

Assessment of the Performance of Community Health Fund Scheme in Central Tanzania: A Case of Mkalama District

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ABSTRACT

The study was conducted at Mkalama district in Singida Region with the objective of assessing the performance of Community Health Funds, in terms of awareness and enrolment trend as well as barriers for joining the scheme. Data were collected through a combination of methods including household questionnaire survey, key informant's interviews and focus group discussions. Both primary and secondary data were collected. The study employed a descriptive statistical method in data analysis. The study revealed that, the majority were aware of the scheme, but the enrolment trend was generally low. Major reasons for people not joining the scheme include poverty, lack of health facilities at the village (e.g. Dispensary), drugs and qualified staff. The study recommended that the district and other stakeholders should improve the availability of health facilities, drugs and qualified staff at the village level, in order to enhance people access to the health services.

Keywords: Community health based financing, enrolment, community health funds

1.0 INTRODUCTION

Tanzania went through a severe economic crisis in the 1980s which adversely affected the financing of the basic social services, including health services (Wangwe and Semboja, 1998). The underfunding of the public health care delivery systems at all levels, led to a quality decline and fall in provision, including shortage of drugs and medical supplies, an overall deterioration of the physical health infrastructure as well as low wages for the health workers resulting in low staff morale. In response, since the early 1990s, the government promoted health sector reforms with the primary objective of increasing funding to the health sector (Maureen *et al.*, 2005). Among the health sector reforms promoted by the government, include the Community Health Based Financing (CBHF) in different forms such as the National Health Insurance Fund (NHIF): Community Health Funds (CHF) and its urban equivalent *Tiba kwa Kadi* (TIKA). The Community Based Health Fund (CBHF) is a mechanism whereby community members (households) finance or co-finance costs associated with health services, offering them a greater involvement in the management of community financing scheme and organization of health services (Carrin *et al.*, 2005). The claimed specific objectives of CHF include: (i) establishing a strong and sustainable financial resource base for basic curative and preventive health care, (ii) ensuring security and equity of access to health services to community members and (iii) improving the protection of

people against the financial consequences of health shocks. This study was focused on objective (ii).

CHF in Tanzania began 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 objective of establishing CHF was to increase the coverage of health services of the rural population and the informal sector in the country. Currently, the CHF has been implemented in 137 district councils (NHIF, 2010). Despite of this initiative, the enrolment of community members in CHF is generally low, almost between 3- 6% in most rural districts against the expected rate of 30% (Shaw, 2002; Musau, 2004), while national wise, the enrolment dropped dramatically from 23% in 1999 (Mtei and Mulligan, 2007) to 8.6% in 2013 (Bultman and Mushy, 2013) which is lower compared to the target of 45% by 2015 (NHIF, 2010). In 2003, the Ministry of Health (MOH) undertook a study of factors affecting enrolment and coverage, and suggested a number of possible explanations for the slow rollout (MOH, 2003). At the regional level, reasons were lack of commitment by some of the regional and district officials, inadequate follow-up from the MOH, lack of capital for initiation of the scheme; lack of uniformity on premiums, inadequate mechanisms for a continuation of membership, and unclear referral mechanisms (MOH, 2003).

Despite of a number of studies related to performance of CHF (see Shaw, 2002; Musau, 2004; Mtei and Mulligan, 2007), little is known on how CHF enhance access to health services and enrolment. Likewise, performance in relation of CHF partly is influenced with socio economic characteristics/settings of a particular locality. CHF in Mkalama (as a new district) was initiated in 2005. Since its establishment, no study has been done to assess the performance of CHF. In addition, following the MOH study (MOH, 2003), with its recommendations, it is now wealth to conduct a study on assessing the performance of CHF. The assessment is important for designing and/or redesigning appropriate strategies for scaling up of the CHF in the district and the national at large. Drawing from this background, this study aimed at assessing the performance of CHF in Mkalama district in terms of awareness, the extent of enrolment, services provided under CHF, and to determine reasons for a low enrolment or drop outs of CHF members.

2.0 METHODOLOGY

2.1 Description of the Study Area

Mkalama district was established in 2012 after the split of Iramba district into Iramba and Mkalama districts. Mkalama district (Latitudes 4⁰ and 4.30⁰ S; Longitudes 34⁰ and 35⁰ E) is situated in the North of the Singida region and covers an area of 3,365.51 square Kilometers of which 44% is arable land (District Strategic Plan, 2013-2018). The selected area for the study was Iguguno ward with the villages of Iguguno, Tumuli, Milade, Senene Lukomo and Kitumbili. The area was selected because since the scale up of CHF in the district, the ward had only registered less than 250 households, against 5152 households (Mkalama District CHF Annual Reports, 2014). However, only two villages were involved for

the study: Iguguno and Tumuli villages. Although two villages were not adequate to be a representative of a district, the selected villages were typical of rural areas in Tanzania with similar social economic characteristics/settings with other villages in the district, hence were considered adequate to make the villages representative to other villages in the district.

According to URT (2012), the total population of the district is 188, 733, among them 93,534 (49.6%) are male and 95,199 (50.4%) are female, with growth rate stands at 2.7% and household size of 5 people. Major economic activities include agriculture, animal husbandry and Lumbering. The district has 35 health facilities both public and private owned including 1 hospital, 4 health centers and 30 dispensaries. The health services are managed and controlled by the Council Health Services Board (CHSB) and Council Health Management Team (CHMT). The council requires 970 health workers, while available staff stood at 118 with shortage of 772 workers. Health facilities have acute shortage of health equipments, medicine and others including WASH facilities. The community had two options to pay for primary health care within the public system; payment of user fees at point of service or joining the CHF.

2.2 Study Design and Data Analysis

A cross sectional research design was adopted to provide both qualitative and quantitative data. The design was adopted by this study because, the design not only allowed a collection of data at a single point in time, but also allows the use of a combination of several methods in data collection, hence increases reliability and accuracy of data (Kothari, 2004; Creswell, 2003). Both primary and secondary data were collected by a combination of methods. Household questionnaire survey, key informant's interview and documentary review were used as methods for data collection. Household question survey was conducted to the head of households selected randomly from two selected villages by using village registers as a sample frame. Iguguno village had 722 households and Tumuli village 584 households making 1306 total households. Intensity sample size of 10% of the total households was selected for the study, this makes a sample size of 130 households selected for the study. A purposeful sampling was used in the selection of the key informants for key informant's interview such as CHF coordinator, Ward Executive Officer and Community Leaders who were the members of Ward Health Committee (WHC). IBM-SPSS version 20 was used in data analysis. A descriptive statistical analysis was employed whereby frequencies; percentages and measure of central tendency were generated.

3.0 RESULTS AND DISCUSSION

3.1 Demographic Characteristics of Respondents

Out of 130 respondents surveyed, males were 57.7% and females 42.3%. The mean age of respondents was 43.7 with the majority aged between 39 – 58 years (46.9). Eighty-one percent of the respondents had attained primary, 9.2% secondary, 1.5 tertiary education levels, while 7.75 had not attended any formal education. Majority of the respondents were marriage couples (66.2%) followed by singles (17.7%) the rest were divorced, widowed

or separated (16.1%). Household's size ranged between 3 and 8 members with a mean of 5 members per household, the while majority of households had a household size between 4 and 5 (70.8%). Agricultural (crop growing) was the main occupation (70%) followed by business (16.9), livestock keeping (10%) and employment (3.1%). Monthly income ranged between 1000 and 350,000/= TAS (1USD = 2160 TAS) with a mean of 633,350/= TAS while the majority had a monthly income ranged between 1001 and 100,000/= (86.2%).

3.2 Community Awareness and CHF Membership

About 79% of the respondents were aware of CHF while 21 were not (Table 1). On the other hand, about 55% of respondents were members of the scheme while 45% were not (Table 1). Indeed, 70 (53.8%) respondents who were aware of the CHF were also members, while only 1 (0.8%) was not aware but joined the scheme. This implied that, the awareness is a pre-requisite for joining CHF. Other studies conducted in East and Central Africa indicated a varying enrolment in the schemes, for instances low percentages of enrolment were observed in a study on five CHIs in East and Southern Africa (Musau, 1999). In four schemes, enrolment percentages vary between 0.3% and 6.5% of the target population. In Senegal, one of the CHI reached a coverage rate of 26% after 3 years of operation whereas another achieved an enrolment rate of 82% of the target population, (Carrin *et al.*, 2005). In Mbulu District, about 28% were reported to be members and 25% non members (Mtei *et al.*, 2014).

Table1: Respondent's awareness and membership to CHF

		Awareness to CHF		Total
		Yes	No	
Membership to CHF	Yes	70(53.8%)	1(0.8%)	71(54.6%)
	No	33(25.4%)	26(20.0%)	59(45.4%)
	Total	103(79.2%)	27(20.8%)	130(100.0%)

However, 33 (25.4%) who were aware of CHF did not join the scheme. The results suggested that although the awareness on the scheme was relatively high, some households did not join the scheme due to some other reasons. Berkhout and Oostingh (2008) urged that, apart from awareness, other factors such as financial constraints and poor health services could prevent people from low income countries from joining Community Based Health Initiatives.

The most important sources of information about the scheme were the village leadership (54.4%), health facility staff (49.5%) followed by the district professionals (35.9%). Other sources mentioned were fellow CHF members (32%), Mass media (radio, TV) (34.0%) and NGOs' staff (12.6%) (Table 2).

Table 2: Sources of information for awareness about CHF

Source of information	Number of response	Percentage of cases
Village leadership	56	54.4
Health staff	51	49.5
District professionals	37	35.9
CHF member	33	32.0
Mass media (Radio, TV)	35	34.0
Relatives	19	18.4
NGO's staff	13	12.6

The same results were reported by Mahingika (2007) in Mfundu whereby health staff and village leaders were identified as the main sources of information. This implied that relationship between community leaders, health staff and the community contributed to the awareness of the scheme to the community. Cohen (2006) identified that outreach workers who had personal relationships with poor families found it much easier to convey the novel concepts and details of health insurance programs to these potential clients.

3.3 The CHF Membership Enrolment Trend

Fig.1 shows enrolment trend for 10 years. Data from 2006 – 2012 included also data of former Iramba district before split into Iramba and Mkalama districts. Majority of the households joined the scheme in 2013, 2014 and 2015 years. Low enrolment was observed in the first five years. The number increased during the year 2011 and 2012 and drop down in year 2013 and 2014. A higher enrolment rate was evidenced in the year 2015 when the enrolment of members reached 1050.

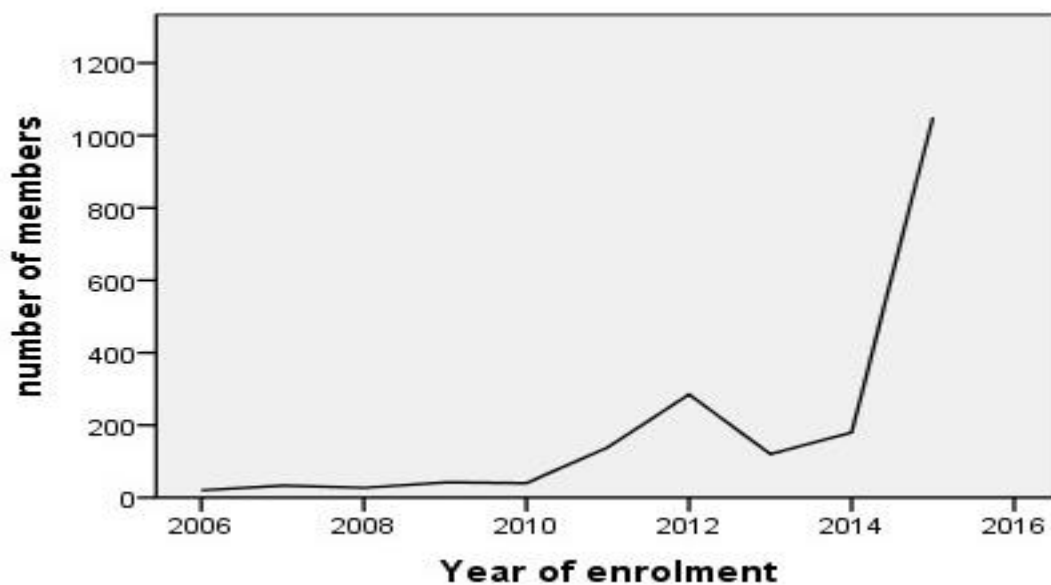


Figure 1: CHF enrolment trend for ten years at Iguguno ward, Mkalama District

One of the reasons given for the high enrolment during the 2015 was the implementation of TASAF III programme, whereby households received conditional cash for health and education. The conditions were that, in order to access health services they should enrol in the scheme. The introduction and implementation of the programmes in the community has been a factor for increasing income of households which increased willingness to pay for their health. A “buyout” local economy project in Democratic Republic of Congo has been cited as one of the factors contributed to the success of the Bwamanda scheme in Zaire (Criel 1998; Creese and Bennett, 1997). Low percentages of enrolment were also observed elsewhere including East and Southern Africa (Musau, 1999) and Senegal (Carrin *et al.*, 2005).

3.4 Package of Health Services Provided by CHF to the Community

CHF provided a number of health services to the community. About 93% of respondents mentioned provision of drugs as a main service provided by CHF, followed by preventive care services (84.3%), laboratory and diagnostic services (63.8%), while inpatient (26%) and referral (26%) services were minimally covered by the scheme (Table 3).

Table 3: Health Services covered by CHF in Mkalama District

Services covered by CHF	Number of responses	Percentage of response
Drugs	118	92.9
Preventive care	107	84.3
Laboratory/diagnostic	81	63.8
Outpatient	68	53.5
Inpatient	33	26.0
Referral	33	26.0

The packages or coverage of services provide under CHF was among the complaints of many people that the package does not cover the inpatient and referral care which in fact are the most expensive services for the poor to afford. Findings from key informants reported that, inpatient services in the district are partially covered by the scheme. The district council had set a fund support ceiling for patients admitted within the district that amounted to 30,000 TAS per member, and the cost exceeding the ceiling should be paid by the patient. Generally, CHF services are mainly limited to health services at the primary levels with a few up to the District level and are not portable outside the district (NHIF, 2010). Several studies conducted in Tanzania have shown that by including hospital care within the CHF benefit package has been reported to be among the reasons for joining the scheme among the majority of households (Mtei and Muligan, 2007). Therefore, the inclusion of inpatient as benefit packages (although partially) might be a reason for the people to join the scheme.

3.5 Reasons for a Low Enrolment

Low enrolment in the scheme was largely attributed by poverty among households (47.3%), lack of health facility in the village (30.9%), inadequate drugs (18.2%), and lack of enough health personnel (5.5%) and not aware of the scheme (9.1%) (Table 4).

Table 4: Reasons for low enrolment into the CHF scheme

Reason for not joining	Number of response	Percentage of cases
Poverty	26	47.3
No health facility in the village	17	30.9
No enough drugs	10	18.2
Not aware	5	9.1
No enough health personnel	3	5.5

3.5.1 Poverty

Poverty was among the factors identified as a attributing to low enrolment in the scheme whereby 47.3% of respondents indicates that lack of enough income to contribute to the CHF was the major barrier for joining the scheme (Table 4). Kamuzora and Gilson (2007) found that inability to pay for annual contribution was a barrier to join the scheme in Tanzania, while in Igunga district the richer joined the scheme than the poor (Msuya *et al.*, 2004) and in Tanzania in general (Macha *et al.*, 2014). A study conducted in Ghana found that many low-income households regularly postponed medical treatment, resorted to self-treatment, or use alternatives provided by unregulated healers, spiritualist, and itinerant drug vendors, often with disastrous results (Oppong *et al.*, 2010).

3.5.2 Lack of health facility in the village

Lack of health facilities in the village was also a reason for low enrolment of members in the scheme (Table 4). These households obtained their health services from another village which is almost 9 Kilometres away from their village. Prekker and Carrin (2004) found that individuals living within 30 minutes of health facilities were 296 % more likely to have participated in the scheme. A study in Rwanda (Rwandan Ministry of Health, 1999) reported that living near health facilities influenced household's demand for health insurance, than household health and economic indicators. This suggests that, lack of health facilities in villages, not only further excludes people from joining and benefiting from the scheme, but also exacerbates out of pocket expenditure among these groups hence accelerating more income poverty.

3.5.3 Inadequate drugs

Results from this study indicated that 18.2% of the respondents were not members because of inadequate drugs in health facilities (Table 4). Drugs out of stocks are common problem in most parts of Tanzania and in other developing countries. This is due to inadequate funding to the health sector. Lacking drugs in health facilities means that households are forced to use out of pocket expenditure to meet their health service's needs. A study conducted in four rural districts of Singida, Mbulu, Kigoma and Kilosa in Tanzania reported that when drugs were out of stock, CHF members had to buy drugs at private pharmacies (Mtei *et al.*, 2014), hence exacerbated income poverty. Similar findings were reported by RTI (2010) in Nepal.

3.5.4 Lack of enough health personnel

Lack of health personnel accounted to 5.5% as a barrier for enrolment of members in the scheme (Table 4). The council had 118 staff while requirement was 970 health workers with a shortage of 772 workers. In addition, health facilities had an acute shortage of health equipments, medicine and others including WASH facilities (District Strategic Plan, 2013-2018). Presence of qualified, competent and committed health personnel is an attractive factor for households to join the scheme. URT (2014) reported that less than 50% of Tanzanians are attended by skilled health workers, most of them are in urban areas while there is a devastating scarcity in rural areas. For instance 1,270 medical doctors are serving in urban population while 439 doctors are serving in rural areas (URT, 2014). Furthermore, in Tanzania, the ratio of doctors varies according to the region, for instances, the ratio of doctors in Dar es Salaam city was 21.2 per 10,000 people compared to 13.7 per 10,000 people in Singida (URT, 2014).

3.5.5 Low awareness on CHF

About 9.1% of the respondents indicated that low awareness on the scheme was a barrier to them to join the scheme (Table 4). This implied that although 79% claimed to be aware of the scheme (see Table 1), sensitization of the community on scheme is still needed. Limited understanding of the insurance concept, which includes risk pooling were found to affect enrolment in a community health financing scheme in Uganda (Mtei and Makawia, 2014). Sensitization of the community has no end, it requires a continuous process to ensure that everybody in the community receives a full package of enlighten about the scheme. In Rwanda, for example, membership to Community Based Health Insurance is both annually renewable, and voluntary which means that people have to be sensitized to the benefits of CBHI and importance of purchasing health insurance each year to ensure that they will join the scheme (MOH, 2012).

4.0 CONCLUSION AND RECOMMENDATIONS

The objective of the study was to assess the performance of CHF in Mkalama district. The study reported that, majority of people were aware of the programme; however, there was low enrolment suggesting that other factors may have prevented high enrolment and general low enrolment trend. The major health services provided under CHF were preventive care, outpatient, drugs and medical equipments, laboratory and diagnostic services. Inpatient care was partially covered in the benefit package while referral system outside the district is not covered at all. Recent enrolment increase was a as result of the implementation of TASAF III which provided poor households with conditional cash to finance their health and education of their children, therefore posed the question of sustainability of enrolment in future. Furthermore, major reasons for low enrolment were poverty, lack of health facilities in the village and inadequate health personnel and drugs. Political commitment is still highly required especially in sensitization of the community, the district council in collaboration with other stakeholders (including central government) should construct health facilities in the villages to reduce walking distance, should ensure that

qualified health personnel and medical facilities (equipments and drugs) are available and equitably distributed to all health facilities.

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