

Variables	Tolerance	VIF
Level of education	0.397	2.519
Family size	0.577	1.734
Income level	0.741	1.350
Occupation	0.653	1.532
Beliefs on traditional healings	0.302	3.313

Table 6: Regression summary

VARIABLES	B	Std. Error	P. value
Socio-demographic factors	0.178	0.065	0.033
Socio-economic factors	0.250	0.141	0.000
Socio-cultural factors	0.145	0.114	0.061

($R^2 = 0.51$, $F = 10.41$, $P = 0.00$)

Multiple regression results

Based on the findings in the table 6 above, all variables included in the model (Socio-demographic, socio-economic and socio-cultural factors) predicted 51% of variations in community health fund scheme growth (Nagelkerke $R^2 = 0.51$). Therefore, all variables included in the model had significant effects or relationship on community health fund scheme growth. Furthermore, socio-demographic factors and socio-

economic factors had positive significant relationship of community health fund scheme growth ($B = 0.178$, $P = 0.033$) and ($B = 0.250$, $P = 0.00$) respectively while socio-cultural factors had no significant relationship on community health fund scheme growth ($B = 0.145$, $P = 0.061$).

The findings and results from table 6 agree with those reported by Stephen (2015) who assumed that affordability of premiums or contributions is a main determinant of membership to any CBHI. The results indicated that people who are richer are more likely to join CHF schemes because they can afford pre-determined premiums. These people who are richer in rural areas are those who engage in multiple occupations like small business/trade owners of small shops, keeping animals as well as farming. In his study, Stephen (2015) revealed that most of rural households and urban households declared that they were not able to pay CHF premiums because of an unstable income. Mushi (2007) found that many people consider the premiums to be too high for them, while others said that lack of money and the premium being too expensive was their first reason for not to joining the CHF. Households that depend on small scale farming, also known as subsistence agriculture, are disadvantaged; they also find it difficult to pay CHF premiums. Msuya *et al.*, (2004) found that a household with many family members were more likely to join the scheme than the small family size. He further suggested that households with more than 5 family members have a great chance to enroll in CHF schemes compared to small size considering that premiums are flat rate, and average contribution becomes less in large families. Similarly, Macha *et al.*, (2014) disclose that a large family size of more than 7 people was the reason for enrolment, other reasons included a male headed household, having completed secondary education and being married. CHF accept membership of only one wife, the second wife will be considered another household and they have to pay membership premium. This is becoming a big burden to poor families.

CONCLUSION

The general objectives of the study was to assess the factors affecting community health fund (CHF) scheme growth in Ilala district. CHF in Tanzania has several successes and challenges in reaching intended objectives. Some of the success includes; members of CHF do access health care more often, some health facilities improved health care using CHF funds. Some of the challenges are poor households cannot afford annual premiums, limitation on the size of the household's membership, traditional beliefs, quality as well as the majority of the citizens don't have reliable jobs that can enable them to afford paying for CHF membership fee. The contribution and prospect of the CHF in overall health financing is questionable. CHF members are not protected from financial catastrophe and poverty. This is because the population covered is too small, the out-of-pocket expenditure is still very high and CHF does not cover most of the services offered at district and specialized hospitals.

Recommendations

To improve the performance of the implementation of CHF scheme, the following are recommended: Households have to be categorized by authorities into strata of different income levels and geographical locations premiums determined according to their ability to pay. Timings for revenue collection to be designed in such a way to suit the situation of different members for example during harvest, by two equal installments, or through peer members. Revenue from alternative sources must be seriously collected from Central or local government. Social mobilization to be done by specialized people and a relevant department for example the community development to sensitize people on importance health insurance and risk pooling. Improve management of CHF schemes to enhance transparency and accountability.

Community involvement in all stages of CHF implementation to build a sense of ownership and work together with existing community based solidarity groups.

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