2012

Assessment of community health fund on non public servants in Dodoma urban district

Abeli, Boniface M.

The University of Dodoma

ASSESMENT OF COMMUNITY HEALTH FUND ON NON PUBLIC SERVANTS IN DODOMA URBAN DISTRICT

By

Boniface Mtiana Abeli

A Dissertation Submitted in partial fulfillment of the Requirements for the Degree of Master of Arts in Demography of the University of Dodoma

University of Dodoma

October, 2012

CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by the University of Dodoma a dissertation entitled: *Assessment of Community Health Fund on non public servants in Dodoma urban* in fulfillment of the requirements of the degree of Master of Arts in Demography of the University of Dodoma.

……

Dr. Kilonzo, Rehema

(Supervisor)

Date…….

DECLARATION AND COPYRIGHT

I, Boniface Mtiana Abeli, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature……

ACKNOWLEDGEMENTS

I would like to express my grateful thanks to all people who in one way or another supported me in accomplishing this study; it was not an easy task to accomplish this study if it was not their willing to support me materially and morally. My sincerely thanks specifically goes to my supervisor Dr Rehema Kilonzo for her unlimited suggestions, challenges and assistance that contributed to the success of this work.

I also thank Mr. Emmanuel Abina who is the Tanzania National Health Insurance Fund director for the central zone in Dodoma and Mr. Isaya Shekifu from the NHIF for their kind assistance in getting the information used in this study. I humbly thank my classmates (Master of Arts in Demography) of University of Dodoma for their constructive criticisms and academic advices they gave me during our studies. Lastly, but not in the order of importance, I thank Doctors, nurses, local leaders and all the people in Dodoma urban who willingly devoted much of their time to take part in this study. However, any shortfall of this dissertation remains my own responsibility.

DEDICATION

I dedicate this study to my beloved mother (Elifrida Abel) for her positive moral and material support which supported me to accomplish this study.

ACRONYMS

CBOs	Community Based Organization
CBHI	Community Based Health Initiative
CHF	Community Health Fund
ELCT	Evangelical Lutheran Church of Tanzania
GTZ	German Technical Cooperation
GEDPF	Government Employees Development Provident Fund
HIV & AIDS	Human Immune Virus and Acquired Immune Deficiency Syndrome
LAPF	Local Authority Pension Fund
MOH	Ministry of Health
MHIS	Micro Health Insurance Scheme
NGO	Non Government Organization
NSSF	National Social Security Fund
PSPF	Public Service Pension Fund
SEWA	Self Employed Women's Association
SDC	Swiss Agency for Development and Cooperation
TIKA	Tiba Kwa Kadi(Treatment by Card)
TDHS	Tanzania Demographic and Health Survey

UNICEF	United Nations Children's Fund
WDC	Ward Development Committee
WHC	Ward Health Committee

ABSTRACT

The assessment of Community Health Fund was conducted in Dodoma urban District within the Dodoma region. Dodoma municipal is among the few municipals in Tanzania whereby the scheme is operating in urban settings. As suggested by Mulligan et al. (2007), by 2015 CHF in urban areas is projected to achieve 15 percent coverage of the urban population. We have very few years to reach the projected time and still the coverage in urban areas is very low.

About 3.4 percent of all Tanzanians benefit from this scheme as premium members or other beneficiaries. Community Health Fund operates in 109 districts in Tanzania. The annual membership fees in all these districts ranges between 5,000 Tsh and 30,000 Tsh; 59 districts have set 5,000 Tsh, 32 district contribute 10,000 Tsh, and 4 districts pay 15,000 Tsh for each household while only one district charges the members 30,000 Tsh annual fees contribution.

This study has examined the willingness of the people to become members of this scheme, and assessed the awareness of the people who lives in Dodoma municipal about this health scheme. The study has observed that low enrollment of CHF members in Dodoma are not due to low economy, poor health services, and absence of drugs in different health centers but is due to the unawareness of the people about the scheme on the importance of joining the Community Health Fund.

The recommendations suggested for this study are policy makers have to change the content of CHF because the Act does not force people to be members of this scheme. The scheme authorities have to sit together with the community and share experiences about good way to operate the scheme. Also the scheme has to create other sources of fund to increase income of the scheme.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

1.1 Background of the Problem

The Community Health Fund is the district based scheme which focuses on serving people who are working in informal sectors. It is a voluntary scheme whereby a household has to contribute annual fees for the fund to work, and they should have been members of the fund before they fall sick (Gilson *et al* 2006). Community Health Fund is mainly for the people who are working in informal sectors (Kapinga *et al*, 2002).

The idea of Community Health Fund was adapted in Africa from Europe whereby this system is well developed. In Western Europe, the concept of Social Health Insurance was developed since 1973. Many European countries have introduced this health system in their countries. For example, this system was introduced in Belgium, France, Germany, Luxembourg, Netherlands, and Switzerland and this health insurance system is very well developed in these countries (Salteman *et al*, 2004).

Another country where this health system is developed and which may have influenced Tanzania and other Sub Saharan African countries to adopt social health insurance is India. In India there is an organization of women entrepreneurs prominently known as Self Employed Women's Association (SEWA) which has more than 700,000 members who are working in small business activities. These women have established their own health scheme for their families. In this organization, members are required to contribute 72.5 rupees and those who want to

include their partners top up 22.5 rupees in their annual contribution (Blaxall, 2004).

In the 1970s, the public health sector in Africa experienced tremendous challenges from the economic crisis in the world and changes of political ideologies in the world. Before 1970s many African countries offered free health services to their people, as they were supported financially and materially by donors and their development partners from America and Europe. After the crisis these system were terminated (Criel *et al*, 2010).

The first community health insurance in Africa was developed at Bwamanda district hospital in the Democratic Republic of Congo in 1986 under high assistance from Europeans (Criel *et al*, 2010). In the same year, the community based health scheme was established in Burkina Faso. Later on, different schemes were established in various regions of west and central Africa and later on followed by East Africa (Criel *et al*, 2010).

In Rwanda the health insurance fund has achieved to enroll more than 93 percent of all people in the community. This scheme has achieved to decentralize the health system in Rwanda and it has enabled the local people from the rural areas to get health services easily and cheaply. In Rwanda the community health fund is prominently known as Mutuelle De Sante (Kayonga, 2007).

Ghana is another country in Africa in which community health service covers a large area of the country and most of the Ghanaians are members and get services from this scheme. In Ghana, about 60 percent of all people in the country are members of any social health scheme. In 2003 the government of Ghana passed an Act which allowed all people in the community to be members of any community health

insurance which are either commonly or privately owned. The Government of Ghana provides matching grants for active members of community health funds (Criel *et al*, 2010).

Early in the 1990s, the government of Tanzania in collaboration with the World Bank agreed to introduce cost sharing in the health sector where every individual has to pay for this services. This happened as a result of minimum contribution of development partners and donors in the government budgets (Kapinga *et al*, 2002).

The concept of Community Health Fund has been adopted from Community Based Health Financing (CBHF) which has emerged in developing countries as a response to the existing challenges in the health financing system, which include low economic growth, constraints in the public sector and low organizational capacity (Mtei *et al*, 2007). This followed the failure of the government to provide free health care to all its citizens due to the increased cost of the services (Mtei *et al*, 2007).

In 1996, the Tanzanian Government initiated community health insurance schemes to improve the access to health care and to reduce the cost of accessing health services in the environment with limited budgets for the health sector (Msuya *et al*, 2004). In cooperation with the World Bank, the Government of Tanzania initiated a number of strategies to increase the access to health care of its citizens in any environment, either rural or urban, due to the rapid budget decline in health and economic sectors. One of the potential initiatives has been to come up with a mechanism through which households and individuals can share community health risks. A community-based health scheme known as community health fund in a Tanzanian context was introduced in Tanzania (Msuya *et al*, 2004).

The scheme was and is still supported by the World Bank and it was implemented for the first time in 1996 in Igunga District in Tabora Region. Community Health Fund began to operate in Igunga District in 1996 for two years, and later the pilot was extended to other nine districts in the country for more practices. After achievement in these districts the Government of Tanzania passed an Act which legalized community health funds to operate in Tanzania from 2001 (Gilson *et al*, 2006).

In Dodoma Region, the community health fund has achieved to enroll 15 percent of the population in Chamwino District, 25 percent of the population in Mpwapwa District, 11 percent of the population in Bahi District, 4.6 percent of the population in Kondoa District and 4.6 percent of the population in Dodoma Municipality. This is a very low enrollment rate because only 4982 households are members of the scheme out of 107,764 households available in Dodoma municipal. In Dodoma Municipality Community Health Fund was introduced in 2001 and the scheme has, until now, enrolled less than 5000 members (MOHSW, 2011).

1.2 Statement of the Problem

The development of social health insurance in Tanzania is still very low especially in urban areas; its pace and adaptation persists to be very low in urban settings. It has been projected that, up to the year 2015 only 15 percent of Tanzanian will be members of any health insurance. Various studies have revealed that less than ten percent of all Tanzanians are served by any community health insurance (MOHSW, 2011; Msuya *et al*, 2004; and Mulligan *et al*, 2005). Studies have been conducted by experts to assess the effectiveness of community health fund in different districts (see for example, Gilson *et al*, 2007; Chee *et al*, 2002; and Kapinga *et al*, 2002). In the assessment of CHF done in Hanang District in 2001 it was found that membership

was around 3 percent of total households (Chee et al, 2002).

Although more than ten years has passed since the introduction of Community Health Fund, the number of people who are members of this scheme is still very low. Factors for the low enrollment in rural settings have been explained by Kamuzora (2000); Kapinga *et al* (2002); Mulligan *et al* (2007). Moreover, various studies have been conducted to assess the willingness of the community to join the Community Health Fund (see for example, Agyemang-Gyou 1998; Steinwachs 2001; Beraldes, 2003; and Carreras, 2003). There are no studies which have been conducted in Dodoma urban and other districts of the region in general to assess the Community Health Fund on non public servant. This study assessed the Community Health Fund in Dodoma urban by examining the willingness of the people to join the scheme, the awareness of the people and the challenges facing the scheme in Dodoma urban.

1.3 General Objective

The main objective of this study was to assess the Community Health Fund to non public servants.

1.4 Specifically Objectives

Specifically the study intends to:

1. To evaluate the awareness of the people about the Community Health Fund.
2. To examine the willingness of the people to join the Community Health Fund.
3. To analyse the main challenges which the Community Health Fund faces in urban settings.

1.5 Research questions

The study is guided by the following research questions

1. To what extent is the community aware of the Community Health Fund?
2. How willing are the people to join the Community Health Fund?
3. What are the challenges facing the Community Health Fund in urban settings?

1.6 Significance of the Study

This study is important to the society because it address important phenomena about peoples' health which may help in improving the function of the community health fund in Dodoma and in other regions of the country. In Africa health sector is a burning issue which affects the life of the people and also consumes a lot of family resources because of insufficient health services and or the available health services may not be functioning effectively to meet the goal of serving peoples' lives. This study will reveal knowledge about the awareness of people, willingness of the people and challenges which people face from the community health fund at Dodoma urban which will help to improve the fund.

The study is also important for policy makers to establish policy, a community health funds policy, which will suit the needs of the public. The review of this act is highly needed so as to resemble those of other countries which require and highly restrict all people to join any of the social health insurances in the countries. This will enable many people to access health services easily and cheaply in the communities since the law will require every individual to be a member of any health insurance in the country.

The study is also important to the community for it will make the community to be familiar with the Community Health Fund and understand the advantages of health insurance to the people with low income.

Moreover, the study will help people to know the roles of the state and private sectors in educating the community to know how the scheme operates, how to join and become an active member of the scheme and the importance of contributing fees at the required time.

1.7 Problems Encountered in this Study

Kombo (2006) defines limitation of the study as a section that indicates challenges anticipated or faced by the researcher during the study. Limitations are common phenomenon which always researchers encounter when doing a research. During this study, the researcher experienced the following problems:

Some of the people reached by this study through either interviews or questionnaires were not easily willing to participate in the study until when the researcher strongly convinced them to give the information they know about CHF, which made this study to be not an easy task. They however provided a lot of information useful in this study.

The amount of money set to cover the expenses of this study could not meet the costs of the study as it was expected, because of the daily growing up inflation in Tanzania. This problem made the researcher not to complete this work at the planned time.

Non response to some questions, most of respondents included in this study were provided the questionnaires which contained number of questions, but some people

were not able to respond to other questions. This made it had for the researcher to analyze those questions. Hence, the researcher had to delete the questions from the analysis.

Poor accessability of accurate information about CHF, the information concerning CHF in Dodoma Municipality in most cases are not public, rather they are made confidential for the government use only. However few outdated literature about community health fund and community based health initiatives in Dodoma area available in internet and library. The research was, however, successful despite the limitations encountered by the researcher.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature related to the topic of study. The chapter provides the theoretical review, definition of terms as they are used in this study. Local and foreign studies done by other researcher are also presented in this chapter.

2.2 Definition of key concepts

Kapinga *et al* (2002) describe Community Health Fund as voluntary scheme which gives an opportunity to household to contribute when they have money and be entitled to the specified benefit packages for one year. Community Health Fund is at district level and voluntary prepayment scheme introduced in parallel with user fees at public health facilities. Community Health Fund should serve 85 percent of the population living in rural areas and/or employed in the informal sectors (Kamuzora, 2006).

Community Health Fund mark substantial contribution in providing health care services such as constant drug and medical supply, rehabilitation of health facilities and influence change in providers' attitude and behavior. Timmis *et al* (2009) add that community based health insurance is a type of insurance that operates at the level of the community.

Community Based Health Insurance is a type of social health insurance that operates at the level of the community (Timmis *et al*, 2009). The development of community based health insurance in Tanzania spearheads the introduction of Community Health Fund.

Cried *et al* (2010**)** argue that community based health services should provide universal coverage**.** They argue that universal coverage refers to the situation where the whole population of a country has access to good quality services according to needs and preferences, regardless of income level, social status or residency. Universal coverage was agreed by many African countries to enable the whole population in the community to access the health sectors. This embraced the introduction of community health fund which covers people from informal sectors, and the introduction of National Health Insurance Fund which mainly service civil servants.

Universal coverage refers to the situation where the whole population of a country has access to good quality services according to needs and preferences, regardless of income level, social status or residency.

The scheme gives exemptions to people with special characteristics. Exemption refers a statutory entitlement to free health care services, granted to individuals who automatically fall under the categories specified in the cost sharing (Mantel *et al*, 2006). The scheme offers identity cards to people who are not able to afford the fees of the scheme: these are disabled people and the elders. Waiver is granted to those patients who do not automatically qualify for statutory exemptions but are in need of the same and classified services which they are unable to pay (Mantel *et al*, 2006). In Tanzania exemption is mainly offered to pregnant women and children less than five ages. This group is not required to use identity cards, to get the free health services when they seek for the service.

Household refers to people who comprise family that mean father, mother and children under five years as well as dependants less than five ages. There is no restriction in terms of number they may be ten or below that, but the premium contributor is only one person. For families with more than one wife the scheme needs every wife to have different registration. Also any person who is above 18 years the scheme recognize as a household.

2.3 Theoretical Review

According to Bangser *et al* (2004), health services are often not accessed by the poor people in Tanzania. But Gilson *et al* (2002) commented that more people from the informal sectors are not enrolled in any Community Based Health Initiatives in Tanzania. Most of these people are very poor and vast of them are living in rural areas whereby most of the infrastructure are very poor in such a way that most of the people are living in extreme poverty level. But in urban areas the situation is more appealing because the scope of employment is wide compared to rural areas and the socio cultural aspect in urban is different, but people are not influenced to join the Community Health Fund. This study will investigate why many people are not members of Community Health Fund in urban settings.

Many studies which have been done in Tanzania reveal that the issue of exemption program is not well implemented in various districts of the country (See for example, Timmis et al, 2009; Bangser *et al* 2004; Kapinga *et al* 2002; Kamuzora 2002; and Chee *et al,* 2000). This process has affected more people who are not able to afford to pay the sum required to be qualified as an active member of the fund. In most cases, these are elders and disables who cannot engage in productive activities.

Bangser *et al* (2004) argued that community participation is very limited in regards

to determining health care priorities, deciding where funds should be allocated, and monitoring expenditures. Also, the study which was done by Gilson *et al* (2002) to assess the Community Health Fund in various district in Tanzania, portrays that in many of these CHF community is not involved in decisions making of the scheme. But Kayonga (2007) commented that community health insurance aimed to decentralize the management and running the health scheme. This has been well achieved in Rwanda, as the community fund has covered a large portion of the population in Rwanda. In Tanzania it seems that this mechanism is not well implemented, therefore this study will focus in this aspect for more findings.

In most cases, the operation of Community Health Fund in Tanzania faces various problems but the most challenging one is low enrolment of the targeted population (Kamuzora, 2006; Kapinga *et al*, 2002). The common factors toward low enrolment are limited coverage, low quality of health services, lack of trust to the Community Health Fund managers (Kamuzora, 2006), management problem and poor information system (Kapinga *et al*, 2002). But many of these studies focused much on Community Health Fund operating in rural areas and left much unknown about problems facing this scheme in the urban areas.

The Community Health Fund is run by Community Health Fund managers in the district level assisted by Ward Health Committee and Village Health Committee at the lower level (MOHSW, 2010). According to Gilson *et al* (2002) some of the districts where Community Health Fund operates failed to get annual matching grants offered by the government because they failed to submit contribution records of their members. In some districts, it has been found that Community Health Fund managers were not competent enough to run the scheme as they were l poorly trained

(Gilson *et al*, 2006). But the in broad, the problem of the scheme on employing experts in the insurance to run it is not yet covered in many studies.

In Hanang district, for example, revenues collected from community health fund were used to expand the district hospital (Kapinga *et al*, 2002). But in Igunga district, the funds collected from community health fund were used to purchase the ambulance (Kiwara *et al*, 1999). In other districts, studies indicate that revenues collected from this scheme were not utilized at all and the money was found saved in bank accounts and others used to pay allowances to some officials (MOHSW, 2011). It seems that there is no clear understanding on proper use of funds collected from this scheme. However, the issue of central management and well prescribed procedures of referral services are inadequate covered.

2.3.1The Epidemiological Transition Theory

The theory which guide this study is the epidemiological transition theory, this theory focuses on the complex changes in the patterns of health and diseases with their determinants and consequences in population groups. It is specifically concerned with the distribution of disease and death with their determinants and their consequences in population groups. Theory has five propositions which are explained below.

Proposition one, the theory at the beginning address that mortality is a fundamental phenomenon for population change in any society. Among the three processes which lead to population change, mortality which occur in all age groups contribute much to changes of numbers of the people in the community.

Proposition two, during the transition a long term shift occurs in mortality and

disease patterns whereby pandemics of infection are gradually displaced by degenerative diseases as the leading causes of death. This proposition explains the transition of mortality causes by looking at three ages. Age one involves, pestilence and famine as the major cause of death. The second age is the age of pandemics, only pandemic diseases remain as the major causes of mortality to the people as epidemics diseases decreases in frequency and magnitude. The third age is the age of degenerative diseases and manmade diseases, during this age the other causes of death; for instance epidemics, endemics as well as infectious diseases declines, has been controlled in the society. This is currently happening in the developed countries (Weeks, 1999).

Proposition three, the theory always shows that women of average ages have a good chance to survive from diseases than men children and adults. Also it tends to explain in favors of women of reproductive age than man of the same ages. Women have high chance to survive than man because of nature the nature of activities they performs (Weeks, 1999).

Proposition four; this explains the shift of diseases and health situation which happened before the twentieth century. In this stage, there is advancement of health care, disease control programmed and supply of adequate food to people. Also people have changed their tendency, now they start attending hospitals for treatment rather than using other services. Fertility decline during this age as people change their life style and the existence of various processes to control fertility and family planning, (Weeks, 1999).

Proposition five, the distinctive variations in the patterns, the pace, the determinants, and the consequences of population change differentiate four basic models of the

epidemiological transition, it involves the classical or Western model, the accelerated variant of the classical model, the delayed model and the transitional variant of the delayed model (Weeks, 1999).

The Community Health Fund in poor community has valuable contribution to the welfare of the household as it serves the following.

It helps to improve the health status of people. Health sector in poor community incurs various related costs which include transport, drugs as well as diagnosis costs. Social health insurance minimizes barriers and thus enables the provision of a range of timely interventions which help to improve the health status of people, including prevention, treatment, and rehabilitation (Harmansdorf, 2009).

It also prevents impoverishing the health care expenditures. In countries where patients are required to pay substantial user charges or co-payments, the financial burden associated with medical care can cause economic ruin for whole families, especially if hospital treatment is needed. The WHO estimates that every year more than 150 million individuals in 44 million households face catastrophic health expenditure as a direct result of health problems. About 25 million households or more than 100 million people impoverish due to medical expenses (Harmansdorf, 2009).

It substitutes inefficient risk coping mechanisms. Health insurance enables the poor community in developing countries to meet high costs, which they may need to incur, by using user fees (Harmansdorf, 2009). When people do not have money for health and they need treatments, they often sell their productive assets, cut down expenditures on other basic necessities such as food and clothing, and take their

children out of school. These types of risk coping mechanism strongly contribute to the persistence of poverty.

It increases people's productivity: By improving the health status of people and by substituting inefficient risk coping mechanisms, social health insurance encourage people's productivity, which in turn promotes employment and economic growth and further facilitates increases in income levels (Harmansdorf, 2009).

It promotes social stability and social cohesion: Social health insurance is firmly grounded on values such as solidarity and equity. (Harmansdorf, 2009) It thereby strengthens the social bonds of cooperation and solidarity, thus enhancing social stability and social cooperation's within a society.

2.4 Empirical Review

Until march 2011 the scheme was operating in 108 districts in Tanzania covering 457,716 household where by about 2,746,296 people were getting health services from this scheme, this is about 7.9 percent of whole people in the country. In Dodoma Municipality about 4,982 household are getting health services from this scheme covering 4.6 percent of all (MOHSW, 2011). The primary aim of Community Health Fund was not to raise additional funds but to improve access to health care for the poor and vulnerable groups (Kapinga *et al*, 2002).

According to the government Act No.1 of 2001, Community Health Fund has the following objectives: First is to mobilize financial resources from the community to provide health care services to its members. This enables the scheme to accumulate enough financial resources for the purposes of ensuring constant supply of drugs in health centers and hospitals. Second is to provide quality and affordable health care

services through sustainable financial mechanism. The last objective is to improve health care services management in the communities through the decentralization by empowering the communities in making decisions and by contributing on matters affecting their health (Ishengoma, 2007).

Community Health Fund membership is voluntary for all residents except for civil servants employed between 1998 and 2001. Before the establishment of NHIF in July 2001, it was compulsory for civil servants to be members of Community Health Fund and their contribution were deducted from their salaries (Kapinga *et al*, 2002).

In many areas where the Community Health Fund is operating it seems that membership is decreasing from time to time. For instance in Hanang district, enrolment rate in 1999 reached 23 percent of all household but declined to 3 percent at the end of October in 2001 (Kapinga *et al*, 2002).

In Iramba district, it was found that out of 212 people who were interviewed, 53 percent declared to be permanent members of Community Health Fund since its establishment in 1998. And more than 95 percent of community members were aware of Community Health Fund (Mwendo, 2001).

This health scheme decentralizes the power to the local people from the grassroots. People are free to set appropriate fees they think is viable for them to contribute per year according to their economic situation. Apart from this fund, also the scheme gets support from the government which is provided in terms of matching funds. Also, it gets support from the World Bank which is also in form of matching funds and technical support in management and coordination of Community Health Fund (Kapinga *et al*, 2002).

In Hanang for instance, the major challenges which was seen during the assessment of Community Health Fund was the problem of management and information system. These require intensive improvement, decentralization, and the management structure of Community Health Fund needs to be reformed so as to promote the involvement of the community. Training for district, ward and health facility staff is also needed to strengthen their capacity to effectively manage the Community Health Fund (Kapinga *et al*, 2002).

Therefore, in order to achieve the transition to better health and population groups equity and massive access to health sectors to all groups in the community is highly needed.

2.5 Research Gap

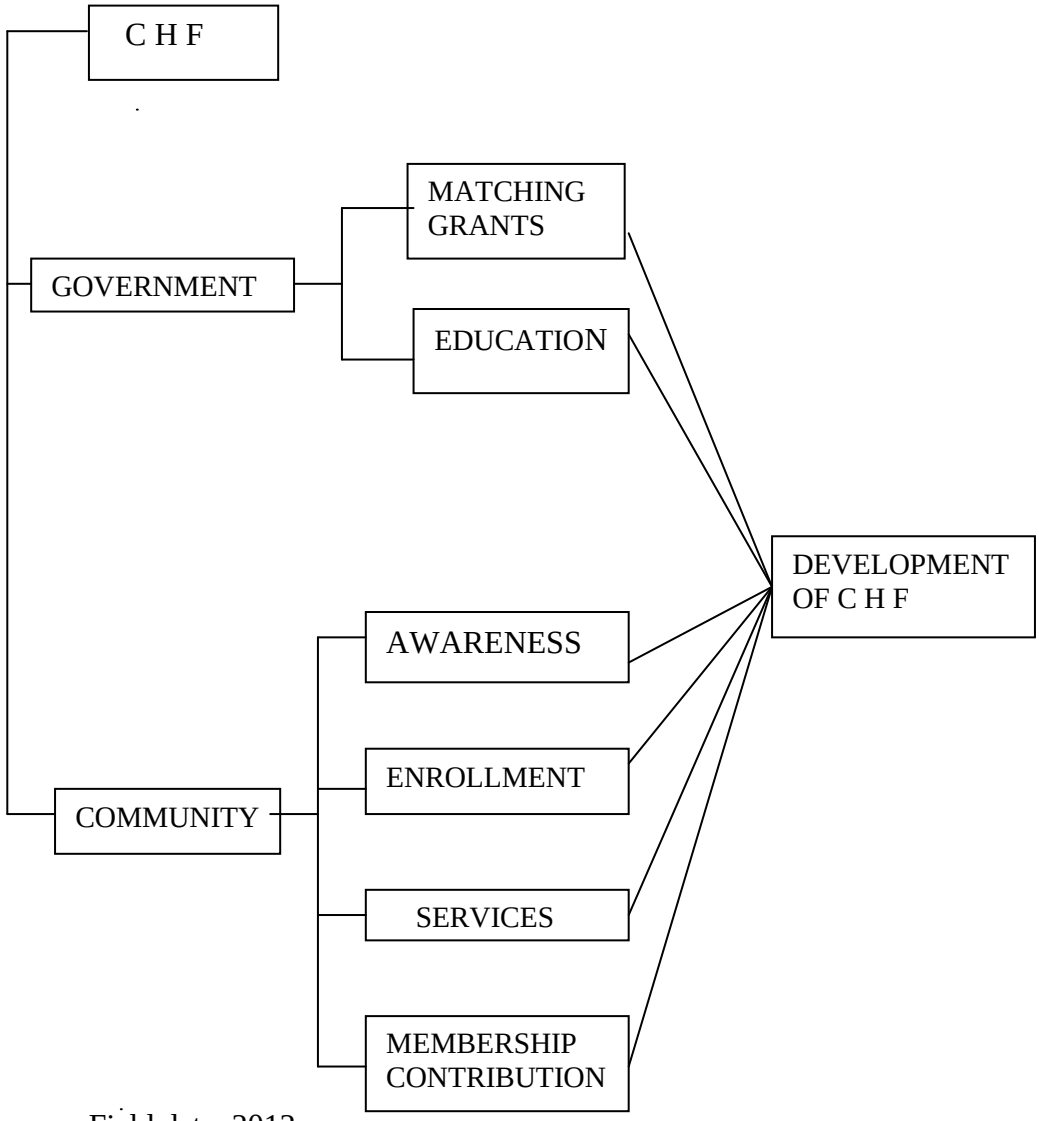
Various studies have been done in regard to the assessment of Community Health Fund in different Districts in Tanzania since 1995. Many of them associated the development of Community Health Fund (Mulligan *et al*, 2007), enrolment patterns (Mwendo, 2001) and reasons for the decline of Community Health Fund (Kamuzora, 2006). But the assessment of Community Health Fund in urban settings in terms of enrolment, reasons why it is not operating in many municipalities and cities in Tanzania and awareness of the people about the scheme is yet to be established. This study will contribute in all these as it will be studied in Dodoma Urban District.

2.6 Conceptual Framework

The community health fund is the social health insurance which is owned by the community and receives matching grants from the Government. It mainly targets the people who are working in the informal sector.

This scheme decentralizes the power to the local people whereby local people set rules, the annual fees and selection of exempted people. Sometimes the scheme receives subsidies from donors. Also, the scheme creates awareness to the people concerning the importance of local people to be members of Community Health Fund. Since the introduction of Community Health Fund in Tanzania in 1996, the scheme has enrolled less than ten percent of all people who are found in the informal sector in Tanzania and it has covered only 109 districts. In Dodoma the enrollment is very low about 4 percent of all household in the municipal.

Figure 1: Conceptual framework



Source: Field data, 2012

Research Variables

The study was guided by the following variables. The independent variables are awareness of the people about the scheme, enrollment of people in the scheme, services offered by this scheme and membership contribution in the scheme. The improvements of these variables influence the dependent variable which is the development of Community Health Fund.

Awareness of the People about Community Health Fund

This is an independent variable which is categorical in terms of measurements; it refers to the extent at which the entire populations in Dodoma municipal understand the Community Health fund. This variable guided this study to expose multiple things regarding the awareness of people about CHF. The study has come out with measurable statistics which support this variable.

Enrolment of the members

This is a numerical variable, whereby the study investigated the membership status that is how many people are members of the scheme. This guided the study where by the membership status in Dodoma municipal has been identified in relation with number of household available. Also willing of people who are not members to enroll into this scheme are established.

Services offered by the scheme

This is another variable which was assessed in this study the quality of services that members are receiving from the scheme. The study has observed that there are a lot of complains about the services offered that is why some people especially elders have opted to the traditional healers. The study also assessed the reactions of the members on the quality of the services which members get when attending the health centers, that is their perception on various rehabilitations which have been done by the scheme in health buildings and purchasing of new health facilities such as storage facilities and ambulances, which may improve the schemes capacity to attend many people and rescue others with urgent requirements.

Decentralization of Services

This is important variable in this study because the existence of CHF needs ownership to the entire community. Under the operations of community health fund in Dodoma, the scheme has decentralized the services to all government health centre and dispensaries which are located to the ward and village levels. This allows many people to get health services within their areas without encoring more cost to travel far distances. Therefore, this study specifically on this has assessed the applications of exemption policy which implemented at the lower level by the local leaders to identify the required group for this service.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Research methodology is an important part of research which refers to the described approaches to kinds and paradigms of research (Cohen *et al*, 2007). The methodology used to complete this study is described in details in this chapter. The chapter explains the research design, research approach, area of the study, sample size, types of data collected, methods of data collection, data analysis and processing as well as validity and reliability.

3.2 Area of the Study

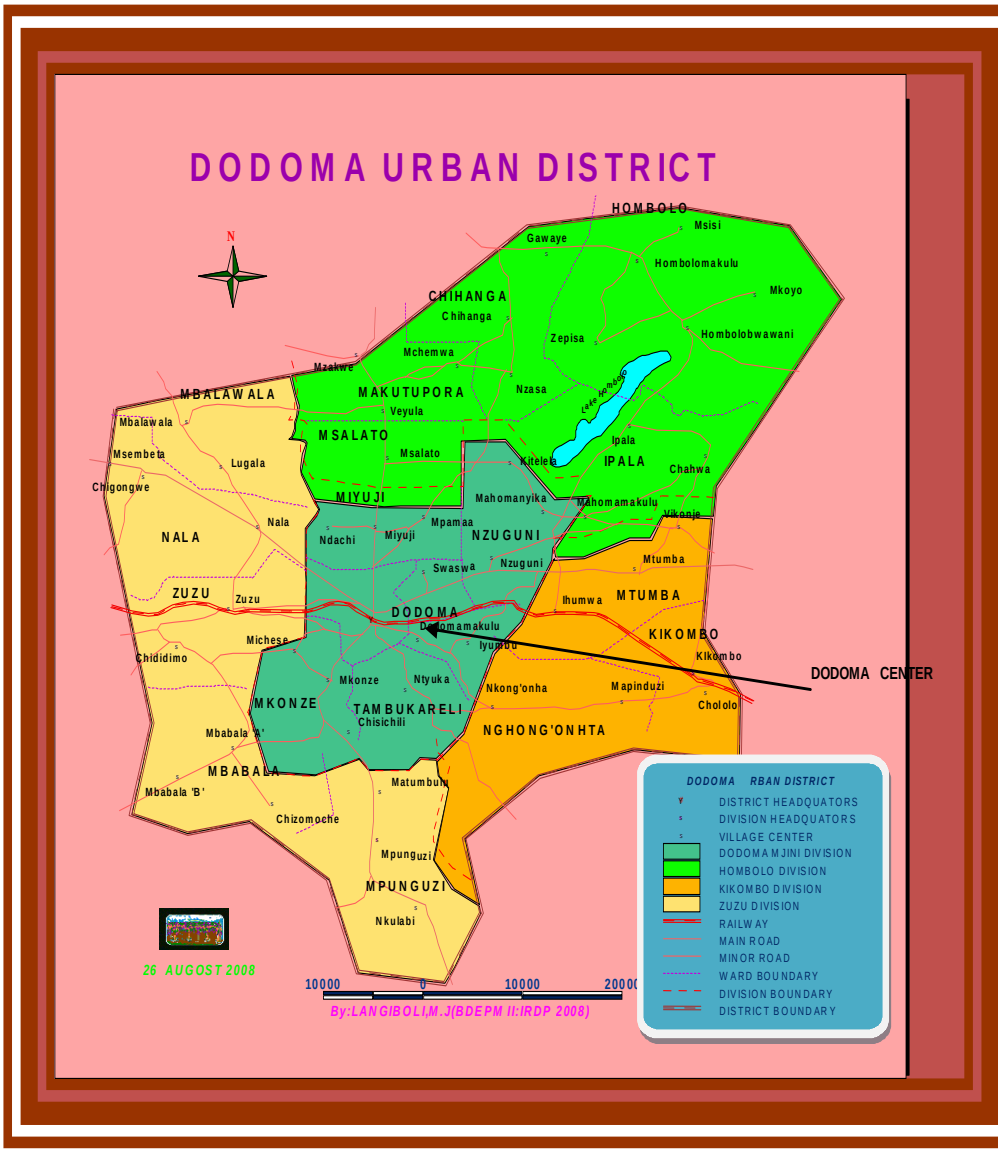
The study was conducted at Dodoma urban in Dodoma region. Dodoma is located in the central part of Tanzania about 521 kilometers away from commercial city, Dar es Salaam (URT, 2008). The area has been selected for this study because it is one of the districts which have the lowest enrollment of CHF members in Tanzania. Dodoma municipal has 107,764 families where only 4,982 families are members of CHF, this approximately range to 4.4 percent. This is a lowest enrollment which needs to be solved so that a lot of the people became members of this scheme.

Dodoma municipal has been selected for this study because it is one of the few municipals in Tanzania which have established Community Health Fund. There are about three municipals operating the CHF these are Tanga, Dodoma and Singida. The plan is in progress to introduce the CHF in three the municipals of Dar es Salaam city. The municipals in plan are Kinondoni, Temeke and Ilala (NHIF, 2011). Previously, the scheme was perceived to be entirely convenient to rural areas which have made its transition to urban dwellers difficult to be accepted many municipals.

Moreover, though the scheme has operated for decades now, it has enrolled only ten percent of all Tanzania citizens (Mulligan *et al,* 2005). Also the population of Dodoma urban is growing very fast as a result of rural urban and urban to urban migration. This needs a wide access of health services.

In Dodoma urban the scheme has enrolled very few people than the other four districts in the region. By the end of 2011, the scheme had only 4.4 percent members Community Health Fund (NHIF, 2011).

Figure 2: Map of Dodoma Municipality



3. 3 Study Population

Population is referred as a group of people, events or things of interest that a researcher wishes to investigate (Kothari, 2006). The study focused mainly to study the people who are working in the informal sectors and secondary school students. These people are the major target of the scheme that is getting health services from this scheme.

3.4 Research Approach

This study used both qualitative and quantitative research methods. Both methods were utilized in this study depending on their nature so long as no single method is sufficient. Many scholars such as Kothari (2004); Kombo *et al* (2006) recommend qualitative and quantitative methods to be used together in the same research project because they help to increase the quality of the collected data. The use of one method cannot produce useful information required as required by the study (Kothari, 2004).

The qualitative approach is very much based on primary source of data whereby the researcher is the main controller who observes and records all information from respondents (Cohen *et al*, 2007). In this method, data are mainly collected in the form of explanations, pictures, records, etc. The qualitative approach used in this study enables researchers to get first hand information from respondents, also because some aspects of research demand explanations than statistical data. This method also enables a researcher to get more information about the matter investigated.

Qualitative method seeks to understand a phenomenon by focusing on the total picture rather than breaking it down into variables. The goal is a holistic picture and in depth way of getting data for the purpose of understanding rather than a numeric analysis of data (Ary *et al*, 2010). Qualitative method involves the use of different data collection methods such as ethnography, content analysis, historical, narratives, phenomenology, and grounded theory. Therefore, this study also used document analysis to collect data from various written documents.

According to Cohen *et al* (2007), quantitative research refers to a study which its findings are mainly the products of statistical summary and analysis. The quantitative

method was used in this study to get some empirical evidence such as the number of CHF members in Tanzania and the Dodoma municipal in particular. Also quantification of some collected information in ratios and percentages were done during data analysis.

3.4 Research Design

Research design refers to a complete scheme or a plan conceived so as to obtain answers to reach questions or the problems (Angela, 2000). Kothari (2004) defined research design as the arrangement of conditions for collection and analysis of data in a manner that explains its relevance to the research purpose. Yin (1994) argues that research design is a plan that guides the researcher in the process of data collection, analysis, and interpretation of findings.

The research design used in this study is cross sectional design. This enables the researcher to know the perception of the people towards the operation of Community Health Fund in Dodoma urban. Also the nature of the study requires the problem to be studied at one specified area and period. Cross sectional studies helps to get the appropriate information at the allocated time because it cannot be affected by the other intervening factors which may happen between, if it is studied for long time in repetition mode (Kothari, 2004).

3.6 Sampling Procedure and Sample Size

The total population of the people in Dodoma Municipality is 324,347 (Dodoma Municipal Council, 2010) whereby 48.5 percent are males and 51.5 percent are females. The study sampled a total number of 184 respondents from which a total of

174 respondents were involved in the study through interviews and questionnaires. The 104 respondents were people who are not members of Community Health Fund, while 70 respondents were members of Community Health Fund in Dodoma municipal. While 10 Community Health Fund officials participated in the study through interviews and questionnaires (5 of them participated through interviews and 5 participated by responding the questionnaires). This sample was obtained through simple random sampling, whereby every item had an equal opportunity to be included in the sample. Ten respondents were randomly obtained from each 8 wards involved in the study.

The interval of four used to support the attainment of the sample size. Tallying was started at second row of the second column counting up to the bottom of the column and then started at the beginning of the next column. The process proceeded until the expected sample of 21 items was reached in one ward and then go to another ward until researcher completed 174 items in all wards. Also the study involved five experts of the scheme who were obtained through quota sampling. These were mainly coordinators of this scheme and workers of NHIF where the scheme is operating. The sample of 184 items was selected because it is convenient for researcher to achieve, appropriate to make analysis as well as it is large enough to get assessment of the scheme from the people.

The selected people were obtained from Kikuyu, Viwandani, Makole, Nkuhungu, Hazina, Maili mbili, Kizota, Chan'gombe and Makulu wards. In each ward the same proportion of sample was obtained which were 21 per every area. The Researcher decided to increase the number of respondents in two wards to become 24 because this study demanded diversity of experience so that specific goal of research can be

achieved. The respondents were increased in Makole and Viwandani wards due to high population of people than in other wards. To increase numbers of respondents overlook the problem of creating errors in research (Kothari, 2006).

Table 1 Distribution of Respondents

S/N	WARD	RESPONDENT	
		Members of CHF	**Non members of CHF**
1	**Kikuyu**	6	15
2	**Maili mbili**	**6**	**15**
3	**Nkuhungu**	**6**	**15**
4	**Makulu**	**6**	**15**
5	**Hazina**	**6**	**15**
6	**Chan'gombe**	**6**	**15**
7	**Makole**	**17**	**07**
8	**Viwandani**	**17**	**07**
Total		70	104

Source, Field data 2012

3.7 Types of data required

The research involved the use of primary and secondary data, primary data was collected from respondents through interviews and questionnaires. Primary data are those data collected afresh and for the first time, and thus happen to be original in the chapter (Kothari, 2004). The primary data were highly required in this study because they give true answers from respondents; through this method, respondents are able to display their real experience about the scheme at Dodoma municipal. The nature of this study required first hand data because of its focus on the awareness,

willingness, and challenges facing the CHF members at Dodoma municipal, these aspects can be achieved through consulting various individuals in the field.

The study also used secondary data from the field of study. Secondary data are those data which have already been collected by someone else and which have already been analyses through statistical processes (Kothari, 2004). Various secondary data used in this study were from reviewed books, journals, dissertations, newspapers, government reports, and forum reports. These documents were collected from different libraries, the internet and some were gathered from NHIF office which supervises the operation of CHF in Tanzania. Secondary data are very crucial to supplements the information which were collected through primary methods of data collection. This enables the researcher to get variety of things about the schemes and other health services.

3.8 Data Collection Methods

In data collection process, the researcher used three data collection methods which are interviews, questionnaires and document analysis. These methods were used in the study because the researcher thought that they can help to get the necessary information needed in this study.

3.8.1 Interviews

According to Cohen *et al* (2007), an interview is described as a conversation between an interviewer and interviewee with a purpose of obtaining some information. This method of data collection involves the use of face to face conversation whereby a researcher asks some questions about the topic to get information from the

respondents. The main respondents were NHIF[1] workers and CHF[2] managers these were achieved through quota sampling because they are expert and employees of the scheme. This has enabled researcher to get more information about the scheme. This method was used because it is suitable for controlling the research sample. Interviews were also used because they help to get personal experience of the respondents from the scheme. Moreover, Interviews were used to get supplementary information important for this study about respondents and their experience with the scheme.

3.8.2 Questionnaire

Kothari (2004) argues that questionnaire is a research instrument for gathering data beyond the physical reach of the observer. Under this method the researcher distributed questionnaires to some sampled respondents from the people living at Dodoma municipal. This method enabled researcher to get enough information from the respondents because some people were able to express themselves more freely on papers than in the interviews.

The method was selected because it is convenient for the large sample used in this research. The assessment needed more time for people to recall various phenomena about the scheme; therefore, it was thought that questionnaires would provide more time for respondents to respond to the questions. The method was also used because it is easy to reach vast respondents through mail, post or physical visits and collect information from them. However, the method is convenient for data analysis through Statistical Package for Social Sciences (SPSS).

[1] National Health Insurance Fund
[2] Community Health Fund

3.7.3 Documentary Review

Document analysis involves the analysis of contents from documentary materials such as books, magazines, newspapers, and the contents of all other verbal materials which can be either spoken or printed (Kothari, 2004).

The documents which were analyzed were obtained from NHIF zone offices and municipals. During the analysis, comparisons were made between the themes of the analyzed documents and the responses obtained from interviews. Important information about CHF was obtained in various literature reviewed through this method. The method was used in this research because some information could not be obtained from respondents through interviews and questionnaires rather they could be easily extracted from related books, journals, magazines and newspapers. Document analysis enabled researcher to get important information about the community health fund at Dodoma municipal and in Tanzania in general.

3.9 Period of the Study

The study was done from October, 2011 to June 2012, which is a period with both dry and rain periods in Dodoma. Therefore, in this period, people get several sicknesses which call people to attend hospitals because of the weather in Dodoma.

3.10 Research Variables

The study was guided by the following variables. The independent variables are awareness of the people about the scheme, enrollment of people in the scheme, services offered by this scheme and membership contribution in the scheme. The improvements of these variables influence the dependent variable which is the development of Community Health Fund.

3.10.1 Awareness of the People about Community Health Fund

This is an independent variable which is categorical in terms of measurements; it refers to the extent at which the entire populations in Dodoma municipal understand the Community Health fund. This variable guided this study to expose multiple things regarding the awareness of people about CHF. The study has come out with measurable statistics which support this variable.

3.10.2 Enrolment of the members.

This is a numerical variable, whereby the study investigated the membership status that is how many people are members of the scheme. This guided the study where by the membership status in Dodoma municipal has been identified in relation with number of household available. Also willing of people who are not members to enroll into this scheme are established.

3.10.3 Services offered by the scheme.

This is another variable which was assessed in this study the quality of services that members are receiving from the scheme. The study has observed that there are a lot of complains about the services offered that is why some people especially elders have opted to the traditional healers. The study also assessed the reactions of the members on the quality of the services which members get when attending the health centers, that is their perception on various rehabilitations which have been done by the scheme in health buildings and purchasing of new health facilities such as storage facilities and ambulances, which may improve the schemes capacity to attend many people and rescue others with urgent requirements.

3.10.4 Decentralization of Services.

This is important variable in this study because the existence of CHF needs ownership to the entire community. Under the operations of community health fund in Dodoma, the scheme has decentralized the services to all government health centre and dispensaries which are located to the ward and village levels. This allows many people to get health services within their areas without encoring more cost to travel far distances. Therefore, this study specifically on this has assessed the applications of exemption policy which implemented at the lower level by the local leaders to identify the required group for this service.

3.11 Data Analysis and Processing

Data analysis refers to as means of computation of certain indices or measures along with searching for patterns of relationship that exist among the data groups (Kothari, 2004). Coding the collected data was done properly in the computer software program known as SPSS. This program categorizes data in logical ways and prepares data ready for analysis to be done. Coding of data is the process of organizing text data into categories and assigning labels to those categories, to prepare them for data analysis (Neuman, 2000).

The data was analyzed by using a programmed computer packed program known as Statistics Package Social Science (SPSS) which assisted the researcher to compute mean and standard deviation, and also convert data into graphs, tables and pie charts through the use of excel program. Also, the analysis of data collected through interviews was done by interpreting the responses from the respondents. Relevant information was extracted from the reviewed documents and was presented as the findings of this research paper.

3.12 Validity and Reliability

Validity refers to the extent to which an instrument measured what it claimed to measure (Ary *et al*, 2010). The term validity has been adopted to mean more appropriate terms such as quality, rigor, and trustworthiness (Fink, 2005). To ensure validity is reached in this study, the researcher used interviews and questionnaires as the methods of data collection which consulted respondents directly; document analysis was also used in the study. The questions for interviews and questionnaires were constructed around the central theme of the research. Discussions during the interviews were guided by confidentiality and truth.

Reliability refers to its ability to operate properly according to a specified standard (Crowder *et al*, 1991). Reliability in this study was ensured through test reset. This method checked the stability of the responses over time for the group as a whole (Fink *et al*, 1985). Verification of age, for instance, has been made to get the correct ages of respondents, because some people prefer some group of ages than others. Women in this case prefer the lower age's compares to the real ages whirl man cares much to add their age (Kpedekpo, 1982).

To get age heaping and misreporting, age ratio method was used as described below:

$$\mathbf{A.R} = \frac{5px}{\frac{1}{2}[5P(x-5) + 5P(x+5)]} X100$$

Where

A.R refers to age ratios,

5Px is the population in age group from age x to age x +5,

5P(x-5) is the population in the preceding age group,

5P(x+5) is the population in the following age group.

This defined the ratio of the population in the two adjacent age groups. The comparison was made by looking the report census of 2002 of youth because they are dominant age group for this character. Misreporting in each age group constitute what is known as accuracy index. If the computed index is low it indicates that the collected data were adequate. The process was done and study calculated very low index which interpreted that the stipulated ages among male and female were almost correct.

CHAPTER FOUR

FINDINGS AND ANALYSIS

4.1 Introduction

This chapter presents the analysis and interpretation of data collected from the field through interviews, questionnaires and documentary analysis. The analysis was based on the general and specific objectives of the study. These involve demographic characteristics of respondents like gender, age, marital status, and education level. Second, evaluation about the awareness of the people at Dodoma urban District on the Community Health Fund was done in this chapter. Third, the willingness of the people to join the Community Health Fund and the main challenges which the Community Health Fund faces at Dodoma urban are analyzed and presented in this chapter.

4.2 Demographic Characteristics of Respondents

This is an important part which describes the general characteristics of respondents who participated in this study in terms of their status, ratio and composition. The part shows the ages, gender, marital status, and education level of the respondents from Dodoma urban involved in this study.

4.2.1 Age of respondents

The information collected show that members of Community Health Fund involved in the study are: 12.9 percent were between the ages of 10-19 years, 38.6 percent were between 20-29 years, 25.7 percent were between 30-39 years, 15.7 percent were between 40-49 years and 7.1 percent were above 50 years. People who are not members of Community Health Fund at Dodoma urban who were involved in this

study are: 23.1 percent of respondents were between 10-19 years, 53 percent were between 20-29 years, 14 percent were between 30-39 years, 12 percent were between 40-49 years and 1 percent was above 50 years.

Table 2: Distribution of Age of Respondents who are non members of CHF

Age group (years)	Frequency	Percent
Between 10-19 years	24	23.1
Between 20-29 years	53	53
Between 30-39 years	14	14
Between 40-49 years	12	12
50 years and above	01	1
Total	104	100.0

Source, Field data (2012)

Therefore, this study has observed that people who are not members of Community Health Fund in Dodoma urban are mostly youth who are aged between 20-29 years. These people contain 53 percent of all people where by this study had found they are not members of this scheme in Dodoma urban. This study has found that most of these people were not married and others were treated in their academic institute health centers where they study. The other group said that they take medicines without doctor prescriptions as they fill ill they go to pharmacy and buy medicines, so there is no need to be member of CHF.

From early 2008 Dodoma urban has attracted more young people who migrated for the purpose of studying and others for seeking employment in various sectors. This came as a result of varieties of high learning institutes which exist in Dodoma urban which are University of Dodoma, St. Johns University, College of Business

Education and Institute of Rural Development Program. Also, another group of people who are not members are between 10-19 years, this constitutes 23.1 percent of all people sampled. Regarding their age, these people are still dependant to their parents and most of them are either primary school students or secondary school students and some engage in small activities.

In Dodoma Municipality, Community Health Fund allows students to contribute 1000 Tsh per year in group of four students from the same school; this is for secondary and primary schools. But this study has observed that little campaigns have been done in all schools to encourage students to organize in their groups and become members of this scheme. For instance, at Dodoma secondary school one of the schools which observe large number of students in Dodoma urban, school nurse responded that:

> *"CHF coordinator visited our school and addressed the entire school community about the scheme but he never returned for more discussion and to supply registration forms"*

Table 3 Distribution of Age of Respondents who are Members of CHF

Age group (years)	Frequency	Percent
Between 10-19 years	09	12.9
Between 20-29 years	27	38.6
Between 30-39 years	18	25.7
Between 40-49 years	11	15.7
50 years and above	05	7.1
Total	70	100.0

Source, Field data (2012)

The main respondents in this category aged between 20 and 29 years which constitute 38.6 percent of all sampled population, 30 and 39 years that constitute 25.7 percent. These were captured in large number because they are in the ages whereby

most of them have their own families; therefore, to cut across the expense of health they decided to join health schemes (Kiwara *et al*, 1997). Also, these groups are mainly composed of the population structure at Dodoma municipal as a result of birth rate and migration (TDHS, 2010). Respondents aged between 10 and 19 was 12.9 percent, are mainly students and few youth, who dropped out schools. Some of these pay premium membership contribution themselves through their own groups formed in their school. But those who are not students and they are less than 18 years are members through their parents.

Respondents who aged between 40 and 49 years constituted 15.7 percent. This implies that very few people under this age group are members CHF at Dodoma municipal, which may be because these people have a good income as they have invested a heavy capital in business activities that is why they prefer user fee and private hospital. As one respondent said:

> *"CHF in Dodoma municipal does not include private hospital especially those owned under religion based organization such as DCMC, Aga khan and St. Gema hospital also members are not entitled even to be served at the General hospital currently referral hospital"*

Also this study has observed that few elders aged above 50 years are members of this scheme because health centers serving members are not able to deal with complicated diseases that usually old people have. These diseases are, for instance, those related to old ages such as diabetes, heart, and cancer.

Therefore, this study observed that large part of people who are members of Community Health Fund in Dodoma municipal are aged between 20 and 29 years. These people constitute 38.6 percent of all members. Furthermore, the study has observed that only youth aged between these years, which have families, were

members of Community Health Fund. While the second group which contains many members was people aged between 30 and 39 years. These constitute 25.7 percent of all members. These are people with their own families which engage in informal sectors. These people have opted to become members of CHF because they cannot afford the user fee charges which are very high beyond their economic abilities.

4.2.2. Gender

Distribution of respondents in terms of gender as captured from the field is indicated in Table 3. It shows that among the non members of the Community Health Fund, males were 44.2 percent and females were 55.8 percent. But for respondents who are members of Community Health Fund, 51.4 percent were males and 48.6 percent were females.

Table 4 Distribution of Respondents from Non CHF members by Gender

Gender	Frequency	Percent
Male	46	44.2
Female	58	55.8
Total	104	100.0

Source: Field Data (2012)

However, the study observed that female contain many of people who are not members of Community Health Fund in Dodoma urban. 58(55.8 percent) female respondents reached by this study declared that they were not members while male constitute only 44.2 percent.

Table 5 Distribution of Respondents from CHF members by gender of the members of CHF

Gender	Frequency	Percent
Male	36	51.4
Female	34	48.6
Total	70	100.0

Source, Field data (2012)

This study observed that CHF members from Dodoma urban are mainly male, 51.4 percent of male respondents were CHF members; while female contain 48.6 percent. Male were seen to be premium members of Community Health Fund and according to the culture, men are responsible for financing their families in everything such as school fees, food, health, and accommodation.

4.2.3. Marital Status

This part explains about the marital status of the respondents, both CHF members and non CHF members. As for the marital status of Community Health Fund members, 51.4 percent of respondents involved in the study were not married, 38.6 percent were married, 5.7 percent were divorced and 4.3 percent were widow (see Table 6).

Table 6 Distribution of Respondents from CHF members by Marital Status

Status	Frequency	Percent
Single	36	51.4
Married	27	38.6
Divorced	04	5.7
Widow	03	1
Total	70	100.0

Source: Field Data (2011-2012)

This study indicates that most of the CHF members, which are 51.4 percent, involved in this study were single, this reveals that members of CHF at Dodoma municipal are not married, some are secondary school students and university students, and others are youth who are above 18 years from the families recognized as a household by the CHF (URT, 2001). The next group is a group of families with single parents who never married. Although most of the members were single but the study has found that these people had families which involved their sisters, brothers and other relatives. The other group had children but they are not married. Family ties and economic hardship triggered these people to become members of Community Health Fund in Dodoma urban.

As shown in Table 7, respondents who are not members of Community Health Fund are 67.3 percent whereas those who are single include 29.8 percent, the married respondents are 1.9 percent and the divorced are 1 percent.

Table 7 Respondents who is Non CHF members

Status	Frequency	Percent
Single	70	67.3
Married	31	29.8
Divorced	02	1.9
Widow	01	01
Total	104	100.0

Source: Field data (2011-2012).

In this group of respondents, people who are not members of the CHF constitute 51.4 percent males while the females contained 48.6 percent of all people participated in the study. Male reached in this study were not aware about the scheme and they have negative attitude as they think that the scheme is mainly to help to treat children and

pregnant women. Therefore they think that women are the targeted population by the scheme. This myth dominates the mind set of men as it was observed that at Makole hospital, which services the CHF members, it was mainly pregnant women and children who were attending the hospital for services through the CHF.

Also males seem to be irresponsible to their families; although they are poor they did not care their family members. This indicates that the authority concerned is yet to enable the community to be aware of the CHF benefits. Also, most of the families in Dodoma municipal are headed by women who engage in small business activities that enable them to run their families. Most of them have very low income in such a way that they are not capable of joining the scheme. One interviewed woman had the following to say:

> *"The expense claimed is not exactly 5000 TSH per year rather there are other expense that person has to face like registration fee which involves photo taking and transport"*

Dodoma urban is one of the areas experiencing the immigration of people moving from other places, youth migrate to this town from villages and other town seeking for employments in construction industry which is a dominant industry at Dodoma urban currently. This study found that youth at Dodoma urban have a large proportion of population group which contain people who are not CHF members. Many of these people do not have families, so they are sure of getting health service when they are ill through user fee services.

4.2.4. Education Level

The education level of the participants is described in Table 8 and Table 9. For instance, of all Community Health Fund members, 33.3 percent of respondents had primary school education level, 63 percent had secondary school education level and

1.2 percent had diploma in education while 2.5 percent were degree holder (see table 9). For the respondents who are not Community Health Fund members, 28.8 percent had primary education level, 62.5 percent had secondary education level, 3.8 percent diploma education level and 4.8 are degree holders (see Table 8).

Table 8 Distribution of Non CHF Members Respondents by their Level of Education

Education level	Frequency	Percent
Primary School	30	28.8
Secondary school	65	62.5
Diploma	04	3.8
Degree	05	4.8
Total	104	100.0

Source, Field data (2011-2012)

Table 9 Distribution of CHF Members Respondents by their Level of Education

Education level	Frequency	Percent
Primary school	35	33.3
Secondary school	32	63
Diploma	01	1.2
Degree	02	2.5
Total	70	100.0

Source: Field data (2011-2012).

This indicates that many people who are CHF members at Dodoma urban had attained primary and secondary school education. These groups are not employed in the government sectors, they usually engage in informal sectors which is not growing as expected in urban areas, hence spearheads the poor in urban. Also this study has

identified that there are few civil servants who are premium members of the CHF especially those with more than one wife and large families. In NHIF where every civil servant are member only allows one wife and four dependants; therefore this enable other family members to join CHF. Very few people with diploma and bachelor degrees identified themselves as CHF members; these people seem to be self employed in the urban.

4.3 Awareness of the People about the Community Health Fund

This section explains in details the awareness or the understanding of the entire community at Dodoma urban about the Community Health Fund.

The peoples' awareness about the importance of the CHF is seen through the peoples' understanding of Community Health Fund, peoples' understanding of the eligible people to become members of CHF, their annual contribution per year, and that how CHF maintain poor people in Dodoma. The following are the findings of the study.

4.3.1 Eligible People to Become Members of Community Health Fund

This part explains the interpretation of the people on how they understand people who qualify to be members of CHF. From the analysis of information from 104 respondents who are not members of Community Health Fund show that 70.2 percent responded that anybody can become a member, 22.1 percent argued that only civil servants can be members, 1.9 percent responded students only and 5.8 percent argued that CHF is for pregnant women.

Table 10 Comments from Respondents About who should be CHF Members

Comments	Frequency	Percent
Any body	73	70.2
Civil servants	23	22.1
Students only	02	1.9
Pregnant women	06	5.8
Total	104	100.0

Source, Field Data (2012)

This shows that many people are aware that anybody in the community can enroll and become the members of CHF. Although civil servants are excluded by this scheme since they have their own health scheme which is not voluntary, they are not restricted; they can join to support their relatives who are not member of NHIF. Every public worker must be member of NHIF; however this scheme has limitations of the number of children which should be four children only. If premium member has more than one wife and children beyond the number required he/she is not free to enroll them to CHF (Shirima, 2007).

Some people also still believe that CHF is suitable for pregnant women only as they are supposed to attend to health facilities regularly to avoid pregnant complications which result to maternal mortality. One old man who lives near the city center said the following during the interview with him:

> *"In our area home delivery are prone to penalty, every pregnant women must delivery at health facilities, he insisted I was away from home while my wife was pregnant when I came back I was told I suppose to pay fine as a result of home delivery"*

This belief has developed negative attitude for men to enroll in this scheme and others have entirely believed on traditional healers for their treatments. Older people

do not go to hospital when they become ill since they believe they will not receive good services, nor will they be able to afford the treatment (HAI, 2003). A local regulation established in rural areas of Dodoma has enabled to raise the number of women who attend to health facilities when they are pregnant. For instance, in 2009, 58.7 percent of all pregnant women in Dodoma region delivered their babies in health centers (TDHS[3], 2010).

4.3.3 How the fund Help the Poor People in the Community

Dodoma region is one among the areas in Tanzania which have an increasing aging population of people who do not have any support from their families. Old people have become beggars in Dodoma and other big cities in Tanzania, some old people have become blind as a result of poor health services. Youth have migrated to other urban areas seeking for better job opportunities (TDHS, 2010). This creates very difficult situation for old people to sustain and manage the costs for health services for them without any assistance, as separation of family has became a dominant situation at Dodoma Municipality.

Although government in Tanzania has the policy which allows older people who are unable to pay for health services to get free the health services. This is not applicable because medicines are not available in all time to most of health centers. However, government introduced this policy so that CHF could support offering services to older people.

[3] Tanzania Demographic Health Survey

Table 11 Distribution of Responses about CHF Exemption of Poor People

Response	Frequency	Percent
Poor are exempted	42.3	44
Poor are supposed to pay	14.4	15
They have to attend to different hospital	29.8	31
Health committee subsidy them	12	14
Total	104	100.0

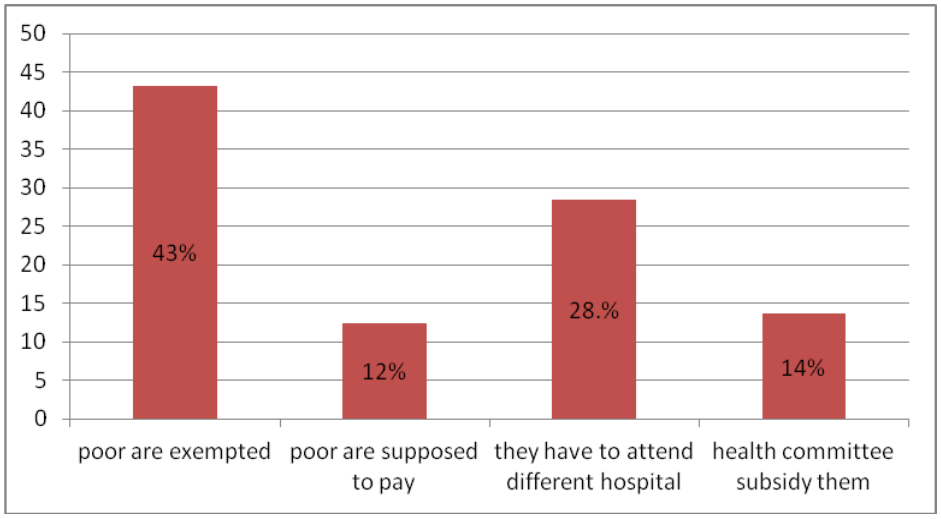
Source: Field Data (2011-2012).

The information from respondents indicates that about 43.2 percent agreed that poor are exempted; 14.4 poor are supposed to pay and 29.8 percent responded that they have to attend to different hospitals; while 11.5 percent indicated that health committee subsidizes them.

According to the CHF Act No. 1 of 2001, poor people need to be exempted from paying direct costs of CHF. Ward and village health committees were entitled with the obligations to identify the poor people from their areas who deserve the CHF benefits. People who can not engage in production activities such as elders and disabled people deserve this category (URT, 2001).

However, this study has observed that the implementation of exemption policy is not well understood by many people even by the leaders of the scheme. Most of the people are not aware whether this is practical in Dodoma Municipality. Hence, exemption for the special people is not exercised. Exemption to old people under Community Health Fund together with government initiatives to offer free health services to old people aimed to enable them to get health services.

Figure 3 Comments on Exemption of Poor People.



Source: Field data (2011-2012).

4.3.4. The Scheme Serves Civil Servants

104 participants responded to this question in particular through interviews and questionnaires. Figure 11 shows that 30.8 percent of respondents strongly agreed that CHF serves civil servants; 22.1 percent strongly disagreed that the scheme serves civil servants, 26.9 percent said that it serves civil servants and 19.2 percent disagreed that CHF serves civil servants in Dodoma Urban District.

Table 12 Responses on whether CHF serves civil servants for respondent who are non members

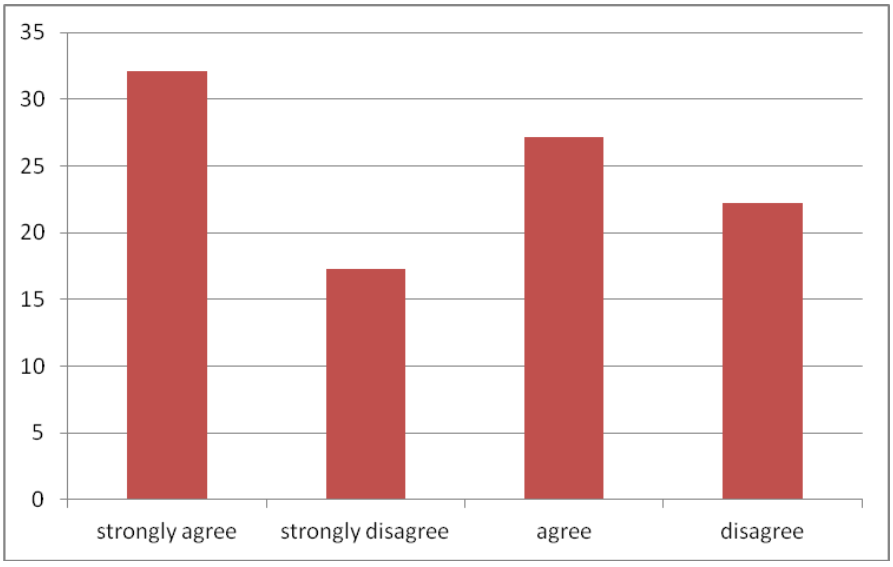
Response	Frequency	Percent
Strongly agree	32	30.8
Strongly disagree	23	22.1
Agree	28	26.9
Disagree	20	19.2
Missing	01	1.0
Total	104	100.0

Source: Field data (2011-2012).

From these statistics, the study has found that the entire population in Dodoma urban represented by this sample does not know the targeted group of people to be serviced by this scheme.

The Community Health Fund is the district based scheme which is special for people who are working in the informal sectors in Tanzania (URT[4], 2001). This is a large group of people in the community, especially in the developing countries such as Tanzania whereby the majority are not employed in the formal sector. Some of these people are students from all levels of education. For instance, in Dodoma municipal the scheme has enrolled students from universities, colleges, primary schools and secondary schools. The other groups are those who engage in informal business activities which enable them to get their daily income.

Figure 4 Distribution of response on whether the scheme serves civil servants who are non CHF members



Source: Field Data (2011-2012).

[4] United Republic of Tanzania

4.3.5. The Scheme is Special for Poor People

Table 12 shows the distribution of respondents' responses on their understanding about CHF. 11.5 percent of the respondents strongly agree that the scheme is for poor people; 24 percent disagree; 20.2 percent agreed that it is for poor people and 42.3 percent disagree that the scheme if for poor people while 1.9 percent did not respond anything on this question which means that they are not aware of who is to be served by the scheme.

Table 13 Distribution of Respondent Responses on Whether CHF is for Poor People

Response	Frequency	Percent
Strongly agree	12	11.5
Strongly disagree	25	24
Agree	21	20.2
Disagree	44	42.3
Missing	02	1.9
Total	104	100.0

Source, Field data (2011-2012)

Participants who responded to this question particularly the people who are not CHF members argue that they are not aware that CHF is special for people with low income. Basically, the intention to introduce CHF was to support the poor people from using a lot of money but this has not been the case as it was intended. For instance, the pilot study which was done in Igunga indicated that households used 17000/= Tsh per year in treatment while their income was very low; hence the government decided to subsidize this expense as it was found that people were able to contribute 5000/= Tsh per year (Gilson *et al*, 2006).

Therefore, this implies that most of the people do not know exactly the core and intentions of establishing this scheme. Some few people know the scheme from their friends and relatives.

4.3.6 Peoples' Awareness about the Community Health Fund

In general, a large number of people at Dodoma municipal seem not to be aware about the Community Health Fund. A large number of people (56.8 percent) involved in this study responded that they do not understand many things about CHF. The major obstacle identified toward poor understanding of this scheme was the peoples' poor understanding of things and lack of the commitment to learn different issues. Only 43.2 percent of people involved in the study said that they understand about the scheme. This implies that there is a great deal of efforts needed to educate all people in the country to understand this scheme.

4.4. Willingness of the people to become CHF members

The section explains the view of the people at Dodoma urban on whether they are ready to become CHF members. Most of the people who participated in this study through interviews and questionnaires were not ready to join the CHF because they have little information about this scheme. Timmis (2009) argues that district managers have a direct influence for people to join the CHF. This study has realized that a large percent of people at Dodoma urban do not understand the CHF; many people fail to differentiate the CHF from the NHIF.

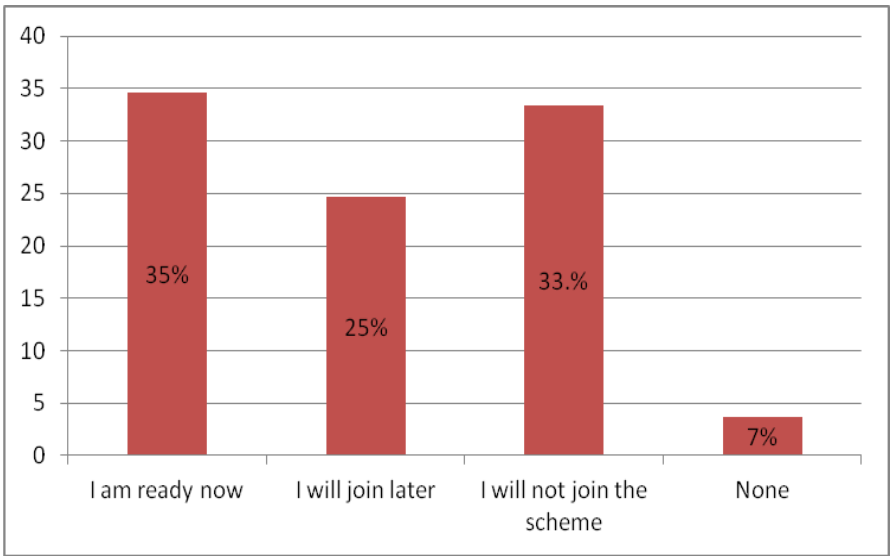
Table 14 Willingness of Respondents to join the CHF

Responses	Frequency	Percent
I am ready now	37	35.6
I will join later	23	22.1
I will not join the scheme	34	32.7
Missing	6	5.8
Total	104	100.0

Source: Field data (2011-2012).

Some people know about the existence of CHF through their friends and relatives but they do not want to join it because they heard that the services offered to CHF members are not satisfying. As described in the table 14, 9.9 percent of the respondents said that services offered are excellent, 21 percent said that they are very good, 30.9 percent said that the services are good and 33.3 percent bad.

Figure 5 Willingness of respondents to join the CHF



Source: Field data (2011-2012).

Lack of the will of many people to become members of CHF is associated with lack of risk pooling knowledge, which is a central theme in operating the CHF. People are not ready to risk their money, they say that a year may pass without getting ill (Timmis, 2009). Stigma and tribal prejudices were also said by some respondents as one of factors which lead to low enrolment.

The study observed that people who are CHF members at Dodoma municipal joined the scheme voluntarily soon as they became aware of CHF. Promotion was done in primary and secondary schools as well in different streets in the town. This means that people have to be educated to promote them to join the scheme. One member raised the following during an interview with him:

> *"I was at the hospital seeking for the service, and one health official introduced the CHF scheme to me, I was interested and later I became premium member of CHF"*

Another group of people who are member of the CHF is a group of university students, these become CHF members because of their economic status. Students were not able to pay high medical capitation imposed by their university and they were given option to be member of any health scheme. This drove many students, especially those from St John's University to become members of this scheme.

4.5 Peoples' Satisfaction from the Services Provided by the CHF

The large percentage of the people participated in this study commented that they are not satisfied with the services offered by the scheme to its members. As described in Table 15, 9.9 percent of the respondents argued that the services are excellent, 21 percent argued that the services are very good, 30.9 percent argued that it is good and 33.3 percent argued that the services are bad. This shows that more people are not

happy with the services offered by the scheme to the people.

Table 15 Peoples' Satisfaction from the Services Provided by the CHF

Level of Satisfaction	Frequency	Percent
Excellent	16	15.4
Very good	18	18.3
Good	32	30.7
Bad	36	33.8
Missing	2	1.8
Total	104	100.0

Source: Field data (2011-2012).

4.6 Health Projection

The establishment of the CHF which was aimed at involving the community to participate in financing provision of health services through cost sharing is obviously not doing well. The MOHSW has a long way to reach the target of enrolling 80 percent of Tanzanian population by 2015 (URT, 2010).

The attainment of this projected achievement needs to be supported by a good budget that directly goes to this sector in the country. The current Tanzania expenditure on health is below the Abuja target of 15% government spending on health, and by 2004 it was only 12 percent of the total budget (Makenda *et al*, 2007). The normal per capital spending on the public health sector has increased from Tsh 8,235 in 2004/5 to 16,975 in 2008/09 due to the increase of inflation in the country.

Table 16 A brief Summaries of the Spending on Health at National and District Level from 2006 to 2010

Indicator	Level	2006/7	2008	2009	2010
Proportion of national budget on health (include CFS)	National	11.8 %	10.3 %	11.0 %	11.52%
Proportion of national budget of health(excluding CFS)	National	13.3	11.3	11.2	10.42
GoT and donor allocation to health per capital	National	13,214	15,368	17,768	23,488
Per capital GoT recurrent Expenditure at District level(TZS)	District	2,969	3,431	3,508	3,715
Per capita GoT recurrent expenditure on primary health care (TZS)	District	,573	1,990	1,926	-

Source: MOHSW (2010)

Health spending refers to the percentage of country's total economic resources or GDP[5] spent on health budgets to facilitate medical care and other programme assigned to help the aged (Mobley, 2006). The amount that a country spends on health care determines the ability of the health system to care for its population.

Although there are slightly increase of one percent at the national level for government health budget of 2008 to 2010 which has reached 11.52 percent, this amount has remained to be below the targeted percent that was agreed in Abuja to be 15 percent of the government budget. However, even this small budget located by the government equal distributions and availability of this money has become a problem

[5] Gross Domestic Products

in Tanzania. Hence health sector experience a lot of problems in terms of health facilities, training environment and working conditions.

4.7 The Main Challenges Facing the CHF in Dodoma Urban District

This section presents in detail the major challenges that the CHF and its members at Dodoma urban are experiencing in this scheme. The findings from the field show that one of the challenges facing the CHF at Dodoma urban is that the scheme is not known to the entire population at Dodoma urban. Some people think that CHF is the health scheme serving workers working in government sectors, while others think that it is special for people in rural areas. This means that the scheme is not promoted enough for the people of Dodoma urban to know its existence and the benefits that they may get from it.

Most of the respondents in this study argued that they are unaware if the scheme operating in Dodoma urban; i.e., 31.4 percent of the respondents argued that they are not aware about the scheme. 18.6 percent explained that they always don't go for health services at health centers, while 8.6 percent of the respondents argued that services are not offered in various health centers, and 18.6 percent of the respondents argued that very few health centers are available to serve CHF members. But 22.8 percent of respondents did not respond to this question which implies that they were not aware of the appropriate answer (see Table 17).

Table 17 Distribution of responses about the challenges facing the CHF at Dodoma urban

Challenges	Frequency	Percent
peoples' unaware about the CHF	33	31.4
Absence of drugs in health centers	19	18.6
Services are not offered	9	8.6
There are very few health centers to serve the CHF members	20	18.6
Missing Responses	23	22.8
Total	104	100.0

Source: Field data (2011-2012).

Another challenge pointed out by many respondents is that the Community Health Fund is highly affected by poor health services offered by this scheme at Dodoma urban. In most cases, members are attended in small health centers which do not have enough capacity to handle complicated diseases common in the community. The scheme in Dodoma urban does not allow its members to get treatments from other hospitals, especially better resourced hospital like the General hospital in Dodoma that has enough health facilities and many experts in different sections of the hospital. Also private hospitals which seem to be preferred by many people are not allowed to offer services.

Another challenge facing the CHF at Dodoma urban is the culture of the people. The study noticed that people have negative attitude towards various schemes, especially those which are run by the government. Many people believe that the schemes are source or way to collect money from the people for other uses by the government. Therefore, people at Dodoma urban are not interested in joining the Community Health Fund. Peoples' lack of interest is also seen through their awareness about the

scheme, if many people responded that they do not know anything about CHF while the scheme has been there for years, then it is clear that people are not interested with the scheme.

However, if one goes around Dodoma town, one can observe different posters and advertisements on peoples' t-shirts announcing the scheme. A good example is Jamatini bus stand at the town where there are lots of posters advertising the scheme. Other advertisements are posted on cars and on various walls as well as through various brochures distributed to people around Dodoma town, but people are still not aware of anything about the Community Health Fund and many people are still visiting traditional hillers for treatments which may also explain why many people are not interested in knowing the Community Health Fund.

Another challenge facing the scheme is high annual fees charged to the CHF members. Most of the people who participated in this study insisted that they are not able to afford the fees charged by the scheme at Dodoma which is TSH 5000/= per annum. Many people suggested for the scheme to lower the annual contribution because their economic status is very poor to contribute this amount while other expenses are also to be covered by them.

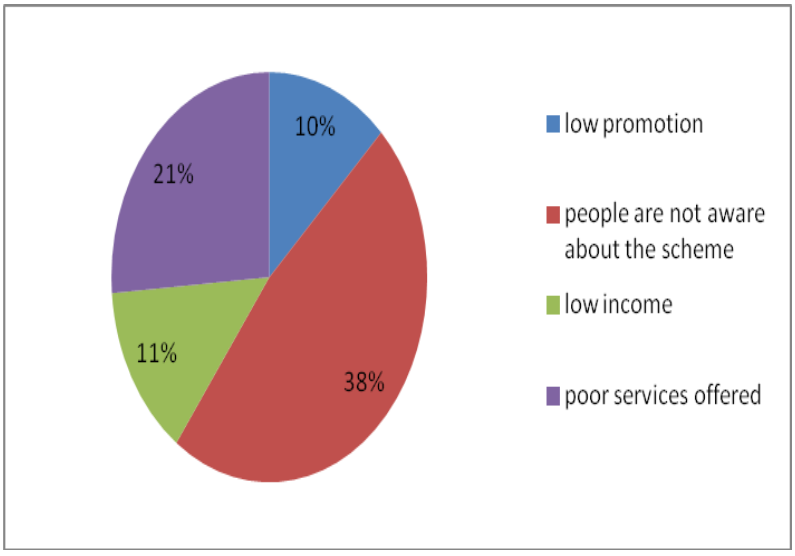
Also transparence of the CHF leaders is another challenge facing the CHF. Most of the participants in this study, especially those who are the CHF members argued that the leaders are not willing to give out the revenue and expenditure reports to the stake holders, which give them a feeling that their money is being misused by the few people authorized to supervise the scheme.

4.8 Reasons for Low Enrolment of New Members

This research found that the irresponsibility of the health attendants is the main reason for low enrollment of new CHF members. Respondents in this study said that when members of CHF go for the services, they do not get the services at the right time while the user fee members receive the services at the right time. Complaints from the CHF members and the peoples' observation on the CHF treatments discourage other people from joining the scheme. The situation in Dodoma urban is different to the situation in Hanang District whereby the members are treated at Dareda hospital which is private hospital.

The low enrollment rate of new members to the Community Health Fund in Tanzania is attributed by the high annual charges charged to the members than it is to the user fee schemes (Mushi, 2004). User fees members are believed to use less money than what the CHF member use per one year. However, this study discovered that CHF members can use much money than the user fee members, because they are sometimes supposed to buy drugs which are not found at the health centers.

Figure 6 Reasons for Low Enrolment of New CHF Members



Source: Field data (2011-2012).

As it can be seen in Figure 6, people in Dodoma urban are not aware of the schemes' benefits; the scheme seems to be new to many people reached by this study, some people seems to know the term CHF but they do not know what it real means, what is it for and who deserves the services. For instance about 38 percent of respondents declared they are not aware about CHF, 21 percent of the people reached agreed that CHF offers poor services to the members that is why other people are reluctant to join this scheme. However, 11 percent argued low income for many people is the contributing reasons toward low enrolment of new CHF members. While 10 percent of respondents declared that low promotion of CHF to vast number of people in Dodoma Municipality is among the reasons toward low enrolment of new CHF members.

Absence of drugs at the health centers discourages the CHF members attending the CHF services, sometimes when the CHF members visit the health centers for treatments they find that they have to incur other expenses to buy the medicines which are not found at the centers. Hence, many people are discouraged with the services they get from the scheme.

Another group of people reached by this study show that more people are not joining this scheme because people who are already members are complaining that the scheme offers very poor services to the people. This causes other people to believe that the scheme is not good hence more people in Dodoma urban are not members of CHF.

Community Health Fund has not yet captured the attention of politicians from various political parties. Politicians do not discuss the CHF to its followers as they do

for education, and other business. This is also among the reasons for many people to be not aware of the scheme.

Most of the respondents participated in this study said that they never had a CHF meeting of the members to discuss the challenges they face in the scheme. This indicates that there is a problem in the administration of the scheme. Therefore, there are no quarterly feedbacks to the members which have also contributed in lowering the attention of the people toward the scheme.

Although the government of Tanzania has tried to combat the problems facing CHF through shifting some CHF responsibilities to the NHIF which has more resources and experts to operate the scheme, still the major responsibilities of the CHF are done by local government.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

In a research work, conclusion and recommendation is crucial part that a researcher must include in the study. This chapter presents this important part of the study; therefore, this chapter presents conclusion and recommendations as well as suggestion for further studies in the same area where the study has conducted.

5.2 Conclusion

The Community Health Fund is the district based health scheme which is intended mainly to serve the people who are working in the informal sectors (Chee et al, 1996). The health schemes are highly recommended nowadays because financial problems are more common and the expenses for health services are also very high, so having health schemes will help to support a lot of the people.

This study found that many people in Tanzania are not members of any health scheme out of many scheme available in Tanzania. Only 10 percent of the people in Tanzania are members, and only 4.4 percent of people in Dodoma Urban District are members of Community Health Fund.

Although the world has transformed into another development level, it seems that more people in Dodoma are still attending to traditional hillers for treatments when they get sick. This has increased a number of deaths of many people. However, some conditions drive them to attend to the health centers.

For instance pregnant women have to attend to the health centers to deliver their babies safely. One respondent in this study argued that, in their village, pregnant women must go to the hospital during deliverance or rather her family will be fined by the authority. This forces many pregnant women to attend to the health centers. But for other diseases, people simply opt to attend to other services providers like the traditional healers.

Also people at Dodoma urban do not have knowledge about the health scheme. More people feared to deposit their fund into this scheme in advance because they think that they may not fall sick and their money would be lost. They complain that this is wastage of resources they have because some people can contribute and they may not get sick throughout the year. And because others are moving from one area to another, they fear that they can become sick while they are away from the centers they have registered and they will suppose have to pay for the services when they are out of their home areas.

Another important observation in this study is the tendency of the people to take medicine without doctor's prescription. More people are regularly attending to pharmacy vending various health medicines. This is a bad behavior developed by many people especially the youth which is the large group of the people in the community. So the authorities concerned have to advice people on the importance of seeking for doctor's check up before taking in of any medicines.

5.3 Recommendations

The researcher recommends the following interventions to be done in order to reach the level where the majority of the members from the community will be members of Community Health Fund in Tanzania, particularly at Dodoma Urban District:

Policy makers have to change the content of Community Health Fund because the Act does not force people to be members of this scheme, hence it is simply voluntary which means one may decide to join or not. The researcher recommends that the Act has to be changed to resemble those from other countries, for instance Rwanda and Ghana where every individual in the community has to join any of the schemes.

The scheme authorities have to sit together with the community and share some experiences about a good way to operate the scheme. Village and ward committees have to work properly with the goal of accomplishing the tasks as described by the Act which established the Community Health Fund. Exemption policy must be exercised and it should be done according to the rules and regulations.

In order for Tanzania to implement the Millennium challenge goals well, especially those which are concerned with the reduction of mortality rate, massive education must be given for the public to enroll into the scheme in the country. The health scheme has to develop some mechanism to accumulate enough funds that can ensure availability of drugs in hospitals, vaccination services and improvements of health facilities in the centers concerned. Through education, patients can always get medicines in hospitals; hence child mortality will be reduced. This may also help to reduce the current increased maternal mortality in the country.

Also the Ward Development Committee (WDC) through the Ward Health Committee has to be alive in implementing its roles of sensitizing and mobilizing community members, tracking the membership base, overseeing premium collections, evaluating Community Health Fund operations and give recommendations for the scheme to develop.

Another recommendation is that the Government of Tanzania has to run this scheme in a professional way. As a health scheme, it needs to be administered by qualified people who know how to run schemes. This will enable to make this scheme more active than it is today and more people will understand it and transparency of the CHF authority will raise confidence to the entire community.

5.4 Suggestion for Further Research

The development of health scheme in Tanzania needs to cover variety of things so that various schemes can be adapted by many people in the country. The scheme still operates in few districts in the country as well as only three municipals throughout the country. The scheme has been positively accepted in rural settings than it is in urban settings (Kapinga *et al* 2002). The Researcher suggests further studies should be conducted in other urban areas so as to know why Community Health Fund is not very much accepted in urban settings than it is in rural areas.

REFERENCES

(Including Singida rural district) Institute of Development Studies, Muhimbili University Dar-es-Salaam,

http//www.heapol.oxfordjournals.org/content/22/2/95,sited on25/06/2011

Adam, J. and Kamuzora, F. (2008), Research Methods for Business and Social Studies, Mzumbe Book Project, Morogoro-Tanzania

Antonia Timmis (2009*)*, the Kongwa Community Based Health Insurance Scheme,

Asfow A, Msuya J.M and Jutting J.P (2004), Impacts of Community Health

Blaxall J, (2004**),** Indian's Self Employment Women's Association (SEWA)

Carrin, G. *et al*. (2004), "The Impact of the Degree of Risk-Sharing in Health Financing on Health System Attainment*"***,** Preker, A.S.; Carrin, G. (ed.), Pp.397-416, Health Financing for Poor People, World Bank, Washington D.C

Chee G, Kimberley S. Kapinga A, and Musau S, (2002) An Assessment Community Health Fund in Hanang District, Technical Report No. 15 Bethesda, MD Partnerships for Health Reform(PHR) Abt Associates Inc; Tanzania. From http//www.bioline.org.br/pdf?/po7006, visited on, 10/04/2011

Cindy Harmansdorf (2009), Health and Social Protection, OCDG

Crowder, M .J. Kimber, A. C., Smith, R. L., and Sweeting, T. J. (1991), Statistical Analysis of Reliability Data. Chapman & Hall, London

Deograsias P. Mushi (2004), Is the Community Health Fund Better than User fees for financing Public Health Care, Brief Project, REPOA, Dar es Salaam, Tanzania.

Empowerment through Mobilization of poor Women on a large scale, Scaling up Poverty Reduction; A Global, Learning Process and Conference. Shanghai, China

Goals to district realities, Ifakara Heath Research and Development Centre, Dar es Salaam, Tanzania

Health Fund scheme (CHF), A case of Igunga Ward in Igunga District, Tabora Tanzania, Dar es Salaam.

Insurance Schemes on Health Care Provision in Rural Tanzania, ZEF Bonn, Bonn, Germany

Ishengoma N, M, (2007**),** Access to quality health care services under Community

Kapinga A and Kiwara A, (1999*)* Quantitative evaluation of CHF Igunga Presents

Koening S, Rosenquis R, (2010*)* Health Spending in Tanzania, The impact of current Aid structures And Aid Effectiveness**,** Action for Global Health, Tanzania.

Kombo, D. K. and Tromp, L. A. (2006), Proposal and Thesis Writing: An Introduction, Pauline's Publications Africa, Nairobi.

Kothari, C. R. (2000), Research Methodology: Methods and Techniques (2nd Ed.). New Age International Publishers, New Delhi

Kothari, C.R. (2004), Research Methodology: Methods and Techniques (2nd Revised Ed.). New Age International Publishers, New Delhi

Kothari, C.R. (2008), Research Methodology Methods and Techniques *(2nd ed.)*, New Age International (P) Ltd, New Delhi

Kpedekpo K, (1982), Essentials of Demographic Analysis for Africa, British Library cataloging in publication Data, Nigeria.

Mamdani M, Bangser M (2006), Poor People's Experiences of health services in Tanzania; A literature review, Tanzania.

Mbuyita S, Makeba A (2007), Equity in Health in Tanzania translating national

Ministry of Health and GTZ, (2003) Report of Community Health Funds Annual Forum, Tanga, from http//www.tnchfo.or.tz/…/ext/…/secure.php visited on 13/06/2011

Mobley, L. R. (2006), "International Journal of Health Geographics: Spatial Analysis of Elderly Access to Primary Care Services", University of Illinois, Volume 5, No. 19, 4-7.

Monica B, Mantel M (2006), Tanzania review of exemptions and waivers, Euro Health, Group, Dar es Salaam

Mwendo, H, M, (2001***),*** Sustainability of accessibility and health services Iramba District, Three years after community health fund implementation, Dar es Salaam.

Neumann, M. L. (1997), Social Research Methods: Qualitative and Quantitative Approaches. Allyn and Bacon. Boston.

Ngumuo, V, I, (2005)**,** Community participation in promoting sustainable water supply and its impact on morbidity and child mortality: A case study of Lindi rural and Liwale District, Tanzania, Dar es Salaam.

Ongwae, K, M, (2000***),*** Factors influencing community health fund payment enrolment in Igunga district Tanzania, Dar es Salaam

Randolph K Quaye, (2004), Paying for Health Services in East Africa: Research Note, Department of Sociology and Anthropology, Palgrove Macmillan Ltd, USA

Sendoro J, (2007), Community Health Fund as a compulsory Financing option in Tanzania, Ministry of Health and Social Work, Dar es Salaam

Shekalaghe, E, (2005), the use of health insurance membership cards: Is misuse of cards being addressed among community health fund and National Health Insurance

Fund members in Iringa rural districts, Dar es Salaam

Tanzania: why is enrolment low and what can be done to increase membership? Nuffield Centre for International Health and Development, University of Leeds

United Republic of Tanzania (1999***),*** the Community Health Fund Act, Government Printer, Dar es Salaam.from http//www.go.tz/government/health.htm, sited on 28/06/2011.

United Republic of Tanzania (1999), the Community Health Fund Design Government Printer, Dar es Salaam. From http//www.gtz.co.tz,28/06/2011

United Republic of Tanzania (1999), The Community Health Fund Design, Government Printer, Dar es Salaam From http//www.gtz.co.tz**,** site visited on 28/06/2011

United Republic of Tanzania (2003).Assessment of Community Health Fund in Tanzania, Factors affecting enrolment and coverage Dar es Salaam; Ministry of Health, from http//www.go.tz/government/health.htm,sited on 29/06/2011

United Republic of Tanzania (2003).Assessment of Community Health Fund in Tanzania, Factors affecting enrolment and coverage Dar es Salaam; Ministry of Health, Dar es Salaam, from http//www.go.tz/government/health.htm, sited on 29/06/2011 United Republic of Tanzania (1999***),*** the Community Health Fund Act, Government Printer, Dar es Salaam. From http//www.go.tz/government/health.htm, sited on 28/06/2011.

United republic of Tanzania (2011), Tanzania Demographic and Health Survey 2010**,** National Bureau of Statistics, ICF Macro, Maryland USA

United republic of Tanzania (2011), Tanzania Demographic and Health Survey 2010, National Bureau of Statistics, ICF Macro,

Waugh, S and Bushell, R. (2002), the World Geography Oxford University Press, London

Weeks, J. R. (1999), Population: An introduction to Concepts and Issues *(7th Ed.)*, Wards Worth Publishing Company, London.

Yin R. (1994), Case study research: Design and methods (2^{nd} edition*)* Beverly Hills, CA Sage Publishing

APPENDIX A

The Research Time Frame

The time that researcher used to conduct this research was ten months; this were covered from October 2011 to June 2012 as described in the table below**.**

(i)	Proposal preparation was done by the researcher assisted by supervisor. This will be done from October 2011 to March 2012.
(ii)	Requesting letter for data collection from University of Dodoma, this was done for two days.
(iii)	Literature review reviewing of various books, journals, magazines and dialogue Concerning CHF. This covers four weeks.
(iv)	Methodology course, the decision of selecting the suitable research methods for this research. This task use three weeks.
(v)	To find members and expert of CHF for interview and questionnaire for two weeks
(vi)	Observation in various hospital and dispensaries attending CHF members. This was done for one week.
(vii)	Data analysis was done for two weeks.
(viii)	Preparation of final draft report was conducted for two weeks.
(ix)	The final report was written the three weeks.

Budget

The following is the total budget which was spent by researcher during the research process;

Item no.	Item of services	Amount
(i)	Stationary	800,000/=
(ii)	Transport	200,000/=
(iii)	Internet services	100,000/=
(iv)	Food	250,000/=
(v)	Soft drinks	30,000/=
(vi)	Telephone costs	100,000/=
TOTAL		1,480,000/=

APPENDIX B

QUESTIONNAIRE FOR MEMBERS OF THE COMMUNITY HEALTH FUND AT DODOMA URBAN

This questionnaire is designed to collect data from non public servants whose responses will help in writing this research about "**Assessment of Community Health Fund on non public servants in Dodoma urban".** You have been selected to be part of this research. Confidentiality will be assured. Thank you in advance for accepting to cooperate.

SECTION A: BACKGROUND INFORMATION

Please tick in the box with the most appropriate answers

1. Sex

A. Male ☐

B. Female ☐

2. The age group you belong

A. 10- 19 years ☐

B. 20- 29 years ☐

C. 30-39 years ☐

D. 40- 49 years ☐

E. 50 and above years ☐

3. Your marital status

A. Single ☐

B. Married ☐

C. Divorced ☐

D. Widow ☐

4. Highest education level reached

A. Primary school ☐ C. Diploma ☐

B. Secondary school ☐ D. Degree ☐

SECTION B. PERSONAL EXPERIENCE

5. How long have been at Dodoma urban?

A. 1-5 years ☐

B. 6-10 years ☐

C. 11 and above ☐

6. How did you know about the Community Health Fund?

A. Newspaper/brochures ☐

B. From district coordinator, health officials and local Leaders ☐

C. Through radios and television ☐

D. Advertisement through posters on cars ☐

E. Through friends ☐

7. How long have you been a member of Community Health Fund?

A. Less than a year ☐

B. 1- 4 years ☐

C. 5-10 years ☐

D. 12 years and above ☐

8. What attracted you to become a member of community health fund?

A. Fees is affordable ☐

B. Services offered are better ☐

C. Community participation ☐

D. Low level of economy ☐

9. How did you join the community health fund?

A. Involuntary ☐

B. Voluntary ☐

C. By pressure ☐

D. By peer group ☐

10. The health services offered by Community Health Fund in Dodoma are satisfactory to the people.

A. Strongly agree ☐

B. I agree ☐

C. Strongly disagree ☐

D. I disagree ☐

11. Do you think Community Health Fund is important to you and the Community in general

A. Strongly agree ☐

B. Strongly disagree ☐

C. Agree ☐

D. Disagree ☐

12. The local leaders participate effectively in selecting exempted people in Dodoma urban

A. Strongly I agree ☐

B. Strongly disagree ☐

C. Agree ☐

D. Disagree ☐

13. How better are the services provided by the community health fund?

A. Excellent ☐

B. Very good ☐

C. Good ☐

D. Bad ☐

14. Among the following amounts of money, which one is more affordable for you to contribute as your annual membership fee?

A. 3000/= ☐ B. 7000/= C. 10000/= ☐

D. 15000/= ☐ E. 20000/= ☐

15. The member of community health fund in Dodoma urban is comfortable with the health centers serving the scheme?

A. Strongly agree ☐

B. Strongly disagree ☐

C. Agree ☐

D. Disagree ☐

16. I am satisfied with the fee paid per annum in relation to the services provided?

Strongly agree ☐

Strongly disagree ☐

Agree ☐

Disagree ☐

17. Being a member of Community Health Fund, what is your opinion about the services offered by the scheme. Please indicate the level by rating the given attribute of scheme**.**

Item No.	Attribute	Strongly agree	Strongly disagree	Agree	Disagree
(i)	Services offered to the members are adequate and efficiency				
(ii)	Referral services to other hospital are offered to the members of the community				
(iii)	The fund educates members issues related to community health fund.				
(iv)	Always drugs are available to the hospitals serving the scheme.				
(v)	The private health centers serve also the CHF members.				

SECTION C:

Questions about the functions of the Community Health Fund

18. Show briefly how the community is involved in making decision concerning Community Health Fund

……

19. In short, explain the differences between CHF and other health schemes.

……

20. Are there any benefits that the Community Health Fund members get different from other scheme?……

21. What has to be done in order to influence many people to be members of the Community Health Fund and to improve the services offered by the scheme?

……

22. What are major challenges facing Community Health Fund in Dodoma urban.

……

APPENDIX C

Guiding questions for interviews with the CHF coordinators and workers of NHIF

1. What is the actual number of the scheme members?
2. How is the pattern of enrollment of the members of the scheme?
3. How does the scheme reach the entire community?
4. How do you cooperate with the village health committee in operating the Community Health Fund?
5. To what extent are people of Dodoma urban aware about the scheme?
6. In which ways does the community get involved in making decision concerning Community Health Fund at Dodoma urban?
7. What is your comment on exemption system?
8. What are the major challenges facing the operation of Community Health Fund.
9. Have you ever received claims regarding the services offered by the scheme
10. In which ways you have reached to the solution.

APPENDIX D

Questionnaire for people who are not members of the CHF in Dodoma municipal

SECTION A. BACKROUND INFORMATION

Tick in the box with the correct information

1. Sex

A. Male ☐

B. Female ☐

2. Age group you belong

A. 10-19 years ☐

B. 20- 29 years ☐

C. 30-39 years ☐

D. 40-59 years ☐

E. 50 years and above ☐

3. Marital status

A. Single ☐

B. Married ☐

C. Divorced ☐

D. Widow ☐

4. Highest education level

A. Primary school ☐

B. Secondary school ☐

C. Diploma ☐

D. Degrees ☐

SECTION B: PERSONAL EXPERIENCE

Tick the correct alternative

5. How do you understand the community health fund in Tanzania

A. Health association ☐

B. Health scheme ☐

C. Government agency ☐

D. Private organization ☐

6. Who is eligible to become a member of community health fund

A. Any body ☐

B. Civil servants ☐

C. Students only ☐

D. Pregnant women ☐

7. What is the annual fee of the community health fund per year?

A. 10000/= ☐

B. 4500/= ☐

C. 5000/= ☐

D. 20000/= ☐

E. 15000/= ☐

8. How the scheme handles the poor people in the society?

A. Poor are exempted ☐

B. Poor people supposed to pay ☐

C. They have to attend different hospital ☐

D. Health committee subsidy them. ☐

9. As a member of the community, what is your opinions regarding the operation of community health fund. Please indicate the level of agreement by rating a given attribute of the scheme.

ItemNo.	Attribute	Strongly Agree	Strongly Disagree	Agree	Disagree
(i)	The community health scheme is helpful to the poor people in the society.				
(ii)	The scheme is special for poor people				
(iii)	It is mainly for poor people in rural areas				
(iv)	The scheme serves mostly the people who work in government institutes.				
(v)	The scheme leaders inform the community how the funds collected are utilized				

10. Are you willing to be a member of community health fund?

A. I am ready now ☐

B. I will join later ☐

C. I will not join the scheme ☐

11. Although you are not member of CHF but through your neighbor and friends

what is your comment concerning the services offered by this scheme. Please tick the appropriate level you think is the best.

Item No.	Attribute	Excellent	Very good	Good	Bad
(i)	The services provided to the members are appropriate				
(ii)	The scheme involves local people in decision making concerning the scheme				
(iii)	The health centers offering the services are of high quality.				
(iv)	The patients are treated at proper time				
(v)	Drugs are constant in the health centers serving CHF members				
(vi)	The funds educates members of the community concerning the scheme				

SECTION C. Explain briefly the following questions

12. What benefits do you think members of CHF are getting in this scheme different from other people who are members in other schemes? Please list them.

……..

13. Give reasons why many people in Dodoma urban are not members of Community Health Fund.……..

14. Suggest what has to be done in order to enable most the people in the society to join community health fund in Dodoma urban

..……

APPENDIX F

Guiding questions for interviews with people who are not members of the Community Health Fund at Dodoma urban

1. Does the scheme leader inform the community about the expenditure of the funds collected per year
2. Are the community conscious about the community health fund in Dodoma
3. Does exempted system implanted in Dodoma urban
4. Does the scheme leaders cooperate the local leaders in the lower areas in attaining the exempted people?
5. What are major challenges facing the community health fund in Dodoma urban.
6. In your opinion do you think the fee of community health fund in
7. Dodoma municipal is appropriate in regard with services offered.
8. Regarding the membership more people are not members of Community
9. Health Fund, what are factors toward low enrollment of people in this scheme in Dodoma urban?
10. Are you satisfied with the services offered by the community health fund in Dodoma Urban?

Dodoso kwaajili ya watu ambao sio wanachama wa mfuko wa afya ya jamii manispaa ya Dodoma.

SEHEMU YA KWANZA: TAARIFA ZA AWALI

1. Jinsia

A. Mwanaume ☐

B. Mwanamke ☐

2. Umri

A. 10-19 ☐

B. 20-29 ☐

C. 30-39 ☐

D. 40-49 ☐

E. 50 na zaidi ☐

3. Hali ya ndoa

A. Sijaoa/sijaolewa ☐

B. Nimeolewa/olewa ☐

C. Talaka ☐

D. Mjana ☐

4. Kiwango cha elimu

A. Elimu ya msingi ☐

B. Elimu ya sekondari ☐

C. Elimu ya stashahada ☐

D. Elimu ya shahada ☐

5.Unauelewaje mfuko wa afya ya jamii

A. Taasisi ya afya ☐

B. Idara ya afya ☐

C. Idara ya sekondari ☐

D. Taasisi binafsi ☐

SEHEMU B. UZUEFU WA MHUSIKA

6. Nani anavigezo vya kuwa mwanachama wa mfuko wa mfuko wa afya ya jamii.

A. Mtu yeyote ☐

B. Mtumishi wa uma ☐

C. Mwanafunzi pekee ☐

D. wanawake wajawazito ☐

7. Ada ya mwanachama kwa mwaka ni kiwango gani?

A. 10000/= ☐

B. 4500/= ☐

C. 5000/= ☐

D. 15000/= ☐

8. Je mfuko unawahudumiaje watu wenye kipato cha chini katika jamii

A. Watu wasio na uwezo kabisa wanamsamaha maalumu ☐

B. Wasio na uwezo lazima wachangie ☐

C. Kamati ya afya inatoa ruzuku kwa wasiona uwezo ☐

D. Wanapaswa kuhudhuria hospitali zingine kwa malipo. ☐

9. Kama mwanajamii nini maoni yako kuhusu uendeshaji wa mfuko wa afya ya jamii. Weka alama ya vema kwenye shemu sahihi

Namba	Wasifu	Nakubali kabisa	Sikubaki kabisa	Nakubali	Sikubali
(i)	Mfuko wa afya ya jamii ni msaada mkubwa kwa watu wenye kipato bkidigo				
(ii)	Mfyko ni maalumu kwa watu maskini				
(iii)	Ni maalumu tu kwa watu masikini wanaoishi vijijini.				
(iv)	Mfuko unawahudumia zaidi wafanyakazi wa serikali na taasisi zake.				
(v)	Viongozib wa mfuko huwa wanatoa taarifa kwa jamii kuhusu mapato na matumizi ya mfuko kwa mwaka.				

10. Je upo tayari kwa sasa kuwa mwanachama wa mfuko wa afya ya jamii?

A. Niko tayari sasa ☐

B. Siko tayari kwa sasa ☐

C. Nitajiunga baadae ☐

D. Sitajiunga na mfuko ☐

11. Ingawa wewe simwanachama wa mfuko lakini kupitia ndugu na rafiki zako unatadhimini vipi huduma zitolewazo na mfuko wa afya ya jamii.

Weka alama ya vema sehemu unayoona ni sahihi.

Namba	Wasifu	Njema	Vizuri sana	Vizuri	Mbaya
(i)	Huduma zinazotolewa kwa wanachama ni za kiwango bora				
(ii)	Mfuko unawahusisha watu katika maamuzi mbalimbali ya mfuko				
(iii)	Vituo vya ktolea huduma kwa wanachama nivya ubora wa hali ya juu				
(iv)	Mfuko unawahudumia wagonjwa kwa muda muafaka wanapohitaji huduma.				
(V)	Dawa zinapatikana muda wote katika vituo vyote vya afya vinavyo hudumia mfuko				
(vi)	Mfuko huu wa afya huwaelimisha wanachama wake mambo mbalimbali kuhusu mfuko huo wa afya				

SEHEMU C. ELEZA KWA KIFUPI KATIKA MASWALI YA FUATAYO

12. Unafikiri ni faida gani wanazopata wanachama wa mfuko wa afya ya jamii tofauti na wanachama kwenye mifuko mingine. Tafadhali orothesha kwa kifupi.

…….

13. Eleza sababu za msingi, kwa nini watu wengi kwenye manispaa ya Dodoma sio wanachama wa mfuko wa afya ya

jamii…….

14. Unafikiri nini kifanyike ili mfuko uweze kuvutia watu wengi wajiunge kwenye huu mfuko hapa manispaa ya

Dodoma.……

Mwongozo wa maswali ya mahojiano na watu ambao sio wanachama wa mfuko wa afya ya Jamii.

1. Ni kwa kiwango gani viongozi wa mfuko huwapa taarifa jamii kuhusu mapato na matumizi ya mfuko.
2. Je, jamii ya watu wa Dodoma wanauelewa gani kuhusu mfuko wa afya ya jamii?
3. Je viongozi wa mfuko huwashirikisha viongozi wa ngazi za chini katika mchakato wa kuwapata watu wanaostahili msamaha.
4. Kuna watu wanaopata msamaha maalumu wa kupata bure huduma za afya?
5. Zipi ni changamoto muhimu zinazo ukumba mfuko wa afya ya jamii.
6. Kwa maoni yako kiwango cha ada kinacholipwa ni sahihi kulingana na huduma zitolewazo za afya.
7. Mfuko huu unawanachama wachache sana hapa Dodoma mjini, nisababu zipi zinapelekea mfuko huu kuwa na wanachama wachache sana.
8. Unaridhika na huduma zitolewazo na mfuko wa afya ya jamii hapa Dodoma mjini.

DODOSO HII NI KWAAJILI YA WANACHAMA WA MFUKO WA AFYA YA JAMII

Dodoso hili limeandaliwa kwa ajili ya kukusanya taarifa kuhusu mada tathimini wa mfuko wa afya ya jamii kwa watu wasio watumishi wa umma Dodoma mjini.

Tafadhali umechaguliwa kuwa miongoni mwa watu watakao shiriki kutoa taarifa katika utafiti huu. Mambo yote yatabaki siri. Natanguliza shukrani za dhati.

SEHEMU A. TAARIFA ZA AWALI

Weka alama ya vema katika jibu lililosahihi.

Jinsia

Mwanaume ☐

Mwanamke ☐

Umri

10- 19 ☐

20- 29 ☐

30- 39 ☐

40- 49 ☐

50 na zaidi ☐

Hali ya ndoa

Sijaoa/sijaolewa ☐

Nimeoa/nimeolewa ☐

Talaka ☐

Mjane ☐

Kiwango cha elimu

Elimu ya msingi ☐

Elimu ya sekondari ☐

Elimu ya stashahada ☐

Elimu ya shahada ☐

SEHEMU B. UZOEFU

Nikwa muda gani umekuwa mkazi wa Dodoma?

1-5 miaka ☐

6- 10 miaka ☐

11- na zaidi ☐

Ni njia ipi kati ya zifuatazo ilikuwesha kujua mfuko wa afya ya jamii

Magazeti na vipeperushi ☐

Uelimishaji kutoka kwa viongozi wa kiwilaya na kijiji. ☐

A. Matangazo mbalimbali ☐

B. Uelimishaji kupitia runinga ☐

C. Hamasa kutoka kwa marafiki ☐

1. Ni kwa kipindi kipi umekuwa mwanachama wa mfuko wa afya ya jamii

A. Chini ya mwaka mmoja ☐

B. 1- 4 miaka ☐

C. 5- 10 miaka ☐

D. 11 na zaidi ☐

2. Vitu gani vilikuvutia mpaka ukawa mwanachama wa mfuko wa afya ya jamii.

A. Ada ni nafuu mno ☐

B. Huduma vitolowazo ni zaubora ☐

C. Ushirikishwaji wa jamii ☐

D. Kiwango kidogo cha uchumi ☐

3. Ulijiunga vipi katika huu mfuko wa afya ya jamii

A. Kwakulazimishwa ☐

B. Kwahiari ☐

C. Kwamsukukmo kwa watu wwngine ☐

D. Kwakuiga misha makun ☐

4. Je huduma za afya zinazotolewa na mfuko wa afya zinatosheleza huduma za watu?

A. Zimekubalika zaidi ☐

B. Zimekubalika ☐

C. Hazijakubalika zaidi ☐

D. Hazijakubalika ☐

5. Unadhani jumuiya ya mfuko wa afya ya jamii ni muhimu katika jumuiya yako na watu wote kwa ujumla?

A. Inakubalika zaidi ☐

B. Inakubalika ☐

C. Haikubaliki zaidi ☐

D. Haikubaliki ☐

6. Je viongozi wa chini wanashirikishwa kikamilifu katika kuwapata watu wanaostahili msahamaha wa kupata huduma bure?

A. Nakubali kabisa ☐

B. Sikubali Kabisa ☐

C. Nakubali ☐

D. Sikubali ☐

7. Huduma zitolewazo na mfuko zina ubora gani?

A. Nzuri zaidi ☐

B. Nzuri sana ☐

C. Nzuri ☐

D. Mbaya ☐

8. Kati ya ada zifuatazo ipi unaweza kuimudu kuchangia kwa mwaka?

A. 3000 ☐

B. 7000 ☐

C. 10000 ☐

D. 15000 ☐

E. 20000 ☐

9. Wanachama wa mfuko wa afya ya jamii wa Dodoma mjini wanaridhika na huduma zitolewazo vituo vyao vya afya?

A. Nakubali zaidi ☐

B. Sikubali zaidi ☐

C. Nakubali ☐

D. Sikubali ☐

10. Je unaridhika na ada unayolipa kwa mwaka ukilinganisha na huduma zitolewazo na mfuko?

A. Nakubali zaidi ☐

B. Sikubali zaidi ☐

C. Nakubali ☐

D. Sikubali ☐

11. Kuwa mwanachama wa mfuko wa afya ya jamii, nini maoni yako kuhusu huduma zitolewazo na mfuko. Tafadhali onesha kiwango kwa kuweka alama ya vema kwenye sehemu ya sifa inayofaa.

Namba	Sifa	Nakubali Zaidi	Sikubali Zaidi	Nakubali	Sikubali
(i)	Huduma zitolewazo zinatosheleza na niza kikamilifu.				
(ii)	Huduma za rufaa kwenye hospitali zingine zinatolewa.				
(iii)	Mfuko huwa unaelimisha wanachama kuhusiana na mambo ya jumuia ya mfuko wa afya.				
(iv)	Mara zote dawa zinapatikana kwenye vituo vitoavyo huduma za mfuko.				
(v)	Vituo visivyo vy serikali pia hutoa huduma kwenye mfuko huu hapa Dodoma mjini.				

SEHEMU C. ELEZA KWA KIFUPI KATIKA MASWALI YAFUATAYO

12. Onesha kwa kifupi jinsi gani mfuko huwa shirikisha wananchi katika maamuzi mbalimbali yahusuyo mfuko wa afya.……

13. Kwa kifupi eleza tofauti kati ya CHF na mifuko mingine ya afya

14. Kuna faida gani nyingine tofauti ambazo wanachama wa mfuko huu wanapata tofauti na wanachama wa mifuko mingine.……..

15. Nini kifanyike ili kuhamasisha watu wengi wawe wanachama wa mfuko huu wa afya.……

16. Ni changamoto zipi zinazoukabili mfuko wa bima ya afya Dodoma mjini.……

Maswali ya muongozo ya mahojiano kwa waratibu wa CHF na wafanyakazi wa NHIF

1. Ni watu wangapi mpaka sasa ni wanachama wa CHF Dodoma mjini?
2. Je mfuko unawafikiaje wananchi katika sehemu mbalimbali za manispaa
3. Ni muuongozo upi unatumika kuwapata watu wanaostahili msamaha?
4. Unashirikiana vipi na kamati za afya wilaya na kijiji katika ufanyaji kazi za mfuko wa afya ya jamii.
5. Je watu wa Dodoma wanafahamu kuhusu mfuko huu?

6. Ni kwa njia zipi jumuiya inajihusisha na kutoa maamuzi kuhusiana na jumuiya ya mfuko wa afya Dodoma mjini?
7. Nini maoni yako katika mfumo unaotumika kuwapata watu wasio na uwezo wanaostahili msamaha.
8. Ni changamoto zipi kubwa zinazoukabili ufanyaji kazi wa mfuko wa afya ya jamii.
9. Je, umewahi kupokea madai yanayohusiana na huduma zitolewazo na mfuko.
10. Ni njia zipi ulitumia kufikia ufumbuzi wa matatizo hayo.