The Performance of Community Health Fund in Tanzania: A case of Chato and Buseresere wards in Chato District

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Abstract

This study was conducted in two wards of Chato district namely; Chato and Buseresere wards. A cross sectional community survey was conducted in these two wards aiming at assessing the challenges on the performance of Community Health Fund (CHF) and peoples' perception on health care services provided by the scheme. The specific objectives were to assess the execution of CHF in the study area, to identify the current enrolment rate and enrolment trend, and to assess the perception of the community on the scheme. The study employed 190 respondents including members and non-members of CHF as well as key informants. The sample was selected by simple random sampling and purposive methods. It was found that, the performance of the scheme in the study area was very poor, enrolment rate was very low and the new enrolment trend was declining. While lack of knowledge of CHF was noted to be one of the main sources of low enrolment, quality of services was very poor and the premium was unaffordable to the majority except for few people. Basing on such result it is recommended that, Effective sensitisation should be carried out and CHF services should be extended to private hospitals. Evaluation of the program should be carried out regularly and there should be specific doctors for members of CHF. This is to say, if quality of services is to improve; and through seminars about CHF targeting people's sensitisation, monitoring and evaluation of the scheme should be regularly done by both the government by involving the beneficiaries

Keywords: Community health fund, enrolment rate, enrolment trend, premium

1.0 Introduction

Many developing countries are striving to find out various options for improving financial sustainability in health sector, while honouring its strong commitment to equity in providing health services. Apart from all these efforts, it is unfortunate that most of them still rely heavily on out of pocket payments to finance their health care systems (WHO, 2000). Experience has shown that out of the pocket health payment is the least efficient and most inequitable means of financing health care (Diop *et al*., 1995). This system also prevents people from seeking health care (Currin *et.al*., 2007) Community Based Health Insurance Schemes (CBHI), CHF being its typical example have been seen as potential option for protection from the impoverishing effect in reaching a large number of poor people who would otherwise have no financial protection against the cost of illness (Dror, 2001). This is a prepayment scheme where people are asked to pay before they need service. Social health insurance introduced in different countries across the world appears in many different shapes and sizes and even others have dared to give them their own names according to what they desires(McIntyre *et al.*, 2003)..

In Tanzania, in 1994, through its health sector reform initiatives, the government in collaboration with the World Bank's international development associations and other donors designed a new approach to improve the financial sustainability in heath sector and to increase access to health services. This was called Community Health Fund (CHF), a form of Community Based Health Insurance (CBHI). Before CHF was introduced to the whole country, Igunga district was selected as a pilot area. The original design of CHF anticipated that, by the end of 2003 all 113 districts in Tanzania would have operating CHF and 60% of all households in each district would have become a CHF member (Baraldes and Carrreras, 2003) and that, 85% of people most of them living in rural areas would become members of CHF by 2015 (URT 2004). However, by April 2003, only 14 districts had an operational CHF and 39 districts had passed the preparatory stage for the implementation of a Council Health Board and required committee within the districts (MOH, 2003).Different studies conducted recently in many areas in Tanzania have revealed low level of enrolment to community health fund (Kamuzora and Gilson, 2007). The general rate of enrolment in Tanzania is below 30% which is very low compared to the rate anticipated by the government to reaching 60% of all households by 2003 and 85% of rural people by 2015. However, this rate of enrolment is uneven and has the tendency of either being stagnant or declining over time (Chee, 2002; Bunnet, 2004).

In the study area, the program started in December 2007. However, the performance of this program is not pleasing at all. Despite having a lot of advantages the response of the people to this program is very low, enrolment on the scheme is very low. This situation calls for in-depth study to understand the reason for such situation. This study therefore

aimed at assessing the execution of CHF in the study area, identifying the current enrolment rate and trend, and assessing the perception of the community on the scheme. It is hoped that the findings for this study will shade the light to the government when planning to improve the performance of CHF in other parts of the country.

2.0 Methodology

2.1 Study area

The study was conducted in two wards of Chato district namely Chato and Buseresere. This is one of the districts in Geita region having a lot of socio-economic transaction covering transportation, mining, fishing and agriculture sectors which attracts many migrants (both permanent and temporary) hence exposing the residents to many water bone and communicable diseases.

2.2 Study methods

The study used a cross sectional study design. This design was helpful in getting the difference between the two wards and was useful in addressing costs and time constraints. Both qualitative and quantitative data were collected from both primary and secondary source. In secondary source, data were extracted from reports, CHF register books and official records. Other secondary sources were the district profile, implementation reports, district plans and other relevant sources which assisted in providing desirable information. All secondary data were collected by using summarisation and abstraction from documentation. In primary source, data were collected directly from the field means of interview using semi structured and structured questionnaires and focus group discussion using checklist. A total of 190 respondents were selected and interviewed. Respondents included people who were members and non-members of CHF, Health workers, members of village government, ward leaders, and district officials. Systematic simple random was used to select respondents from members, simple random selection was useful for non-members of CHF and purposive for key informants. Data analysis was done using scientific package for social science (SPSS). Descriptive statistics such as frequency table and percentiles were used. Tables, charts (graphs) were used in presentation of analysed data. The analyed data were interpreted so that to give the real picture of the problem.

3.0 Results and Discussion

3.1 Demographic characteristics

The general characteristics of respondents are presented in Table 1. Results from the Table indicate that, distribution of respondents by sex, marital status and age between the

two groups shared different patterns. Male were 62 percent for non CHF members making a difference of 24 percent with female compared to a slight 5 percent difference for CHF members. Results further reveal that, although most of the respondents in both groups were married however, there were a significant proportion of respondents i.e. 25 percent for CHF members and 12 percent for non CHF member that were widow and widower. Table 1 further shows that, 11 percent of respondents for CHF members were aged below 30 years compared to non CHF members in which 20 percent of respondents had age below 30 years. This can be noted that CHF members group involved relatively older individuals compared to non CHF group. Enrolment to CHF program in most places where they exist is usually guided by particular enrolment criteria i.e. widow, orphans, and indigents may be encouraged to join (Jutting, 2001). Therefore, the observed differences between the two groups in distribution of respondents by the above demographic characteristics could be contributed by those enrolment criteria to CHF in the area. It can also be seen in Table 1 that, more than half of respondents indicated their household to involve at least five individuals for CHF member.

Table 1. Respondent's demographic characteristics

VARIABLES	CHF MEMBERS		CHF NON MEMBERS		TOTAL	
	Frequency	%	Frequency	%	Frequency	%
Sex						
Male	38	47.5	59	62.1	97	55.6
Female	42	52.5	36	37.9	78	44.6
Marital status						
Married	33	41.3	79	83.2	112	64
Single	14	17.5	4	4.2	18	10.3
Divorced	13	16.3	1	1.1	14	8
Widowed	20	25	11	11.6	31	17.7
Age						
< 30	9	11.3	18	19.6	27	15.7
30-45	48	60	43	46.7	91	52.9
>45	23	28.8	31	33.7	54	31.4
Household size						
<5	30	38	38	41.3	68	39.8
5 to 10	43	54.4	35	38	78	45.6
>10	6	7.6	19	20.7	25	14.6
Distance to the health facility						
<5 kms	57	71.3	58	62.4	115	66.5
5 to 10	23	28.8	29	31.2	52	30.1
.>10kms	0	0	6	6.5	6	3.5

Income is given more weight since it is the main determinant of the ability of the household to pay for the premium. Households with reliable source of income are likely to join the CHF program while low income prevents people from seeking health care (Currin *et.al*.,

2007). Results from Table 3 indicate that 91 percent practice farming and it is their major means of livelihood. Respondents' also were engaged in small business that account for 39 percent and the rest of activities account for less than 10 percent of the livelihood in the area

Table 2: Distribution of respondents by major source of income

Source of income	*Frequency*	*%*
House renting	9	5.1
Farming	159	90.9
Fishing	14	7.9
Small bussness	68	38.9
Tailor	11	6.3
Selling charcal	12	6.9
Selling water	3	1.7
Carpeter	2	1.1
Wage employment	7	4
Selling second hand clothes	1	0.6
Selling livestock	14	8
Selling cereals	3	1.7
Selling bricks	2	1.1
Lumbering	1	0.6
Shop	6	3.4
Guest house	1	0.6
Selling labor	3	1.7
Grants from relatives	1	0.6

3.2 Program implementation/execution

CHF program started to be implemented in the study area in 2007. The first people to be registered were those enrolled and sponsored by Rulenge Diocese Development Office (RUDDO). This is a religious Non-Governmental Organization (NGO) involved in helping people living in difficult environment, old people, very poor people, widows, and orphans. This organisation pays the premium for these people as well as providing them with other necessities like school uniforms to orphans who are in schools; clothes for widows as well as mobilizing groups of people to initiate their own development projects by supporting them with capital. RUDDO is performing these activities through involving hamlet leaders and self-volunteered people who assist in identifying people with such characteristics. However, RUDDO operates in Chato ward only and it can be seen by having a large number of CHF members compared to Buseresere which indicate that enrolment by voluntary is minimal as it will be seen in enrolment rate report

The paying of contribution by churches and other charitable organizations is not new as it has also been reported in the Senegal study (Jutting, 2001) and in China (Shi et al 2010). It was reported that, since the introduction of the program, voluntary enrolment to CHF by the community was very minimal and discouraging. In this study it was found that until recently when the study was undertaken apart from the individual enrolled by RUDDO, only 5 individual in Chato out of 157 members, enrolled voluntarily to the program. Similarly, very few individuals (15) in Buseresere ward were found to be enrolled. Delay in sensitization on program by responsible people from CHF and district authority was among the factors for the observed trend. The following quotation from Chato ward councilor confirms, "I delayed doing it because I had no means for sensitization". By means he meant funds for facilitating sensitization.

The study also found that, although RUDDO had been involved in enrolling people into CHF and was supposed to sponsor them, it seems that RUDDO did not do so accordingly. Consequently, CHF members enrolled by RUDDO frequently encountered difficulties in accessing services at the hospital. A woman *from Muungano-Chato* was blaming saying

"when we go to the hospital we are told that RUDDO is no longer recognized, they do not pay the premium for their members, thereafter, we are told to wait until all who pay cash on spot are attended. Isn't this a discrimination of its own kind?"

This statement was also supported by the words of the Coordinator of people living in difficult environment employed by RUDDO who was quoted saying,

"One old man who is a member of CHF under RUDDO reported to me saying, he went to Chato hospital but he was not given service instead after waiting for a long time he went to buy drugs from private medical shop"

Generally, the implementation of CHF program in the study area has not been undertaken seriously. No follow up is made upon its operation. This situation puts at risk the health of the poor whom the CHF intended to rescue. A quick and appropriate measure need to be undertaken by the government to correct this situation and revive the operation of CHF.

3.3 CHF enrolment

3.3.1 Enrolment rate

When Government instituted this scheme, it had a long term target of reaching 85 percent of poor people most of them living in rural areas (URT 2004). However, the rate of enrolment on CHF in the study area is not encouraging at all. Since the commencement of the program to date, only 157 households which is equal to 2.3 percent of all households in

Chato ward have been enrolled on CHF in which 96.8 percent were enrolled and sponsored by RUDDO. With regard to Buseresere only 15 households which is equivalent to 0.1 percent of all households in the area have been enrolled into CHF. There is no RUDDO project in Buseresere, therefore all those 15 households have been enrolled on voluntary basis. Such low enrolment was also revealed by WHO study made in 1998 concerning 82 non-profit health insurance schemes for people outside the formal sector employment in developing countries where it was observed that very few of these schemes covered large populations or did not even cover high proportions of the eligible population (Carrin, 2003). Shaw (2002) observed such low enrolment in Tanzania where he found that, CHF membership is still relatively low and dropout rates are increasing even for those schemes that have been in operation for some time such as Igunga and Singida. Such low enrolment implies that a large population will continue depending on out of pocket payment which has a harmful impact as it may lead to prolonged impoverishment of poor household (Shi *et al*., 2010).

3.3.2 Enrolment trend in the study area

Generally, the new enrolments in both wards are declining at an alarming rate. Results in Figure 1 show that, the number of new enrolees declined from 138 in 2007 to 5 in 2009 in Chato ward and from 13 to 0 in 2009 in Buseresere ward. Such negative trend correlates to the findings of other studies in other areas. For example, Chee *et al*. (2002) in their assessment of the CHF in Hanang district in Tanzania found that membership in 2001 was around 3 percent of total households. However, more recent data collected in the same area indicated that enrolment fell further to 2.2 percent in 2003 (Musau, 2004).. Such negative trend implies the reduction in the revenue generated and thus poses threat on the sustainability of the program. Not only that but also creates fear on meeting the target of the Government of reaching 85 percent of the people living in rural areas by 2015 (URT 2004), unless the government intervene this situation

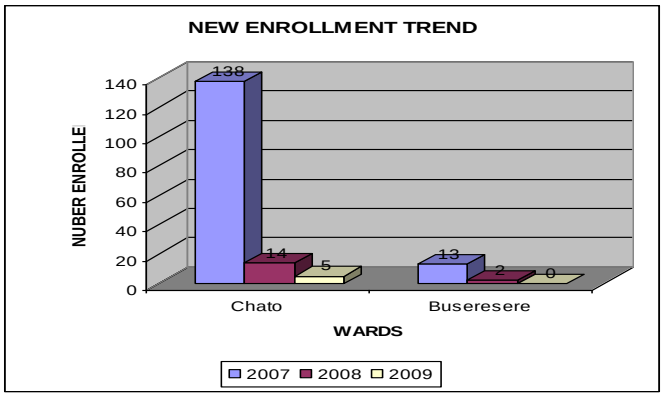

Figure 1: Trend of new enrolment in the study area

3.3.3 Interventions used to enhance enrolment

When asked about the interventions used to influence people's enrolment, some of the respondents who were responsible for sensitizing people to enrol, they mentioned methods like open air meetings, public meeting, talking to people face to face, and talking to patients when they come to hospital for treatment and through Ward Development Committees meetings (WDCs). However, all of them agreed that despite the usage of all these approaches, still the extent of their successfulness is almost negligible. This situation calls for improvements of methods and strategies to be used in approaching these communities. On the other hand, effectiveness of the program itself can be one of the methods. If and only if member of CHF enjoys the services can attract others as s/he [beneficiaries] stand as good as point of reference.

3.4 CHF awareness

The study also wanted to measure the extent to which CHF is known to people. In this regard, non-members were asked to indicate if they are aware of CHF in their area or not. Results from Table 3 indicate that, 93 percent of non-member respondents were not aware of the existence of the CHF program within their area. These results indicate that lack of knowledge about CHF could be among of the factors for the observed low enrolment trend in the study area. It is difficult for people to enrol on something they do not know. Similar findings were reported by Chee, (2002) where among others, he mentioned lack of knowledge of the CHF to be the source of low enrolment. Therefore, educating people about the program need to be given the first priority rather than throwing the blames to them for not enrolling.

Table 3: Non-member's knowledge about CHF

Response	Frequency	%
YES	7	7.4
NO	87	92.6
TOTAL	94	100

3.4.1 Distance versus knowledge about CHF

Distance from health centre and remoteness has a great influence in knowledge of people about CHF. In most cases people who live in remote areas far from health facility are not reached by sensitization team due to poor transport, lack of fund etc. (Leterveer *et al*., 2004).

The study therefore wanted to identify the relationship between distance from health facility and knowledge of CHF in the study area. Results from Table 4 indicate the inverse relationship between distance to health facility providing CHF and the knowledge of CHF. All 100 percent of non-member respondents who claimed to know about CHF live within 5kms from their home steady to health facility providing CHF. In contrast, substantial proportion of respondents 41 percent who claimed not to be aware of CHF lived more than 5kms from their home steady to health facility with CHF. This implies that majority of vulnerable people are unaware of CHF schemes and among other things, this is attributed to the distance from their home to the health facility providing CHF. This result is on line with the conclusion made by WHO in its study of 82 schemes that, "very few schemes reached the vulnerable population groups" (Carrin, 2003). Furthermore, the majority of respondents particularly CHF members as indicated in Table 4; 71 percent versus 62 percent for non-members were living within 5kms from their home steady to the nearest health facility. This bear a resemblance to Laterver *et al*. (2004) who urged that distance to the nearest health facility has a substantial influence on health seeking behaviour and enrolment on CHF and that, in most cases, long distance to the nearest health facility tends to influence negatively and perhaps it is one of the reasons the study observed 7 percent of non-member for those who were above 10 kilometres a distance against zero for members in Table 4.

Table 4: Distance versus knowledge of CHF

Distance	YES		NO		TOTAL	
	Frequenc	%	Frequenc	%	Freque	%
<5kms	7	100	50	59.0	57	62.0
5 to 10	0	0	29	34.1	29	31.5
>10	0	0	6	7.0	6	6.5
Total	7	100	85	100	92	100

3.5 Perception of the community on CHF scheme

3.5.1 Current services provided

The study aimed at exploring the views of the community on the services provided by the scheme. In this aspect CHF members were asked to judge the quality of services, care by health facility workers and cleanliness at hospital as they are perceived to be. With the exception to cleanness, quality of services and care by hospital workers were judged poorly by 64 percent and 68 percent respectively. Cleanliness of the hospital were fairly well in which more than two third of the total respondents judged it as average to good.

Table 5: Rating of health services

Rating	Quality of service		Care by Hospital		Cleanness	
	Frequency	%	Frequency	%	Frequency	%
Good	11	14.5	14	18.7	27	36.5
Average	16	21.1	10	13.3	25	33.8
Poor	49	64.5	51	68	22	29.7
Total	76	100	75	100	74	100

Poor quality of services and care by health workers in most of the Government hospital was also portrayed by the results from non-members FGD conducted in Chato ward. In this FGD all people who attended, together agreed that the services are poor. When asked 'why do you say that services are poor while you are not a member and you have never been enrolled" one participant responded by saying

"We see other people who are supposed to receive free services like old people, women with little babies, and pregnant women the way they are treated. We are served by the same doctors; procedures for obtaining services are the same, we stand on the same waiting line. How can we escape this annoyance?"

Non-members from FGD Buseresere when asked are you willing to enrol after knowing the advantages of CHF, they all agreed but they expressed their worry on the services provided by the scheme. One woman stood up and busted saying, "When we go to hospital, we are often told there are no drugs" This statement was supported by councillor of Chato ward, who was quoted saying,

"I once received a case of one woman whose drugs were prescribed by a doctor and was told to go and take drugs from the pharmacy. When she reached at the window where drugs are given, she was told that, those drugs are out of stock and that she is supposed to go and buy them. That woman brought that case to me. Because I knew that at the

hospital we have enough stock of drugs, the next day I went at the same window with the same paper of prescription and wonderful enough I was given those drugs."

Poor quality of services offered by Government hospitals has also been reported by other studies. Report by URT (2003) indicated that most public health facilities in Tanzania suffered from severe shortage of antibiotics, antacids, and anti-diarrhoea drugs and that the supply did not appear to be closely related to patient's attendance and activities of the health facilities. In this study it was found that, health system factors such as staff behaviours influenced choice of place of delivery (home versus health facility) by pregnant women. These staff behaviours include abusive language, denying women service, lack of compassion and refuse to assist them properly. Bonu *et al*. (2003) argue that the poor enrolment rates in many CHF may be linked to a perception of poor quality of care. Thus those who register initially into the scheme may drop out quickly if the quality of care does not reach their expectations. Basing on all these arguments, it is futile to relegate the issue of poor services provided by CHF at hospitals in the study area. Drug unavailability, long waiting time and use of abusive language are some among many aspects which calls for policy makers to act upon them rapidly so as to change the situation.

3.5.2 Health services before and after the scheme

The study also wanted to explore how people perceive the service before and after the scheme. A total of 61 members of CHF responded to this question and 19 didn't say anything because they had never attended to the Government hospital for treatment because of long distance. Results from Figure 5 shows that 71 percent of the respondents were of opinion that, the quality of services remained constant even after the introduction of the scheme, meaning that no improvement. Only 16 percent said the services improved after the introduction of the scheme while 13 percent went far saying the services were deteriorating.

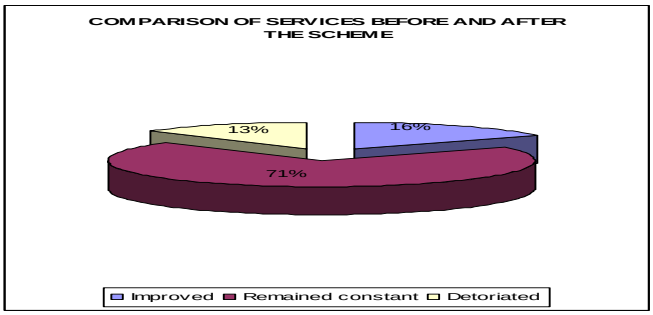

Figure 2: Health services before and after the scheme

Focus Group Discussion (FGD) also revealed the same results where one member quoted saying,

"we are experiencing the same problems like those we experienced before the scheme, problems of drugs unavailability, long waiting time and bribes are still existing as in those days, how can we say the services have improved."(by a member from FDG Buseresere).

3.5.3 Premium affordability

The premium paid in both wards are the same, i.e. Tshs.5000/= per year. However there is a slight difference in limit of members to be enrolled. In Chato ward the limit of members is 10 per single premium while in Buseresere ward there is no limit of members provided they all belong to the same household. The premium is for the whole household regardless its size. The study therefore wanted to explore the views of the people with regard to affordability of the set premium. A total of 161 members and non-members responded to this question and the results are as displayed in the Table 6 below. Results from this table shows that, most of the interviewed respondents in both groups of member and non-member were of the opinion that, the amount of the premium set by the program is affordable. This was indicated by 82 percent and 73 percent of members and non-members respectively.These results contradict what has been reported in Congo by Criel (1998) where subscribers were quoted saying, "*we are not refusing to pay but we can't afford it*". In Congo's study it was found that, majority of residents where the scheme operated viewed the premium set to be a major barrier to the enrolment to the scheme.

Table 6: Affordability of the premium

	MEMBER		NON MEMBER		TOTAL	
	Frequency	%	Frequency	%	Frequency	%
Affordable	62	81.6	62	72.9	124	77
Not affordable	14	18.4	23	27.1	37	23
Total	76	100	85	100	161	100

3.6 Suggestions by the community for improvement of CHF

Sustainability of any project dependents largely on the involvement of beneficiaries in making major decisions pertaining to the management and operation of that project thus, CHF calls for an important role of the community in designing and running the scheme (Jutting, 2001). For members to join a community scheme there is a need to involve members from the beginning of the formulation of the scheme in order to make them feel as part of the scheme (Mulligan and Mtei, 2007). Regarding this aspect, the study wanted

to seek the views of the community on what should be done to improve CHF services.Table7 assert that 31 percent of the respondents were of the opinion that sensitization should be increased, 39 percent drug availability should be ensured in the hospitals and 14 percent health workers should stop using abusive language and should be compassion.

Table 7: Suggestion by the community for improvement of CHF

Suggestions	Frequency	%
Increased sensitization	22	31.4
Reduce waiting time	4	5.7
improve drug availability	27	38.6
Stopping abusive language	10	14.3
Care improvement	7	10
Follow up on CHF operation	8	11.4
Cleanness improvement	2	2.9
Premium reduction to 1000	1	1.4
Premium reduction to 2000	1	1.4
People to be given grants	1	1.4
Service improvement	16	22.9
Extending services to private health facility	4	5.7
Presence of specific doctor for CHF	1	1.4

4.0 Conclusion and Recommendations

The performance of CHF in the study area is very poor; Lack of knowledge about CHF is the main hindrance to the people's enrolment. Sensitization has not been made seriously; There is lack of seriousness among hospital workers, community leaders, and other higher authority leaders in sensitizing communities to join CHF; The district and other higher authority leaders put little emphasis on CHF; Enrolment rate is very low and it shows no sign of increasing; the trend of enrolment is declining at a very rapid rate; A quality of services care by hospital workers and patients' health personnel relationships is not pleasing at all; Drug unavailability and use of abusive language to patients are the examples of annoyance that faces people; The premium is not a big problem to many people except few of them. Many people are willing to join at the prevailing premium but their hesitations are on the quality of health services provided by the existing health facilities. Basing on the finding, it is recommended that, Effective sensitization should be

carried out and CHF services should be extended to private hospitals. Evaluation of the program should be carried out frequently and there should be specific doctors for members of CHF. This is to say, if quality of services is to improve; and through seminars about CHF targeting people's sensitization, monitoring and evaluation of the scheme should be regularly done by both the government by involving the beneficiaries.

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References

Baraldes, C. and Carreras, L. (2003). Willingness to pay for Community Health Fund Card in Mtwara rural health district Tanzania, Medicines sans Frontiers Spain.

Black R. and Kremer, M. (2004). Targeting development: Critical perspectives on the millennium development goals, Taylor & Francis, London.

Bonu S. and Manju, R. (2003). "Using willingness to pay to investigate regressiveness of user fees in health facilities in Tanzania." *Health Policy and Planning*, 18: 370-382.

Bunnet, S. (2004). The role of community based health insurance within the health care financing system: a framework for analysis in health for analysis in: *Health Policy and Planning*, 19(3): 147-158.

Carrin, G. (2003). Community based health insurance schemes in Developing countries: Facts problems and perspectives.discussion paper No 1-2003, Geneva, WHO.

Chee, G. and Smith, K. (2002). Assessment of the Community Health Fund in Hanang District in Tanzania, Dar es Salaam PHR plus.

Criel, B. (1998), District based health insurance in sub-Saharan Africa: Part 1 from theory practice; Studies in health service organization and policy, Antwerp.

DiopYazbeck, A. and Bitràn, R. (1995). Low –Income populations still rely heavily on out-of-pocket expenditure instead of risk-sharing arrangements to pay for care, exposing themselves to the risk of impoverishment (bankrupt), Germany's Social Long term Care Insurance, Schneider 1999 pp 43

Dror D. M. (2001), Reinsurance of health insurance for the informal sector. *Bulletin of the World Health Organization*, 79(7): 672-678.

Jutting J. (2001). The impact of community health financing on financial protection: A case study of Senegal, World Bank discussion series on health, nutrition and population.

Kamuzora P and Gilson, L. (2007), Factors influencing implementation of Community Health Fund in Tanzania, health policy plan, Dar es Salaam, Tanzania.

Laterveer, L., Niessen, L.W and S.Yazbeck. (2004). Equity implication in health sector user fee in Tanzania, Leusden, the Netherlands.

McIntyre D., Doherty J and Gilson, L. (2003). A Tale of Two Visions: The changing fortunes of social health insurance in South Africa. *Journal of Health Policy and Planning*, 18(1): 47-58.

Mulligan, J and Mtei, M. (2007). Community Health Funds in Tanzania: A literature Review Ifakara Health Research and Development Centre.

Musau S. (2004). The Community Health Fund: Assessing Implementation of New management procures in Hanang district in Tanzania, Bethesda, the partners for health reform plus Project, Abt Associates.

Shi W Chongsuvivatwong V, GeaterA,Zhang J, Zhang H, Brombal D. (2010), The influence of rural health security schemes on health utilization and household impoverishment in rural China, BioMed Central Ltd Beijing.

URT (2004), Technical review of health delivery at district level, Ministry of health, Dar es Salaam.

WHO (2000), Health System: Improving Performance, The World Health Report Geneva.

World Bank (1993), World development report: investigating in Health, Washington DC.

World Health Organization (WHO) (2007), Regional overview of social Health insurance in south East Asia: 'Overview of health care financing'.