COMMUNITY HEALTH FUND AND QUALITY HEALTH SERVICES IN MOROGORO DISTRICT, TANZANIA

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF ARTS IN RURAL DEVELOPMENT OF SOKOINE UNIVERSITY OF AGRICULTURE. MOROGORO, TANZANIA.

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ABSTRACT

The study was conducted to assess the contribution of Community Health Fund (CHF) on the quality of health services in Morogoro District. Specifically, the study assessed the utilization of health services by members and non-members of CHF on accessibility, affordability, availability and acceptability; compared the attitude of CHF members and non-CHF members on the quality of health service and identified the challenges facing CHF members and non-members in accessing and utilization of health services. A cross-sectional research design was adopted. Both purposive and simple random sampling techniques were used. A total of 100 respondents were interviewed. Data were collected using a questionnaire whereby quantitative data were collected. The analysis of data was done using the Statistical Package for Social Sciences (SPSS). It was found that attitude of respondents towards the quality of health services did not differ significantly among members and non-members of CHF. Similarly, the majority of the respondents complained that poor health services were the greatest challenge. Eventually, half of the respondents confirmed that the availability and acceptability of health services were the problem to their nearest health facilities. However, less than fifty percent of the respondents had access to health services. Therefore, they managed to afford the services. It is concluded that poor health services is one among the factors contribute people dropping out from the CHF scheme. It is recommended that the Ministry of Health and Social Welfare should strive to improve the quality of health services to both members and non-members of CHF.

DECLERATION

I, George Kivelege, do hereby declare to the Senate of Sokoine University of Agriculture that this dissertation is my own work done within the period of registration and that it has neither been submitted nor being concurrently submitted for a degree award at any other institution.

_____ _____

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(M.A. Candidate)

The above declaration is confirmed by

_____ _____

Prof. Kim Abel Kayunze Date

(Supervisor)

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DEDICATION

This dissertation is dedicated to my beloved parents, Patrick Kivelege and Grace Ndahlawa and my beloved sisters whose support helped me to reach this successful stage. May the Almighty God be with all of us in every aspect of our life.

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LIST OF ABBREVIATIONS AND ACRONYMS

CHF	Community Health Fund
CHIF	Community Health Insurance Fund
DED	District Executive Director
MDG	Millennium Development Goals
MoH	Ministry of Health
NBS	National Bureau of Statistics
NSGRP	National Strategy for Growth and Reduction of Poverty
SAP	Structural Adjustment Programme
SPSS	Statistical Package for Social Sciences
URT	United Republic of Tanzania
WHC	Ward Health Committee

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Community health financing emerged in developing countries following the challenges that exist in health financing system which include low income growth, constraints in the public sector and organization capacity (Carrin, 2003). It was also influenced by health sector reforms as an impact from the Structural Adjustment Programs (SAPs) which aimed at introducing cost sharing as a way of reducing government expenditure since the 1990s (URT, 2001). Nevertheless, Community Health Fund (CHF) can be seen as a step towards universal coverage following the widely acknowledged difficulties which exist in tax financing and social health, insurance especially in less developed countries (Carrin, 2003).

In the context of Tanzania, CHF is a district council based pre-payment scheme, and the council officials are responsible for implementing the fund successfully (Stoermer *et al.,* 2012). CHF started in 1996, and at first it was introduced in Igunga District as a pilot scheme and later on expanded to other councils. However, CHF is now covering the entire country (URT, 1999; Martin and Manfred, 2011; Rebhan, 2009). The objectives of CHF in Tanzania include mobilization of financial resources from the community for the provision of health care services to its members, provide quality and affordable health care services through sustainable financial mechanisms and 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).

The linkage between CHF and quality health services is that the use of CHF and other financial resources ensure quality improvements of the health services being offered at the health facilities, especially the availability of medicines and supplies. This can be realized through supplementary procurement using CHF funds and other sources, as well as through improvements in the control and management of drugs within the facility (Shleifer and Vishny, 1993; Mubyazi *et al.,* 2005; Stoermer *et al.,* 2012) assert that, for a common community member, good quality of health service might mean the availability of drugs, diagnostic and bed facilities, short patient waiting time and staff courtesy. The interest of a health worker might include things like working environment, such as attractive and well-equipped offices, building, working gears, and greater autonomy to make decisions about their patients' health, including among other things the mandate to prescribe drugs.

In Tanzania, literature shows contradiction on the improvement in the provision of quality health services after the introduction of CHF. For example, Shaw, 2002; Rogers *et al,* 2009) argued that the CHF fund helped to improve the quality of health services through ensuring availability of important equipment and supplies in various hospitals. Other studies have linked CHF with provision of poor quality health care hence registered members have been dropping out tremendously after realizing CHF does not meet their anticipations (Ritchie and Lewis, 2003; Musau, 2004). In view of this, Mtei and Mulligan (2007) suggest that there is a need to address some important issues concerning provision of services under CHF. Therefore, the study for this dissertation was intended to assess the quality of health services utilized by members and non-members with CHF in Morogoro District.

1.2 Problem Statement

Community Health Fund (CHF) was introduced to improve the quality of health services. However, it has been noticed in some places that CHF has not helped improve the quality of health services. This is indicated by high dropout rate of its members. Data show that the number of members to CHF is low and declined from 5.2% in 2008/09 to 2.2% in 2010/11. For instance, literature documents that CHF contributes to the quality and affordable health care services through sustainable financial mechanism and 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).

Given the scenery of quality of health services and community health fund, many of studies in Tanzania (Agyemang-Gyau, 1998; URT, 2006; Mtei and Mulligan, 2007; Abu-Zaineh *et al.,* 2008; McIntyre *et al.,* 2008; Macha *et al.,* 2012; Lekashingo, 2012) have largely centred on assessing the enrolment, coverage and willingness of the community to join CHF. However, such studies have not provided empirical comparisons on the quality of health services accessed by members and non-members of CHF despite the fact that literature unveils two contradictory findings on the improvement of the quality of health services to its members, Mtei *et al.* (2007) reported that there is no significant impact of CHF in improving health services while, Sauerborn *et al.* (1996) opined that CHF plays an important role in improving health services. This study went beyond by assessing the quality of health services utilized by members and non-members of CHF in Morogoro District.

1.3 Justification for the Study

One of the objectives of CHF in Tanzania has been to provide quality and affordable health care services through sustainable financial mechanisms. However, available

literature reports contradictory results. For example, in some cases, CHF has enabled its members to access improved health services while in other incidences members of CHF have been dropping out of the scheme following receiving poor health care. In view of this, it was worthwhile to conduct this study since the study results provide information to health planners about the responses of the community (both CHF members and non-members) on quality of health services accessed with and without community health fund necessary for reviewing the implementation strategies. Therefore, this study corresponds to the Millennium Development Goals (MDGs) particular MDG 6. It is also in line with the National Strategy for Growth and Reduction of Poverty (NSGRP) cluster II which specifically advocates about combating HIV Malaria and other diseases.

1.4 Research Objectives

1.4.1 General objective

The general objective of this study was to examine the quality of health services utilized by CHF members and non-members in Morogoro District.

1.4.2 Specific objectives

i. To assess utilization of health services by CHF members and non-members.
ii. To compare the attitudes of CHF members and non-members on the quality of health services delivered.
iii. To identify the challenges facing CHF members and non-members in accessing and utilization of health services.

1.4.3 Research questions

i. How do CHF members and non-members access and utilize health services in the study area?

ii. What were the attitudes of CHF members and non-members towards quality of health service delivered?

iii. What were the challenges facing CHF members and non-members in accessing and utilization of health services?

1.5 Null Hypotheses

i. There is no significant association between being a CHF member and getting quality health services.

ii. Attitude towards the contribution of CHF in improving the quality of health services does not differ significantly differ between CHF members and non-members.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 The Concept of Community Health Fund

According to Dror and Jacquier (1999), the concept of CHF is theoretically appealing; its merits still have to be proven in practice. In literature, this question is controversially debated; proponents opine that CHF schemes are conceivable instrument of protection from the impoverishing effects of health expenditures for low income populations. Kamuzora and Gilson (2007) accentuate that CHF schemes are effective in reaching a large number of poor people who would otherwise lack access to financial protection against the cost of illness but other available studies are less optimistic. Community structures may not necessarily reflect the views of the wider population, critical decisions may not take into account the interest of the poorest, and they may not be excluded from decision making. Carrin *et al.* (2005) indicated that the common characteristics are that they are run on a non-profit basis and they apply the basic principle of risk sharing.

2.2 Utilization of Health Services

A study done by Chee (2002) found that utilization of health services has continued to decline from 1998 through 2001. One of the explanations given for the decline in utilization is that implementation of user fees reduced the number of people who sought care for minor illnesses or who visited the facility only to collect drugs for future illness or to sell for profit. In a related way most CHF members reported that it was easier to seek care at the health facility when ill with a CHF membership card because services are free. However, CHF members did not feel that they overuse services by going to the health facility for minor illnesses. Most non-members of CHF claimed that the implementation of user fees had not affected their utilization of health facilities. Some non-members,

however, believed that since the establishment of user fees, more people preferred to do directly to the pharmacy and buy prescription drugs, which was less expensive than the user fee. They noted that some commonly prescribed drugs were not always available at the health facility, so many people ended up paying the user fee and for the prescription drugs (Chee, 2002).

2.3 Attitude towards the Quality of Health Service

Existing literature opines different perceptions on the quality of health service delivered to CHF members and non-members. A study done by Ekman (2004) found that non CHF members perceived that CHF members were attending first before those paying user fees. This may be a reason for prompting people to join CHF. Furthermore, less CHF members compared to non-CHF members perceived that CHF members had a better health outcome. Being a second measure of quality of service explored in this study, CHF members were perceived to be receiving a better quality of health compared to non CHF members. On the other hand, a greater proportion of CHF members perceived that they (CHF member) waited longer to be attended at the health facilities (Chatama, 2007).

On the other hand, Lekashingo (2012) also found out that, more non-CHF members compared to CHF members perceived that people paying user fees were more satisfied with the health care provided. This is similar to what Dror (2001) cited by Litvack and Bodart (2012) who found that health care providers preferred user fees in Tanzania and Uganda respectively. Unlike CHF premiums which are retained at the district levels, all the user fees were retained at the health facilities and were used to recover operating costs and pay for workers incentives. This may imply that, the preference of health care providers to people paying user fees may be a motivation for people not joining CHF membership. Respondents who have never joined CHF schemes have not had the

opportunities that CHF schemes provides or they may have not heard of the benefit of risk pooling, and therefore may not see the importance of joining CHF. Indeed a greater proportion of non-CHF members had paid user fees compared to only CHF members. If all these were motivated to join CHF then the fund would have been larger, hence enabling improvement of health services (Turkson, 2009).

2.4 Challenges Facing Utilization of Health Services

According to Lekashingo (2012), CHF members in Tanzania were found to experience poor quality of health services at the facilities, poor administrative capacity at the district level, low knowledge on the part of individuals regarding the principles of health insurance, low sensitization regarding CHF and adverse selection. Adverse selection is a result of low enrollment as a consequence of the voluntary nature of CHF. The scheme with voluntary membership has the risk of adverse selection, which can lead to healthy people to leave the pool and eventually the costs of supporting the scheme to spiral and scheme being not sustainable. Eventually, the sick people may be excluded as well because the costs of supporting the scheme may become too high for the scheme authorities and thus the sustainability of the fund will become a challenge and subsequently it may fail. In the case of Tanzanian CHF which has a small pool, the sick are more likely to enroll CHF leading to limited cross subsidies from the healthy to the poor and limited capacity to provide health services. All these will lead to threatened viability and sustainability of the scheme which will lead to the scheme being unattractive to the healthy people. User fee as an alternative to CHF in Tanzania has its challenges.

2.5 Empirical Review

Various studies (Agyemang-Gyau, 1998; Steinwachs, 2001; Shaw, 2002; Beraldes and Carreras, 2003; Musau, 2004; Msuya *et al.*, 2004 and URT, 2006) in Tanzania have

largely centered on assessing the reasons for low enrollment, coverage and willingness of the community to join CHF. However, they have not provided empirical comparisons on the quality of health services utilized by members and non-members of CHF. Agyemang-Gyau (1998) assessed the ability and willingness of people to pay for their health care in Lushoto District, Tanzania. In his study it was revealed that in some ways community participation can be facilitated through willingness to pay. This study helped to provide an understanding of the willingness of the community to participate in CHF and how much they were able to contribute. In a related way, Steinwachs (2001) assessed the potential of social structures in regard to health financing and the perspectives of the local populations on willingness to pay for CHF. It was found that community members were willing to pay for CHF: for example, in Mtwara rural, members were willing to contribute between 4500 and 6500 Tshs per household. Whilst in Lushoto, members' willingness to contribute varied between 3000 and 10 000Tsh given that the services granted had to be improved. Furthermore, Beraldes and Carreras (2003) assessed the willingness of community members to join the CHF. They found that the concept of insurance was poorly understood amongst community members, and they therefore required a lot of sense to join the CHF.

Another study by Shaw (2002) assessed the Tanzania's Community Health Fund prepayment as an alternative to the user fee. The assessment found that enrollment of community members to the scheme in Igunga and Singida rural districts were 6 and 4 percent, respectively, which was low in comparison to expectations of 30 percent. Also Shaw (2003) argued that one of the reasons for low enrolment rates could be the low user fees set in public facilities as these gave little incentive for community members to join an alternative financing system like the CHF. User fees in some council like Nzega were set at 1000 shilling per visit at health center level and many community members were willing to pay the user fee rather than the higher CHF premium. Similarly, Chee *et al*.

(2002) assessed the community health fund in Hanang district. In their study it was found that CHF membership in 2001 was around 3 percent of total households. However, in 2003 fell further to 2.2 per cent. The results further revealed some weaknesses in CHF financial management and information systems, especially in the operation at the ward health committee (WHC). Musau (2004) assessed the community health fund in implementation of new management procedures in Hanang district. It was found that CHF membership that had reached a peak of 23 percent in 1999 yet within just a few years had apparently fallen dramatically to less than 3 percent. Hence, Musau suggested the need to address some important issues concerning provision of services.

On the other hand, MoH (2006) mapped the operation of the community health fund. It was noted that, in some councils, community members were unaware of how the membership fee was set, This meant that where a CHF member was in need of referral care, the only option was out-of-pocket payment which led to catastrophic expenditure. Some district councils, such as Hanang, Igunga, Mwanga and Rombo, have gone beyond the original CHF design and extended the coverage of CHF benefits to hospitals using CHF revenue, although there was little information on the impact of this. Msuya *et al.,* (2004) assessed the impact of community health insurance schemes on health care provision in rural Tanzania. They found that 60% of richer households in Igunga district joined the scheme compared to 33% of the poorest households. The reasons were found to be lack of information due to insufficient sensitization or education 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 facilities (drug availability and inadequate service provision) poor staff attitudes, and broad exemption policies which leave a limited number of people contributing to the CHF.

2.6 Research Gap

Much has been done by previous researcher concerning the enrolment in CHF in different geographical area, and came up with various findings on the reasons largely centred on the reasons for law enrolment rate, poor coverage and willingness of the community to join CHF. However, they have not provided empirical comparison on the quality of health services accessed by members and non-members of CHF despite `the fact that literature unveils two contradictory findings regarding the quality of health services provided to members and non-members of CHF.

2.7 Conceptual Framework

Access to health services is an important aspect in the wellbeing of people irrespective of their enrolment status to social security schemes which provide health care services. However, the decision of choosing the right place for accessing health services is influenced by the number of factors such as education, income, distance, and age. In the process of seeking quality health services individuals may opt for enrolment to schemes which provide health care CHF in this particular or otherwise. Additionally individuals may opt for private owned health facilities or public health facilities. Quality of health care provided significantly affects the decision of the household to join CHF scheme. Health service utilization challenges and attitude toward health quality delivery are yet another determinants when it comes to enrolment to CHF. Nevertheless, if clients' anticipations of getting tailor information on their needs and getting the right information on the method accepted are not attuned may suggest for the sustainability of services provided with the scheme and will assure clients' knowledge, satisfaction, and health.

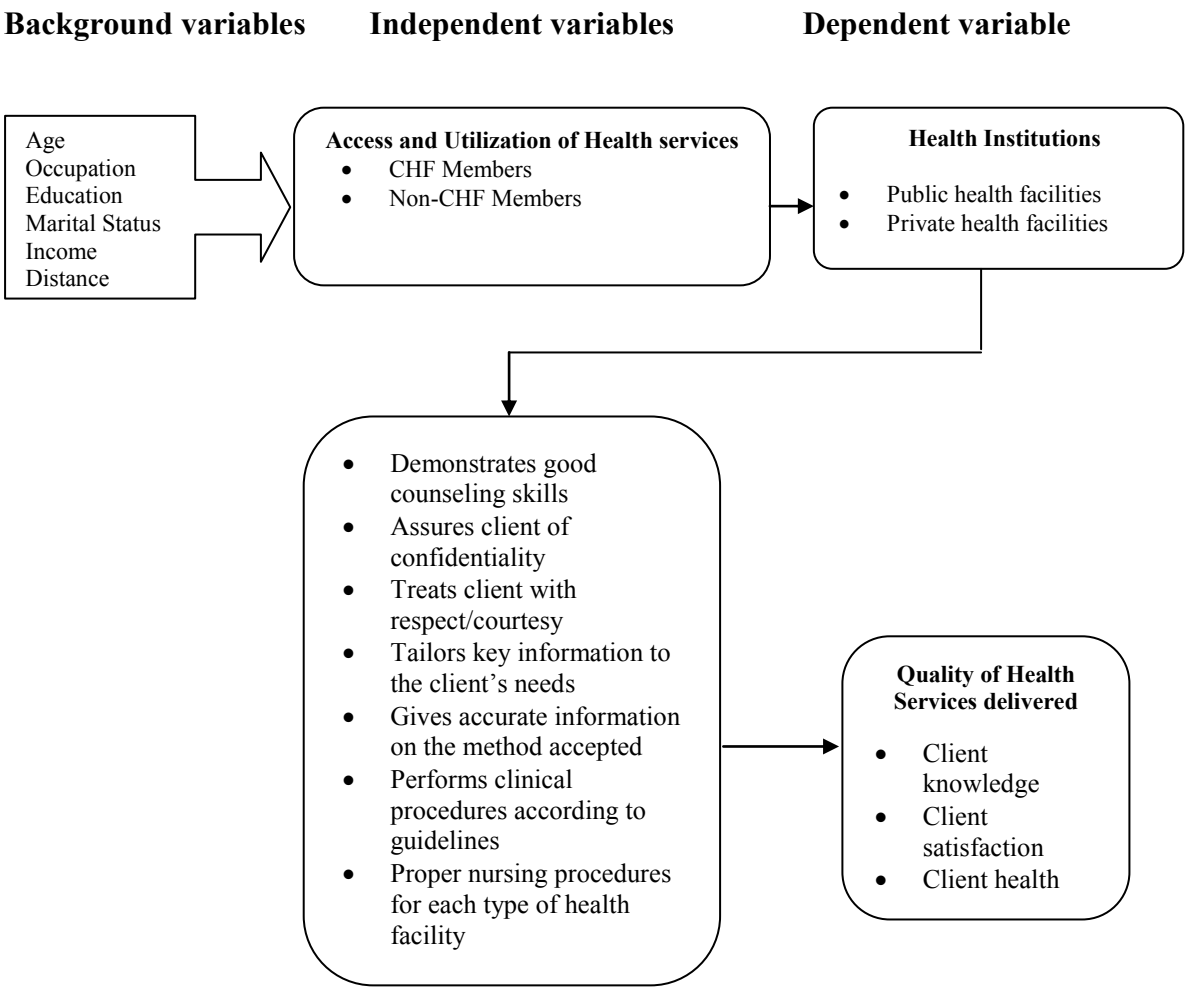

Figure 1: Conceptual framework community health fund and quality health services

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Description of Study Area

The study was carried out in Morogoro Municipal council in Morogoro Region, Tanzania. The Region lies between latitudes 5°58" and 10°0" to the South of the Equator and longitudes 35°25" and 35°30" to the East of the Greenwich Meridian. Other districts of Morogoro Region are Morogoro Rural, Ulanga, Kilombero, Mvomero, Gairo and Kilosa. The main economic activities that take place in the district include agriculture, fishing, Livestock keeping (chicken, cattle, goats, sheep and pigs), and others. In view of this, agriculture is the main source of income of the people of the district. According to the 2012 National Population and Housing Census (URT, 2013), the population of Morogoro Municipal Council was 315 866 in 2012, including 164,166 and male and 151,700 male.

3.2 Research Design

A cross-sectional research design was adopted in this study. The design was favourable because of various reasons, especially the nature of the study objectives, which needed data to be collected at a single point in time.

3.3 Study Population

The population for this study comprised all individuals who were users of health services in Morogoro, both members and non-members of CHF.

3.3.1 Attributes of the respondents

(i) (CHF members): For a participant to be included in the study, she/he was supposed to be a head of the household, a spouse or an active CHF member, attending any of health facility.

(ii) (Non CHF member**):** For a participant to be included in the study she/he was supposed to be a head of the household, a spouse or non-CHF member; attending any of health

3.4 Sampling Procedures and Sample Size

In selecting study wards, purposive sampling was used to select five (5) wards namely Sabasaba*, Uwanja wa Taifa, Kiwanja cha Ndege,* Mafiga and Kihonda. The wards were selected due to having health facilities. Again, based on the availability of health centres, out of these wards, ten streets were purposively selected. The streets included Kiswanya 'A', Kiswanya 'B', Kambaya, Mafiga 'A', Kwamkomola, Kwachambo, Polisi, Mtagwa, Tupendane and Makondeko. On the other hand, in selecting households, snowball sampling was applied. Of the 3098 households, ten (10) streets were selected. This percentage was chosen in order to enable the researcher to have a sample size of between 80 and 120 respondents which is suitable for rigorous statistical analysis (Matata *et al*., 2010). A total of 100 households were selected. The sample size is justified on the basis of arguments by Bailey (1994) that the bare minimum sample size for a research in which statistical data analysis is to be done is 30 cases, regardless of the population size, and that in most cases a sample of 100 cases is ideal.

3.5 Pre-Testing of Data Collection Instruments

According to Kothari (2004), it is always suitable to do pre-testing of the instruments because it brings to the light weaknesses of the instruments and also of the survey techniques; and from the experience gained in this way, improvement can be effected. Therefore, data collection instruments for this study were pre-tested in one street (Misufini) which had similar characteristics to the study wards. According to Schwab (1998), pre-testing of data collection instruments can be categorized into two types. The

first is the participatory pre-testing that requires the researcher to let the respondents know that the pre-testing is being done. The second is the undeclared pre-testing that obliges the researcher not to inform the respondents. In this regard, the first type of pre-testing was employed in this study.

3.6 Data Collection Methods

Both primary and secondary data were collected in this study. Primary data were collected using a questionnaire, whereby the researcher asked questions written in the questionnaire to the respondents and recorded answers in the spaces provided. A questionnaire was used for the reason that it ensured uniformity of answers from respondents hence consistent results were obtained. On the other hand, secondary data were collected through reading various publications and reports of the central and local governments, statistics from hospitals and health centres, wards; and district, regional and national offices.

3.7 Data Analysis

Data processing and analysis were done at Sokoine University of Agriculture, Morogoro, Tanzania. The data collected were sorted, coded and summarized prior to analysis. The analysis was done using the Statistical Package for Social Sciences (SPSS) computer software Version 17.0. Descriptive analysis included computing means, frequencies and percentages. Inferential analysis was done to test the research hypotheses, whereby chi-square and independent samples t-test were used.

3.8 Ethical Considerations

During the survey, the participants had the right to participate or not to participate in the study or to withdraw any time during the interview. Confidentiality was always maintained by making the interviews in the private places. This is also supported by

Bhattacherjee (2012) who argues that voluntary participation and harmlessness (informed consent), anonymity and confidentiality (privacy), disclosure, honesty with professional colleagues are important ethical issues to be adhered to by researchers. Accordingly, these ethical considerations were inevitably considered in this study. Also Bhattacherjee (2012) argues that respondents in a research project must be aware that their involvement in a study is voluntary, that they have the free will to withdraw from the study at any time without any unfavourable penalty, and they are not harmed as a consequence of their participation or non-participation in the research.

3.9 Limitations of the Study

(i) Some of the respondents refused to be involved in the study, while others decided to quit at the middle of interview for several reasons, and some were not at their households during the day of promise while others, especially women, required the researcher to seek permission from their husbands and get it before interviewing them. This forced the researcher to prolong the time for data collection and hence spend extra amount of money to replace the incompletely felled questionnaire copies. It also led to extra costs in terms fare to revisit those who were not available during the arranged date of enumeration.

(ii) Some of the respondents were interviewed while working. This was considered to be a problem due to the fact that it narrowed the possibility of getting more clarification of the questions which were asked by the researcher.

(iii) Some respondents demanded for compensation before the interview believing that most of health services issues are funded by donors. This took a lot time for the

researcher to explain that the information sought was for academic purposes and that no donor fund had been disbursed for that research.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.1 Demographic Characteristics of Respondents

Sex, age, main occupation, marital status and education level of respondents are presented in Table 1. These characteristics provide demographic characteristics of the respondents and were expected to have influence on CHF.

4.1.1 Sex

The majority (75%) of the respondents were males; only 25% were females. This implies that two-thirds of the respondents in this study were males. This is not surprising simply because the majority of households in Tanzania are dominated by male household heads. Additionally, this finding implies that the majority of CHF members in the study area were men.

4.1.2 Age

Age is an important demographic variable and is the basis for demographic classification as vital statistics, censuses, and surveys (URT, 2005). A total of 100 respondents were interviewed, 75 % of whom were male and 25% were female. In this study, the age distribution of the household heads as presented in Table 1 illustrates that the minimum age of household heads for all the surveyed households was 18, while the maximum age was 60 years. This shows that all the respondents were adults, and for that reason they were able to take household responsibilities. Out of the 100 households surveyed, 63% were $\leq$ 35 years old, a group which is considered to be of working ages, while household heads ranging between 36 to 60 years constituted 37%, who are considered to be of working ages. The 2012 Population and Housing Census showed that the proportion of the

population aged below 15 was 43.9% while those aged 65 years and above were 3.9% indicating that Tanzania has a young population. This youthful age structure entails a larger population in future, In addition to this, the average age for all surveyed household heads was 33.8 years, which ranged from 18 to 60 years.

Table 1: **Age of respondents**

Age	**Male**		**Female**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**
≤ 35	48	48	15	15	63	63
36 - 64	27	27	10	10	37	37
Total	75	75	**25**	25	100	100

4.1.3 Marital status

Regarding marital status of the respondents, the results in Table 3 show that the majority (54%) of the respondents were married and 19% were single while 16% were widow and 11% were divorced. This implies that more than half of the respondents in the study area were married as well as the majority of CHF members were married people.

4.1.4 Education level

The study results in Table 2 show the level of education that the household heads had attained. According to URT (2007), education provides people with knowledge and skills that can lead them to a better quality of health. Thus, education level is expected to enable a person to do basic decisions when it comes to attaining good health services since the higher the education the higher the ability to interpret information and act more rationally. The findings show that educational attainment was somewhat high; 43% of the household heads had attended ordinary secondary education, while 19% had attended

certificate/diploma education level compared to 15% of all household heads who had attended primary school while 12% of the interviewed household heads had attained higher education level. Furthermore, 5% of household heads had managed to acquire secondary education but had not finished their secondary school education. Also, only 4% of the respondents had not even attended a single class of education level while 2% had dropped out of primary education.

Table 2: Education level of household heads

Years	Male		Female		Total	
	n	%	n	%	n	%
0 (Illiterates)	4	5.3	0	0	4	4
6 (Dropped out)	2	2.7	0	0	2	2
7 (Completed Std.7)	13	17.6	2	7.7	15	15
9 (Not finished 11)	4	5.4	1	3.8	5	5
11 (Form four)	32	43.2	11	42.3	43	43
13 (certificate)	13	17.6	6	23.1	19	19
16 (Bachelor)	6	8.1	6	23.1	12	12
Total	**74**	**100**	**26**	**100**	**100**	**100.0**

4.1.5 Main occupations

Regarding household heads' main occupations, the results in Table 3 indicate that the greatest proportion (37%) of respondents interviewed were civil servants and few (7%) were students. This implies that the greatest proportion of CHF members in the study area were civil servants, though experience shows that the majority of civil servants are normally members to National Health Insurance Fund (NHIF).

Table 3: Demographic characteristics of the respondents

Variable	Frequency	Percentage
Sex		
Male	75	75.0
Female	25	25.0
Marital status		
Married	54	54
Divorced	11	11
Widowed	16	16
Never married	19	19
Main occupation		
Peasant	14	14
Civil servant	37	37
Business	32	32
Student	7	7
Others	10	10

4.2 Utilization of Health Services by CHF Members and Non-Members

4.2.1 Membership to Community Health Fund (CHF)

The respondents were asked if their households were members of CHF. The results are presented in Table 4 and indicate that 61% of the households were not members to CHF or CHIF; only 39% were members to CHF or CHIF. Furthermore, 24% of the households sampled had once been members to CHF or CHIF, but had dropped out due to different reasons such as, lack of drugs at the health centres, financial constraints and loss of identity cards. This finding concurs with findings of studies by Mæstad, (2006). and Lekashingo (2012) who found that poor quality health services, corruption, long distances to health facilities, governance and accountability, and poor CHF leadership are responsible for households droping out by members to CHF/CHIF. Moreover, 76% of the respondents had never been members to either CHF/ CHIF. Despite the discussion above,

the respondents interviewed agreed that they were aware of the benefits to which members to CHF/CHIF were entitled.

Table 4: Membership of the respondents in CHF or CHIF

Membership status	Frequency	Percentage
Members	39	39
Non-members	61	61
Total	**100**	**100.0**

4.2.2 Distance from home to the nearest health facility

Long distance from home to the nearest health facility is among problems that constrain access to health services; in some areas people need to travel long distance and for many hours before reaching the health services delivery facilities (URT, 2007). The findings in Table 5 show that the approximate maximum distance from home to the nearest pharmacy among the respondents was 3 kilometres while the minimum distance was 0.1 kilometre, and the mean distance was 1.2 kilometres. The results further indicate that the maximum distance from household to the nearest District/Referral Hospital was 11 kilometres while the minimum was 0.6 kilometre and the mean was 4.2 kilometres. This implies that distance was not considered as a barrier to accessing health services.

Table 5: Distance in km/m to dispensary/health posts

Health facility	Approximate distance in km		
	Min.	**Max.**	**Mean**
Dispensary	1	3	0.43
Health centre	1	7	1.65
District Hospital	0.3	9	2.47
Referral Hospital	0.6	11	4.17
Pharmacy	0.1	3	1.20

4.2.3 Time used to access nearest health facility

In this study, the approximate time on foot used by all respondents to reach the nearest human health facility ranged from 0 to 120 minutes. The respondents used 60 minutes when the means of transport was bicycle, and 30 minutes when the transport means was a motorcycle. And when the means of transport was by car, it took 20 minutes to access services from the nearest health facility.

Table 6: Time used to access nearest health facility

Means of going to nearest health facility	n	Min. Approximate minutes	Max. Approximate minutes	Mean Time	Std.
On foot	100	1	120	34.02	29.55
By bicycle	100	0	60	17.8	13.97
By motorcycle	100	0	30	9.34	6.81
By car	100	0	20	6.08	3.79
Other means	100	1	30	5.35	5.61

4.2.3 Preferences for Sources of Healthcare

The results in Table 7 indicate that majority (75%) of the respondents preferred government owned facilities. Most of them gave the reasons that they provided services at cheaper prices and that most of them were near their places of residence. However, 18% of the respondents preferred privately owned facilities due to provision of better health services. On the other hand, 7% of the respondents preferred pharmacies which were owned by individuals and doctors from government facilities because they had wider options of services and drugs in respect to amount of money they had.

Table 7: Respondents preferences for sources of healthcare

Statements	Frequency	Percentage
Government hospital/dispensary	75	75
Private hospital/dispensary	18	18
Pharmacy	7	7
Total	**100**	**100**

4.2.4 Utilization of Health Services

4.2.4.1 Accessibility of health services

The findings from this study revealed that 44% of the respondents argued that health services were very accessible while 39% argued that the services were not very accessible. On the other hand, 17% of the respondents had no opinion about accessibility of health services in their nearest facilities. Despite the discussion above, chi-square test revealed that there were no statistical significant association between accessing health services and membership to CHF ($\chi^2 = 1.420$, $p > 0.05$). These results, therefore, suggest that a large proportion of the respondents indicated to have access to health services but a number of challenges were associated with their access to the services such as poor equipment at most facilities.

4.2.4.2 Affordability of health services

The results in Table 8 indicate that 42% of the respondents were of the opinion that health services provided were affordable; while 32% of the respondents complained that health services were expensive but affordable among members and non-members of CHF. Fifteen percent (15%) of the respondents argued that the services were cheap, while 11% of the respondents complained they were too expensive for them to afford. A chi-squire test revealed that there was no significant association between membership to CHF and affordability of health ($\chi^2 = 1.180$, $p > 0.05$).

4.2.4.3 Availability of health services

The results in Table 8 indicates that more than a half (52%) of the respondents said that health services were highly available while 40% of the respondents said that the services were slightly available. On the other hand, 6% of the respondents had no opinion on health services availability and 2% said that health services were not available. Despite the discussion above, a chi-square test revealed that there was no significant association between membership to CHF and in availability of health services ($\chi^2 = 3.463$, $p > 0.05$).

4.2.4.4 Acceptability of health Services

A chi-square test further revealed that there was no significant association between membership to CHF and acceptability of health services ($\chi^2 = 1.320$, $p > 0.05$). A half (50%) of the respondents said that health services provided were acceptable compared to 6% of the respondents who complained that the services were not acceptable.

Table 8: Utilization of health services

Health services		CHF Members		Non-members		χ^2	P-value
		n	%	n	%		
Accessibility	No opinion	8	20.5	9	14.8	1.420	0.492
	Accessible little	17	43.6	23	37.7		
	Very accessible	14	35.9	29	47.5		
Affordability	Cheap	5	12	10	16.4	1.180	0.758
	Affordable	17	43.2	25	41.0		
	Expensive but affordable	14	35.9	18	29.5		
	Too expensive to afford	3	7.7	8	13.1		
Availability	Not available	2	5.1	0	0	3.463	0.326
	No opinion	2	5.1	3	4.9		
	Available little	17	43.6	25	41		
	Much available	18	46.2	33	54.1		
Acceptability	Not acceptable	3	7.7	3	4.9	1.320	0.724
	No opinion	12	30.8	15	24.6		
	Acceptable	19	48.7	31	50.8		
	Very acceptable	5	12.8	12	19.7		

4.2.5 Level of Client's Satisfaction

A chi-square test revealed that there was no significant association between being a CHF member and getting quality health services (χ^2= 1.297, p > 0.05).This implies that level of satisfaction among member and non-member of CHF was the same. Therefore, the null hypothesis was accepted. These results therefore, suggest that CHF did not meet the anticipations of members in providing quality health services.

Table 9: Level of clients' satisfaction

Satisfaction status	Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
	n	F-value	P-value	t-test	df	P-value	Mean difference	Std	Lower	Upper
Member	39	0.002	0.961	-0.024	98	0.981	-0.005	0.20644	-0.41472	0.40463
Non-member	61			-0.024	80.815	0.981	-0.005	0.20668	-0.41628	0.40619

4.2.5.1 Views on Quality of Health Services Delivered

In order to evaluate the quality of health services delivered, the respondents were asked about accessibility and utilization of the health services in their nearest health facilities. Their views are summarized in Table 10. Among all the views given, the lowest proportions of the respondents agreed with the statements that people who get health services at the nearest health facility are accountable to the health staff who serve them (5.7%) and the poor have access to health services provided in the nearest health facility (6.8%) as seen in Table 10.

Table 10, also shows the scores that were obtained for each of the statements. The scores were obtained by adding up all the points that a statement scored from all the respondents. Since the minimum and maximum scores per statement per person were 0 and 1 and there were 100 respondents, each statement had chances of getting a minimum of 0 and a maximum of 100 points. The minimum and maximum points scored were 49 and 96, respectively as seen in Table 10.

Table 10: Respondent's views on quality of health services delivered

Views on quality of health services delivered	Response		%
	n	%	of cases
1. Do you get proper nursing procedures for each type of health facility	74	8.6	74
2. Assures client of confidentiality	94	10.9	94
3. Treats client with respect/courtesy	92	10.7	92
4. Tailors key information to the client's needs	93	10.8	93
5. Gives accurate information on the method accepted	96	11.1	96
6. Performs clinical procedures according to guidelines	81	9.4	81
7. Whether health services are provided by health staffs in the nearest health facilities in open ways without corruption	68	7.9	68
8. Health staff are accountable to the people whom they serve	67	7.8	67
9. People who get health services at the nearest health facility are accountable to the health staff who serve them	49	5.7	49
10. Whether the poor have access to health services provided in the nearest health facility	58	6.8	58
11. In your nearest health dispensary/health centre/hospital is there effective service delivery	92	10.6	92
Total	**864**	**100**	**864**

*Multiple response were allowed

The statements with the highest scores were "Gives accurate information on the method accepted" (96 points out of 100), "Assures client of confidentiality" (94 point out of 100 points), and "Tailors key information to the clients' needs" (93 point out of 100 points) whereby "Treats client with respect/courtesy" and "In your nearest health dispensary/health centre/hospital is there effective service delivery" both scored 92 points

out of 100. The statements with the lowest scores were “People who get health services at the nearest health facility are accountable to the health staffs who serve them (49 points out of 100). The scores for the other statements are as seen in Table 10.

4.2.5.2 Assurance with Client’s Health Delivery

The findings in Table 11 indicate that the majority (65%) of the respondents responded that they were assured of client health delivery contrary to 35% who responded that they were not assured of client health delivery. Both members and non-members of CHF or CHIF had different thoughts on the aspects of quality client health delivery; 26% of the respondents appreciated the advice given by the practitioners, while 19% of the respondents were satisfied with the procedures in getting health services. The results further indicated that 14% and 6% of the respondents said clients were treated with courtesy and also gave accurate information on the methods accepted and were assured of treatment with confidentiality. However, a small proportion (14%) of the respondents complained that in their nearest health facilities there was no information to the clients’ needs compared to 12% who complained that health service practitioners did not demonstrate good counselling skills to clients. Additionally, 8% and 1% of the respondents complained that health services providers did not treat clients with respect/courtesy.

Table 11: Respondents assurance with client's health deliver

Variable	Frequency	Percentage
Yes	65	65
No	35	35
Aspects of quality which were more appreciated		
Procedures	19	19
Gives accurate information on the method accepted	6	5
Assures client with confidentiality	14	14
Advice	26	26
Aspects of quality which were most not appreciated		
Poor health services	8	8
They do not provide tailors information to the client's needs	14	14
They do not demonstrates good counselling skills	12	12
They treat clients with no respect /courtesy	1	1
Total	**100**	**100**

4.3 Attitude towards CHF Health Services Delivered

The second specific objective was about comparing the attitudes of CHF members and non-members on the quality of health services delivered.Before the comparison was done, scores of both categories of respondents on a Likert scale, which was used to gauge their attitudes, were determined. The Likert scale had twelve (12) statements, which are seen in Table 12, and the respondents were required to state whether they strongly agreed (5 points), agreed (4 points), were undecided (3 points), disagreed (2 points) or strongly disagreed (1 point) with each of the statements. If one had chosen strongly disagree for all the 12 statements, one would have got 12; if one had chosen 3 for all the 12 statements, one would have got 36, and if one had chosen 5 one would have got 60. Therefore, overall for all the respondents, the range of 12 to 35.99 points represented unfavourable attitude; a

score of 36.0 represented a neutral attitude; and a range to 60 represented favourable attitude.

The results showed that, overall, the respondents had favourable attitude towards health services, with an overall score of 38.26 points out of a maximum of 60.0. Contrary to the expectation that members of CHF would have more positive attitude towards the quality of health services, they had less positive attitude compared to those who were not members of CHF. The points scored by CHF members and CHF non-members on the attitudinal scale used were 37.41 and 38.80, respectively, out of 60.00. However, comparing the scores using an F-test showed that they were not significantly different ($F = 2.910$, $p = 0.091$). On the basis of these findings, the null hypothesis that **a**ttitude towards the contribution of CHF in improving the quality of health services does not differ significantly between CHF members and non-members is accepted. This means that both categories of respondents had almost the same attitudes towards the contribution of CHF to improving the quality of health services.

Table 12: index score of attitude

Statements		Disagree		Neutral		Agree		MSs
		n	%	n	%	n	%	n
1	CHF increases accessibility of health services to individuals	11	11	38	38	51	51	3.4
2	CHF helps to improve the quality of health services	8	8	15	15	77	77	3.69
3	CHF is just a means of its planners to steal money from poor people	34	34	38	38	28	28	2.94
4	CHF members did not feel that they overuse services by going to the health facility for minor illnesses	33	33	41	41	26	26	2.93
5	People paying user fees have better access to health services in their areas	8	8	33	33	59	59	3.51
6	People paying user fees are more satisfied with the care given	7	7	32	32	61	61	3.54
7	People paying have better health outcome	2	2	35	35	63	63	3.61
8	CHF provides assurance of health of services when one gets sick	28	28	39	39	33	33	3.05
9	CHF members enjoy less quality services compared to non-members	21	21	49	49	30	30	3.09
10	CHF members do not have better relationship with health care providers	25	25	39	39	36	36	3.1
11	CHF is for the poor and those working in rural areas/informal sector	62	62	15	15	23	23	2.61
12	People prefer dropping from CHF because it's too costly	59	59	5	5	36	36	2.77

Key: MSs = Mean scores

On the basis of the average of overall points scored, the respondents were categorised into those who had unfavourable, neutral and favourable attitudes. The results, which are presented in Table 13 and Fig. 2, show that 51.0%, 11.0% and 38.0% of the respondents had unfavourable, neutral and favourable attitudes, respectively towards CHF providing quality services.

Table 13: Respondents with various attitudes towards CHF's provision of health services

Attitude categories	CHF members (%)	CHF non-members (%)	Both groups (%)
Unfavourable attitude	51.3	50.8	51.0
Neutral attitude	10.3	11.5	11.0
Favourable attitude	38.4	37.7	38.0
Total	**100.0**	**100.0**	**100.0**

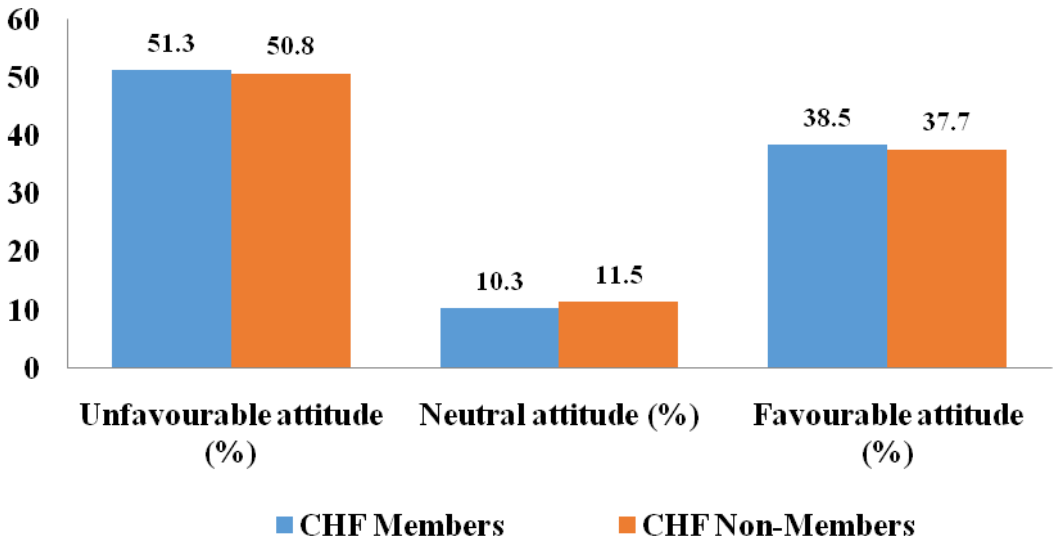

Figure 2: Respondents with various attitudes towards CHF's provision of health services

4.4 Challenges on Accessing Health Services

To capture this segment, the respondents were asked to mention the challenges they faced in accessing Health services. The results indicated that 27% of the respondents complained of shortage of drugs and unnecessary delays in addressing patients to be the major challenges. Furthermore, it was observed that expensive drugs, especially for complicated health challenges, were not provided unless extra payment was made or they were directed to buy them from private pharmacies. On the other, hand 26% complained about corruption to be the major challenge in accessing health services while 20% complained that they had to pay extra costs which are not specific in their purposes.

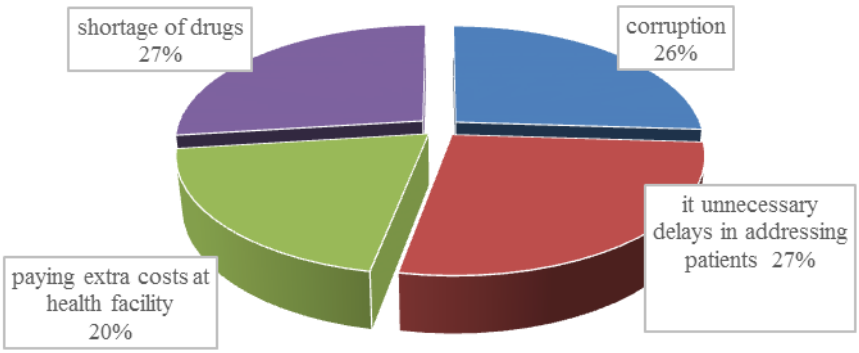

Figure 3: Challenges in accessing health services

4.4.1 Index Scores on Challenges in Accessing Health Services

In comparing perception of members and non-members on challenges in health services delivered, an index scale was used. Therefore, the results in Table 15 indicate that the majority (72.8%) of the respondents complained that poor health services were a challenge and 64.4% complained about poor referral mechanism. Furthermore, 63% of the respondents interviewed said services were very expensive. The average score of 65.5% shows that there was high degree of challenges facing members and non-members in accessing health services. These findings are in line with Alexander *et al.*(2002); Mtei *et*

al.(2007) who indicated that people lack access to affordable drugs, surgery and other interventions, largely because of weakness in financing thus, delays in procurement and distribution by Medical Store Department (MSD) (URT, 2000). Also a study done by Ha, Na. and Larsen (2002) shows that there are challenges on health services delivery by involving both government referral and district hospital. The study revealed that the poor were willing to pay for better quality of care but services were not improving. However, low levels of care, lack of care, lack of advice and lack of professionalism dominated the results.

Table 14: Challenges in accessing health services

Challenging factors	**Percentage**
Poor health services	72.8
Poor referral mechanism	64.4
Take long time to get registered	65.5
Poor leadership	61.6
Expensive	63.8

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

Based on the study findings, interpretations, and the experience gained during the conduct of the study, a number of conclusions have been drawn. For clarity purposes, the conclusions are organized into four sections.

5.1 Conclusions

5.1.1 Utilization of Health services by CHF members and CHF non-members

It was found that there was no significant different in utilization of health services between member and non–member of CHF. Similarly, respondents admitted that health services from their nearest health facility were available, affordable, accessible and acceptable. On the basis of these findings, it is concluded that CHF has significantly failed to establish it's self as an improving health services tool.

5.1.2 Attitude towards health service delivery

Regarding attitude towards the quality of health provided, it was found that the attitude on the quality of health services among members and non-members of CHF did not differ significantly. Accordingly, it is concluded that CHF has failed to inspire people about services it deliver.

5.1.3 Challenges in accessing health services

It was found that the majority of the respondents lamented poor health services as the major prevailing challenge; therefore, this study is concluding that, for CHF to gain people's trust must distinguish its self from other health service providers.

5.2 Recommendations

Based on the study findings, a number of recommendations can be made:

i. The government and development partners should allocate enough budgets to CHF to improve the quality of services delivered and enhance its competitive power against other health services funds.

ii. CHF must be empowered by the responsible ministry to initiate their own facilities at least in every region of the country, which should be used to demonstrate the quality of health services required. This will also build people's trust to CHF and therefore, reduce the pace of members drop-out.

iii. The introduction NHIF was identified by this study as a major threat to CHF by being responsible for the CHF members' drop-out due to the fact that it is mandatory for civil servant to join the NHIF scheme. Therefore, this study is recommending that, the government should establish a fair ground for these two schemes to compete.

5.2.1 Areas for further research

Findings of this study was drawn from only 100 cases, therefore, it is acclaimed further researches that will involve many cases and cover many district of the country to facilitate generalization of the findings. Furthermore, there is a need to conduct a comparative study to compare the quality health services delivered among the two schemes (NHIF and CHF).

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APPENDICES

Appendix 1: Operational Definition

Table 15: **Background Variables**

Variable	Operational definition	Measurement	Unit
Age	Years since one was born	Ratio	Years
Sex	Biological difference between male and female	Nominal	1=Male 2=Female
Marital status	The state of having a spouse or not	Ordinal	1=Married 2= Divorced 3= Widowed 4=Never married 5=Others
Education level	Level of education one has attained	Ordinal	1=Illiterate 2=Adult education 3=Primary 4=Secondary 5=College
Distance	The place in which health centre located from the household domicile	Ordinal	1=Meter 2=Kilometre 3=Others
Occupation	Legal activity enabling a person to earn income	Ordinal	1=Peasant 2=Civil servant 3=Business 4=Student 5=Others

Table 16: Independent Variables

Variable	Operational definition	Measurement	Units
Demonstrate good counselling skills	The extent to which staffs enhance communication by helping a medical professional to establish a good rapport with a patient or client.	Dummy	1=Yes 0=No
Assures client of confidentiality	The extent that health centre or staff member should not reveal information about their clients to a third party without the consent of their client or a clear legal reason.	Dummy	1=Yes 0=No
Treat client with respect/courtesy	The extent in which the health workers respect the inherent dignity and worth of the person.	Dummy	1=Yes 0=No
Tailors key information to client's needs	Provision the necessary information which is convinced, designed, built to suit that specific costumer/client	Dummy	1=Yes 0=No
Gives accurate information on the method accepted	Extent in which clients courteously with dignity and respect before consenting to specific care choices,	Dummy	1=Yes 0=No
Performs clinical procedures according to guidelines	Provision all clinical procedures according to guidelines which are convinced, designed, built to suit that specific costumers/clients	Dummy	1=Yes 0=No
Proper nursing procedures for each type of health facility	The extent in which standardized procedures used by health workers to archive a high level of patient care for each health facility	Dummy	1=Yes 0=No

Table 17: Dependent Variable (Quality of health services delivered)

Variable	Operational definition	Measurement	Unit
Client knowledge	Client knowledge means information, and skills that staffs providing to clients relate to preserving or maintaining people free of illness	Ordinal	1=Not satisfied 2=little satisfied 3.Much satisfied
Client health deliver	Client health deliver means information, and skills that clients receiving from staff relate to preserving or maintaining people free of illness	Dummy	1=Yes 0=No
Client satisfaction	Client satisfaction means information, and skills that clients receiving from staff relate to preserving or maintaining people free of illness is satisfied	Dummy	1=Yes 0=No

Appendix 2: Households Questionnaire

SOKOINE UNIVERSITY OF AGRICULTURE

Questionnaire Number

DEVELOPMENT STUDIES INSTITUTE

A Household Questionnaire for Research on:

COMMUNITY HEALTH FUND AND QUALITY HEALTH SERVICES: A CASE OF MOROGORO DISTRICT

By

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

1. Ward …… Location of the ward: 1. Morogoro District
2. Village …… OR Street ……

PART A. BACKGROUND INFORMATION

3. Household composition

Variables	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**	**P10**
Age										
Sex (1 = Male, 2 = Female)										
Marital status (1.Married, 2.Divorced, 3.Widowed, 4.Never Married, 5. Others)										
Years of schooling										
Main occupation										
Health status on the date of interview (1.Ill,2.Not ill)										
Did any person suffer from any disease within the past 12 months? (1.Yes, 2.No)										

4. For how long have you been living in Morogoro District? ……... (years)
5. For how long have you been living in this ward ……. (years)
6. For how long have you been living in this village/ street? ……. (years)

PART B: INFORMATION ABOUT HEALTH FACILITIES

7. How far is the nearest health facility from your home?

Facility	**Approximate distance (km or m)**	**Ownership (1=Public, 2=Private; if private, specify the owner)**
1. Dispensary/Health post		
2. Health centre/Clinic		
3. District Hospital		
4. Referral Hospital		
5. Human medicines pharmacy		

8. Approximately how much time do you use to get access to the nearest health facility by the following means

Means of going to health facilities for human health services	**Minutes/Hours**	**Extent of using the means (%)**
1. On foot		
2. By bicycle		
3. By motorcycle		
4. By car		
5. Other means (Specify)		

9. (a) Whether the household is a member of CHF or CHIF 1. Yes 2. No

   (b) If No, have you ever been a member?

   (c) If you are a member, what benefits do you get? ……..

PART C: UTILIZATION OF HEALTH SERVICES BY CHF MEMBERS AND NON-MEMBERS ACCESSIBILITY, AFFORDABILITY, AVAILABILTY AND ACCEPTABILITY

10. To what extent are the health services available at nearest health facility where you mostly get services

Level of accessibility	**View (Explanation) accessibility**
Not accessible	
No opinion	
accessible little	
Much accessible	

11. To what extent are the health services acceptable at the health facility where you mostly go?

Level of acceptability	**View (Explanation) of the acceptability**
1. Not acceptable	
2. I have no opinion about this	
3. Acceptable	
4. Very acceptable	

12. To what extent are the health services affordable at the health facility where you mostly get services

Level of affordability	**View (Explanation) affordability**
Cheap	
Affordable	
Expensive, but affordable	
Too expensive to afford	

13. To what extent are the health services accessible at the health facility where you mostly go?

Level of availability	**View (Explanation) of the availability**
1. Not available	
2. I have no opinion about this	
3. available little	
4. Very available	

14. Please enter 1 for Yes and 0 for No against the following statements, which are meant to get your views on accessibility and utilization of health services

Health services	**Yes = 1**	**No = 0**
12. Do you get proper nursing procedures for each type of health facility		
13. Assures client of confidentiality		
14. Treats client with respect/courtesy		
15. Tailors key information to the client's needs		
16. Gives accurate information on the method accepted		
17. Performs clinical procedures according to guidelines		
18. Whether health services are provided by health staffs in the nearest health facilities in open ways without corruption		
19. Health staff are accountable to the people whom they serve		
20. People who get health services at the nearest health facility are accountable to the health staff who serve them		
21. Whether the poor have access to health services provided in the nearest health facility		
22. In your nearest health dispensary/health centre/hospital is there effective service delivery		
23. Is there effective client knowledge delivery		
24. Do they assure Client health		
25. Client satisfied with the health services		

PART D: ATTITUDE OF CHF MEMBERS AND NON-MEMBERS ON HEALTH SERVICE DELIVER

15. How much do you pay as a CHF premium per year? …….Tshs

16. (a) Is the amount of money you pay fair in comparison with the services you get per year? (1) yes (2) No

    (b) If no, please give a reasons …….

17. In your opinion, the followings are important issues of being a CHF member/not being a CHF member) *** depends on the nature of respondent***

NOTE: 5=Strong Agree 4=Agree 3=Un decided 2=Disagree 1=Strong disagree

		1	**2**	**3**	**4**	**5**
1.	CHF Increase accessibility of health services to the individuals					
2.	CHF Helps to improve the quality of health services					
3.	CHF is just a means for its planners to steal money for poor people					
4.	CHF members did not feel that they overuse services by going to the health facility for minor illnesses.					
5.	People paying user fees have better access to health services in their areas					
6.	People paying user fees are more satisfied with the care given					
7.	People paying user fees have better health outcome					
8.	CHF Provides assurance of health services when one gets sick					
9.	CHF members enjoy less quality services compared to non-member					
10.	CHF member do not have better relationship with health care providers					
11.	CHF is for the poor and those working in the rural areas and/or the informal sector					
12.	People preferred to drop from CHF because it's too costly					
Total						

PART E: CHALLENGES FACING CHF MEMBERS AND NON-MEMBERS IN ACCESSING HEALTH SERVICES

18. Did you face challenges in accessing health services? (1)Yes (2) No
19. What challenges did you face recently in accessing health services?
20. Did those challenges very severe (1) Yes (2) No
21. If yes what are those challenges?
22. On your opinion, CHF has the following challenges

Challenging factors facing CHF	**Maximum score**	**Index score**
1.Poor health services	**5**	
2.Poor referral mechanisms	**5**	
3.Takes long to get Registered	**5**	
4.poor leadership	**5**	
5.Expensive	**5**	
Total index score	**25**	

23. If the participant had been a member of CHF.
24. Have you ever joined and dropped from CHF? (a) Yes, (b) No If no skip to Qn no 20
25. Why did you drop out of CHF?
    1. Poor health services
    2. Poor referral mechanisms
    3. Takes long to get registered
    4. Poor leadership
    5. Affordability
    6. Had to pay extra costs at health facility

F. QUALITY OF HEALTH SERVICES DELIVERED

26. Were you satisfied with the services?

    1. Not satisfied

    2. Satisfied

27. If yes explain……...

28 if no explain…….

29. Were you assured with client health deliver?

    1. Yes

    2. No

30. If yes explain…….

31. If no explain……..

THANK YOU FOR YOUR COOPERATION