THE ROLE OF CONDITIONAL CASH TRANSFER IN PROMOTING HEALTH INSURANCE DEMAND AMONG TASAF BENEFICIARIES

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION IN FINANCE OF THE OPEN UNIVERSITY OF TANZANIA

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CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by the Open University Tanzania a dissertation proposal titled: The role of conditional cash transfer in promoting health insurance demand among TASAF beneficiaries, in partial fulfillment of the requirements Master Degree of Business Administration in Finance at Open University of Tanzania.

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Supervisor

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DECLARATION

I, Ritha G. Mapunda, do hereby 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 similar or any other degree award.

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Dr. Saganga Kapaya

Signature

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Date

DEDICATION

I would like to dedicate this paper to my loving family especially my husband Jackson Kunambi, my parents Mr. & Mrs. Godfrey Mapunda and my office supervisor Dr. Robert Tillya who provided genuine moral and emotional support. I would have not been able to complete this dissertation without their presence, which strengthened me.

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ABSTRACT

The study was done to assess the role of conditional cash transfer in promoting health insurance demand among TASAF beneficiaries. There were three specific objectives one being to assessing beneficiariesô attitude toward the adoption of health insurance using CCT, to assess factors hindering wards the adoption of health insurance using CCT and to investigate the strategies made by TASAF beneficiaries towards the adoption of health insurance using CCT. The study was done based on survey where Goba and Kwembe wards in Dar es Salaam were used as areas of the study. The population of the study was890 from which a sample of 95 respondents was randomly chosen. The study was based on qualitative from primary data was collected through interview while secondary data was collated from relevant documents. The study found that the beneficiaries had attitude toward adoption of social health care insurance using CCT. On the other hand, it was found that there were several factors hindering TASAF beneficiariesô adoption of social health care insurance using CCT including poverty, low education and believes. It was found the need of several strategies for improvement of the adoption of social health care insurance using CCT.

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LIST OF ABBREVIATIONS

CCT	Conditional Cash Transfer
WHO	World Health Organization
RHL	Reproductive Health Library
TASAF	Tanzanian Social Action Fund
MeSH	Medical Subject Headings

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter presents background of the problem, statement of the problem, objectives of the study, research questions, significance of the study, limitations of the study, scope of the study and organization of the study. It deals with the introductory part of the research study.

1.2 Background of the Problem

TASAF was established in 2000 as part of the Government of Tanzaniaôs strategy to reduce poverty. Phase I (2000ï 2005) focused on improving social service delivery; capacity enhancement for communities, including overseeing 1,704 community-run sub-projects such as construction and rehabilitation of health care facilities, schools and other small-scale infrastructure; and a Public Works Program (PWP) component with 113,646 direct beneficiaries. The second Phase (2005ï 2013) expanded the first stage commitments to address a shortage of social services, capacity enhancement (including 12,347 community sub-projects) and income poverty, including a pilot of community-based conditional cash transfers (CCT) reaching 11,576 households in communities that were strengthened during the first phase.

The third phase of TASAF, the PSSN, supports a national social protection programme aimed at putting in place the building blocks of a permanent national social safety system. Key elements of this Project are the CCT programme complemented with public works and livelihoods enhancement. The programme provides cash transfers to poor and vulnerable households in Tanzania conditional on

their use of health and education services along with opportunities to earn additional income through public works and livelihood. The objectives of the PSSN include: 1) increase consumption of the extremely poor on a permanent basis, 2) smooth consumption during lean seasons and shocks, 3) invest in human capital, 4) strengthen links with income generating activities, and 5) increase access to improved social services. It aims to improve consumption and human capital accumulation and to reduce the poverty headcount and poverty gap by 5 per cent and 30 per cent, respectively. In 2015, TASAF successfully implemented a massive scale-up of the PSSN from 250,000 households to 1.1 million households (10.5 per cent of the population) in Tanzania.

Conditional Cash Transfer (CCT) programs have been widely adopted as a new approach in social assistance that may hold promise for combating poverty and fostering social inclusion. Given the success of (CCT) programs elsewhere, in 2010 the Government of Tanzania rolled out a pilot CCT program in three districts (Evans *et al.,* 20114). Its aim was to see if, using a model relying on communities to target beneficiaries and deliver payments, the program could improve outcomes for the poor the way centrally-run CCT programs have in other contexts. The program provided cash payments to poor households, but conditioned payments on complying with certain health and education requirements (Attanasio and Mesnard, 2015).

Given the success of conditional cash transfer (CCT) programs elsewhere, in 2010 the Government of Tanzania rolled out a pilot CCT program in three districts. Its aim was to see if, using a model relying on communities to target beneficiaries and deliver payments, the program could improve outcomes for the poor the way

centrally-run CCT programs have in other contexts. The program provided cash payments to poor households, but conditioned payments on complying with certain health and education requirements. Given scarce resources, the Government randomly selected 40 out of 80 eligible villages to receive the pilot program. Households in participating and comparison villages were broadly comparable at baseline.

This report describes the program and the results of a rigorous, mixed methods impact evaluation. Two and a half years into the program, participating households were healthier and more educated. Health improvements due to the CCT program were greatest for the poorest half of householdsð the poorest of the poor. They experienced a half a day per month reduction in sick days on average, and poor children age 0-4 in particular had a full day per month reduction in sick days. In education, the program showed clear positive impacts on whether children had ever attended school and on whether they completed Standard 7. Households were also more likely to buy shoes for children, which can promote both health and school attendance.

In response to the program, households also made investments to reduce risk: Participating households were much more likely to finance medical care with insurance and much more likely to purchase health insurance than were their comparison counterparts. The program did not significantly affect savings on average, although it did increase non-bank savings amongst the poorest half of households. Participating households also invested in more livestock assets, which they used to create small enterprises. The program did not, however, have significant

impacts on food consumption. On the whole, the results suggest that households focused on reducing risk and on improving their livelihoods rather than principally on increasing consumption. There is also evidence that the project had positive effects on community cohesion (Evans, 2014).

Conditional Cash Transfer programs (CCTs) provide money to poor families contingent upon certain verifiable actions, generally minimum investments in childrenôs human capital such as regular school attendance or basic preventative health care. They therefore hold promise for addressing the inter-generational transmission of poverty and fostering social inclusion by explicitly targeting the poor, focusing on children, delivering transfers to women, and changing social accountability relationships between beneficiaries, service providers and governments (Rawlings and Rubio, 2005).

The CCT program is part of the World Bank-supported Tanzania Productive Social Safety Net Project, which aims to increase income and food consumption for vulnerable groups, and strengthen their ability to cope with shocks. Despite respectable economic growth rates averaging 7% over the past decade, the poverty rate remains at 28%, with about 9% of the population (four million citizens) affected by food poverty. Funded in part by IDA, the Bankôs fund for the poorest, the Tanzanian government piloted the conditional cash transfer program in 2010 in support of its broader social protection strategy. Families enrolled in the program received a small amount of cash (approx. $13 each month) as incentive to increase household consumption of food, particularly proteins, as well as health and education services which they would otherwise have had to forego (Word Bank,

2016).

Households with children: in areas where health services are available, children under two years old should undergo a routine health check once a month and children over two years old should have a routine check every semester. In areas where health services are unavailable, caretakers of children under 60 months of age should attend health and nutrition training sessions every two months. School enrolment and attendance (at least 80 per cent of school days per month) is also required for children 5ï 18 years old. Households with pregnant women: attendance at four antenatal exams or health and nutrition sessions every two months, for areas where health services are not available (socialprotection.org, 2017).

1.3 Statement of the Problem

The adoption of health insurance has been a big challenge to most of the Tanzanians especially the people with low income and the aged ones. The available CCT provided by TASAF raises the need to investigate its contributions to the adoption of health insurance among the beneficiaries. Despite the CCT play important role in promoting insurance up-take within informal sector, very little has been known concerning the in promoting insurance up-take within informal sector (Evans 2014). Though CCT programs have achieved quantified success in promoting insurance up-take within informal sector, most of them have not been in existence long enough to evaluate their success in reaching their longer-term poverty alleviation objectives. Many programs remain limited in coverage relative to the population of eligible beneficiaries. There is thus an active debate on their actual and potential contributions to social inclusion which is spurring a rich variety of approaches to

program design and implementation.

There has been a debate within Tanzaniaôs government about whether to continue the Productive Social Safety Net (PSSN), a project which supports social insurance and assistance to the poorest households. Some policymakers have argued that the PSSN has had few results on children and negative labour supply effects by getting households ñon the doleò, despite little evidence. In early discussions with the World Bank, the Government of Tanzania specifically had many questions about whether PSSN has impacted small business and asset investment, as well as worker outcomes. The original design for the PSSN included a workfare component, which was not fully implemented by the time the midline survey completed. As such, much of the analysis thus far has focused on understanding the impacts of the transfers on employment outcomes, as well as investments in productive assets (Hanna, 2019).

Also CCT programs are facing a number of challenges as they evolve, from reaching vulnerable groups to fostering transparency and accountability, especially at the community level (Attanasio and Mesnard, 2015). Given the success of conditional cash transfer (CCT) programs elsewhere in the world, in January 2010 the Government of Tanzania rolled out a CCT program in three relatively poor districts: Bagamoyo, Chamwino, and Kibaha. The program was led by the TASAF. Its aim was to see if, using a model that relied heavily on communities to target beneficiaries and deliver payments, the program could improve outcomes for the poor the way centrally-run CCT programs have in other contexts. Given scarce resources, TASAF randomly selected 40 villages out of 80 eligible villages in the three study districts to be treated under the pilot program.

Communities selected the most vulnerable households to participate before learning which villages were randomly selected to participate in the program. This provided a group of comparison households in the 40 untreated villages. The program provided benefits for poor households based on the number of vulnerable children (age 0-15) and elderly (age 60+) therein. Payments were made every other month, or six times each year. While CCT payments which averaged about US $14.50 per month or about 13 percent of total expenditures were made at the household level, conditions applied at the individual level.

Children aged 0 ï 5 were required to visit a health clinic at least six times per year, elderly aged 60 and over were required to visit at least once per year, and no health conditions applied to other individuals. Children aged 7-15 were required to enroll in primary school and maintain an 80 percent attendance record. Locally-elected community management committees monitored compliance with these conditions and penalized participating households that did not comply by docking payments or in extreme cases removing households from the program (Evans, 2016).

In Tanzania, poverty levels have dropped from 60% in 2007 to 47% in 2016. However, 12 million people live in extreme poverty, earning less than US$0.60 per day. While Tanzania is close to the African regional average in terms of health and education statistics, it diverges significantly from the rest of the region on some measures. In January 2010, the government launched the community-based conditional cash transfer (CCT) programme, aimed at improving the health of young children and the elderly and increasing investment in education for children aged 7ï 15. This intervention uniquely involved members of the community in the

programme implementation and management. In 2012, the International Initiative for Impact Evaluation (3ie) supported researchers at the International Food Policy Research Institute to evaluate the impact of this pilot programme on outcomes related to health-seeking behaviour, the health and education of household members, asset ownership, savings, credit, consumption and community relations.

The programme is associated with an increase in trust in community leaders as well as increased trust in some sub-groups of community members. The programme showed clearly positive impacts on whether children had ever attended school. Literacy rates increased significantly for girls aged 5ï 18. There was no significant impact on savings. However, participating households that were not exposed to drought or flood shocks were more likely to have non-bank savings. After an initial surge in health clinic visits, participating households reduced the number of visits, but were healthier. Health improvements were concentrated among young children aged 0ï 5, with no detectable health improvements for the elderly.

Households increased expenditure on health insurance, most notably the government-run community health fund. There was a significant increase in childrenôs ownership of shoes and slippers, which the public health community associates with lower exposure to worms. These impacts are larger for the extremely poor. There were no significant impacts on ownership of food or non-food household items among participating households. There were increased investments in livestock, such as goats and chickens, for income-generating activities (Reliefweb, 2017).

The study aim at finding out on how the TASAF CCT can be used in promoting the health insurance of which most of the poor have no access. Most of the done on this area have not taken much concern on this issue of CCT and health insurance. The lower families need to be given this opportunity so as they enjoy a secured treatment for their survival.

1.4 Objectives of the Study

1.4.1 General Objective

The general objective for this study is to investigate the role of Conditional Cash transfer in promoting Health Insurance Demand among TASAF beneficiaries.

1.4.2 Specific Objectives

The study was guided by the following specific objectives

i. To identify TASAF beneficiariesô attitude toward adoption of social health care insurance using CCT
ii. To analyze factors hindering TASAF beneficiaryôs adoption of social health care insurance using CCT
iii. To examine strategies that can be used to improve TASAF beneficiaries adoption of social health care insurance using CCT

1.5 Research Questions

i. What is the attitude of TASAF beneficiaries toward adoption of social health care insurance using CCT?
ii. What are the factors hindering TASAF beneficiariesôadoption of social health care insurance using CCT?

iii. What are the strategies that can be used to improve TASAF beneficiaries ó adoption of social health care insurance using CCT?

1.6 Significance of the Study

The study will enhance the identification of TASAF beneficiariesô attitude toward adoption of social health care insurance using CCT. The choice to adopt the health services by the people who benefit CCT from TASAF is very important to be known by the stakeholders. This will help TASAF to make an increase of this needful service to the people who are in need especially the poor and the aged people. Analyzing the factors hinder TASAF beneficiaries adoption of social health care insurance using CCT is very important. This will assist the stakeholders to remove all obstacles for adopting the health care insurance using TASAF CCT. It will make an increase of the people using the CCT from TASAF to use the health insurance.

After we know the obstacles the study will make the CCT providers to plan strategies for making beneficiaries adoption of social health care insurance using CCT. The aim of this study is mainly insisting the adoption of CCT on health insurance hence making improvement of CCT provided by TASAF will increase the people using this valuable health insurance especially to the poor and the aged one.

1.7 Limitations of the Study

The limitations of the study are those characteristics of design or methodology that impacted or influenced the interpretation of the findings from your research. They are the constraints on general, applications to practice, and/or utility of findings that are the result of the ways in which you initially chose to design the study or the

method used to establish internal and external validity or the result of unanticipated challenges that emerged during the study (James and Murnan, 2004). There is a likely accessibility limitation. The TASAF population is scattered all over the sampled area as it is in the country at large. The researcher took more time to reach the sample which is likely to affect or delay the findings. This was electrified by making a careful sample selection as well getting assistance from local authorities of a sampled population.

Testing altitude made another limitation as the sampled population may be not responding correctly. The study composed questionnaires with simple and direct question to capture the information. Time factor also may make delay of getting information from which a force time of gating to framed time may make the data not realizable. The researcher was very careful on time so as to improve the accuracy of the data.

1.8 Scope of the Study

The scope of the study basically means all those things that were being covered in the research project. It defines clearly the extent of content that will be covered by the means of the research in order to come to more logical conclusions and give conclusive and satisfactory answers to the research. The scope of the study has to be defined at a preliminary stage and that is very important. It cannot be done in the later phase of doing the research as it creates a lot of ambiguity about the research goals. If the researcher fails to define the scope at the initial stage itself it is indicative that the research would eventually not meet the expectations set by the dissertation committee (Admin, 2014).

The study intended to cover the effect of TASAF conditional cash transfer (CCT) in promoting health insurance adoption among the beneficiaries. The findings, specifically, seeks to cover TASAF beneficiariesô attitude toward adoption of social health care insurance using CCT so as to make improvements. The study also scopes on analyzing factors hinder TASAF beneficiaries adoption of social health care insurance using CCT. This intends at making many beneficiaries to have access of the valuable service in case of sickness. The study lastly focuses on strategies that can be used to improve TASAF beneficiaries adoption of social health care insurance using CCT. The essence of this was to tell the stake holders to see the best ways of dealing with obstacles directly from the CCT beneficiaries.

1.9 Organization of the Study

The study was basically cover five chapters including introduction, literature review and methodology and data analysis and conclusion part. Each chapter consists of sub chapters from which each was numbered.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter covers different studies related to this research problem. The chapter is specifically focusing on conceptual definitions, theories, empirical studies, research gap and the conceptual framework.

2.2 Conceptual Definitions

Conditional cash transfer programmes give money to households on the condition that they comply with certain pre-defined requirements. These conditions can include, for example, up-to-date vaccinations, regular visits to a health care facility, regular school attendance by children, and complying with health and nutrition promotion activities (e.g. attending education sessions, taking nutritional supplements, etc.). Conditional cash transfer programmes are aimed at reducing poverty as well as breaking the cycle of poverty for the next generation through the development of human capital. Current evidence suggests that conditional cash transfer programmes can be effective in increasing the use of health services and improving health outcomes including nutritional status, however, further research is needed before specific recommendations can be made (WHO, 2019).

Health Insurance, system for the financing of medical expenses by means of contributions or taxes paid into a common fund to pay for all or part of health services specified in an insurance policy or the law. The key elements common to most health insurance plans are advance payment of premiums or taxes, pooling of funds, and eligibility for benefits on the basis of contributions or employment

(Rogers, 2018).

A beneficiary is any person who gains an advantage or profits from something. In the financial world, a beneficiary typically refers to someone who is eligible to received distributions from a trust, or life insurance policy. Beneficiaries are either named specifically in these documents or have met the stipulations that make them eligible for whatever distribution is specified (Julia, 2018).

2.3 Research Theories

2.3.1 Economic Theory of Insurance

According to Denuit(2008),there is an economic theory that explains why insured are willing to pay a premium larger than the *net premium*, that is, the mathematical expectation of the insured loss. This theory postulates that a decision maker, generally without being aware of it, attaches a value $u(w)$to his wealth instead of just$w$, where $u(.)$ is called his utility function. To decide between random losses XMandY, he compares E[u $(w-X)$] withE[u $(w-Y)$]and chooses the loss with the highest expected utility.

With this model, the insured with wealth$w$is able to determine the maximum premium $P+$he is prepared to pay for a random loss$X$. This is done by solving the equilibrium equation $E[u(w-X)] = u(w\bar{\imath} P)$. At the equilibrium, he does not care in terms of utility, if he is insured or not. The model applies to the other party involved as well. The insurer, with his own utility function and perhaps supplementary expenses, will determine a minimum premium $P-$. If the insuredôs maximum

premium *P*+ is larger than the insurerôs minimum premium *P*-, both parties involved increase their utility if the premium is between Pī and P+.

2.3.2 Theory of Change

According to Browne (2013) the theory of change for imposing conditions on CT was summarised in Bastagli (2009). The broad aim of conditionality is to improve human capital outcomes and promote resilience through impacts on behaviour. By adding conditions, CTs aim to incentivize investment in mid- to long-term human capital accumulation, which can be under-served by poor people making short-term coping decisions. Conditions also aim to increase intra-household bargaining power of weaker individuals, and increase human capital across society. Most Latin American CTs are entirely conditional. There are few rigorous comparisons of conditional versus unconditional transfers (UCT), but the evidence base points towards positive impacts on human capital outcomes through improved resilience. This is variable depending on programme design and implementation.

2.4 Review of related Literature

Hossain (2018) did a study assessing conditional cash transfers for maternal health interventions, factors influencing uptake in north-central Nigeria. The study was conducted in a rural community in North Central Nigeria. Having identified programme beneficiaries by randomly sampling contact details obtained from the programme database, using snowball sampling method; sourced non-beneficiaries list based on recommendations from beneficiaries and other community members. Thereafter they undertook semi-structured interviews on both beneficiaries and non-beneficiaries and analyzed data obtained thematically.

The findings revealed that, while beneficiaries of the programme were influenced by the cash transfers, cash may not be sufficient incentive for uptake by non-beneficiaries of CCT in Nigeria. They further found factors such as community and spousal influence, availability of free drugs, proximity to health facility are critical factors that affect uptake in our study context. On the other hand, they found that poor programme administration; mistrust for government initiatives as well as poor quality of services could significantly constrain service utilization despite cash transfers. They concluded that considering that a number of barriers to uptake of the CCT programmer similar to barriers to maternal health services, it is essential that maternal health services are available, accessible and of acceptable quality to target recipients for CCT programmes to reach their full implementation potential.

Brown and Biosca (2015) did study entitled as boosting health insurance coverage in developing countries: do conditional cash transfer programmes matter in Mexico? The study was exploring if participation in a CCT programme in Mexico was significantly associated with self-reported enrolment in a public health insurance programme. The study employed cross-sectional data from 2007 collected on 29 595 Mexican households where the household head is aged between ages 15 and 60 were analysed.

A longitudinal model was used to estimate the association between Oportunidade (a government social assistance program in Mexico founded in 2002, based on a previous program called Progresa, created in 1997) participation and awareness of enrolment in a public health insurance programme. The study found that Participation in the Oportunidade programme is associated with a 25% higher

likelihood of being actively aware of enrolment in Saguaro Popular, a public health insurance scheme for the lowest socio-economic groups. The study concluded that participation in the Oportunidade CCT programme is positively associated with awareness of enrolment in public health insurance. CCT programmes may be used to promote participation of the lowest socio-economic groups in universal public health insurance systems. This is crucial to achieving universal health insurance coverage in developing countries.

Neto (2017) conducted a study assessing conditional cash transfers and the creation of equal opportunities of health for children in low and middle-income countries. A comprehensive literature searches were conducted in the Academic Search Complete (EBSCO), PubMed/Medline, Scopus and Web of Science electronic bibliographic databases. Relevant studies were searched using the combination of key words (either based on Medical Subject Headings (MeSH) terms or free text terms) related to conditional cash transfers, child health and equality of opportunity. An integrative research review was conducted on 17 quantitative studies.

The findings revealed that the effects of CCTs on childrenôs health outcomes related to Social Health Determinants were mostly positive for immunization rates or vaccination coverage and for improvements in child morbidity. Nevertheless, the study found that the effects of CCTs were mixed for the child mortality indicators and biochemical or biometric health outcomes. The study concluded that the present literature review identified five CCTs that provided evidence regarding the creation of health opportunities for children under 5 years old. Nevertheless, cash transfers alone or the use of conditions may not be able to mitigate poverty and health

inequalities in the presence of poor health services.

Huntington (2010) assessed the impact of conditional cash transfers on health outcomes and the use of health services in low- and middle-income countries. The study performed an extensive search of 24 databases for randomized controlled trials, interrupted time series analysis or controlled beforeï after studies. This search yielded more than 24 000 references, out of which 29 papers were identified as 'potentially relevant'. The authors sought studies from low- and middle-income countries that included an objective measurement of at least one of the following outcomes: use of health-care services, expenditure on health care, specific health conditions or changes in equity (e.g. changes in use of services by disadvantaged groups).

Studies involving all types of provider (private, governmental, and nongovernmental organizations) were included. The types of intervention sought in the studies included direct monetary transfers made to households on the condition that people in the household perform a particular action. The research analysed the studies systematically for risk of bias. It was found that a total of 10 papers met the inclusion criteria. The papers were published between 2004 and 2005, even though the authors sought papers published up to May 2009.

The included papers relate to the results of six CCT programmes conducted in Brazil, Colombia, Honduras, Malawi, Mexico, and Nicaragua. The papers focused exclusively on CCTs (omitting in-kind or non-conditional transfers). Only four of these programmes included conditionality related to reproductive health (pre/post-

natal care, nutritional supplements for pregnant or lactating women, or testing of HIV status). The interventions and reported outcomes in the included studies were too diverse to combine the results in a meta-analysis.

TASAF III has four main pillars, which include a conditional cash transfer (CCT) program, a public works program focused on green jobs, a capacity-building component targeted at livelihood skills and an institutional strengthening component. The CCT program includes one health-related conditionality related to the number of times beneficiaries visit health centers per year. An impact evaluation of the program concluded that the scheme had led to a reduction in the number of visits. This can be partly explained by the fact that the likelihood that beneficiaries reported being sick in the past four weeks was smaller than in the control group. Furthermore, the number of visits required by the program was lower than the baselines value, so the condition was binding for a small share of the beneficiaries (World Bank 2013).

2.5 Research Gap

The study was mainly focusing on CCT provided by TASAF on the promotion of health insurance among the lower income families in Tanzania. There were several studies conducted in this field but mostly were not based on Tanzanian environment. Therefore the study focused on TASAF dealing with lower income families in Tanzania. The study is looking to uncover the way TASAF CCT can be used in promoting the health insurance of which most of the poor have no access. The studies reviewed have not concentrated on the how lower income families can be given an opportunity to these people. This study was finding the way to make the poor family access the health care through the health insurance.

2.6 Conceptual Framework

This part of the study presents variables related use of CCT provided by TASAF towards adoption of health insurance. The figure shows the relationship of two categories of variable named as independent and dependent. The adoption of health insurance was likely affected by awareness on health insurance by the beneficiaries. Family income of the beneficiaries, CCT predetermined use as directed by TASAF and the level use of traditional treatments by the beneficiaries. Other factors include believes and taboos, education level and low acceptance of insurance by the b

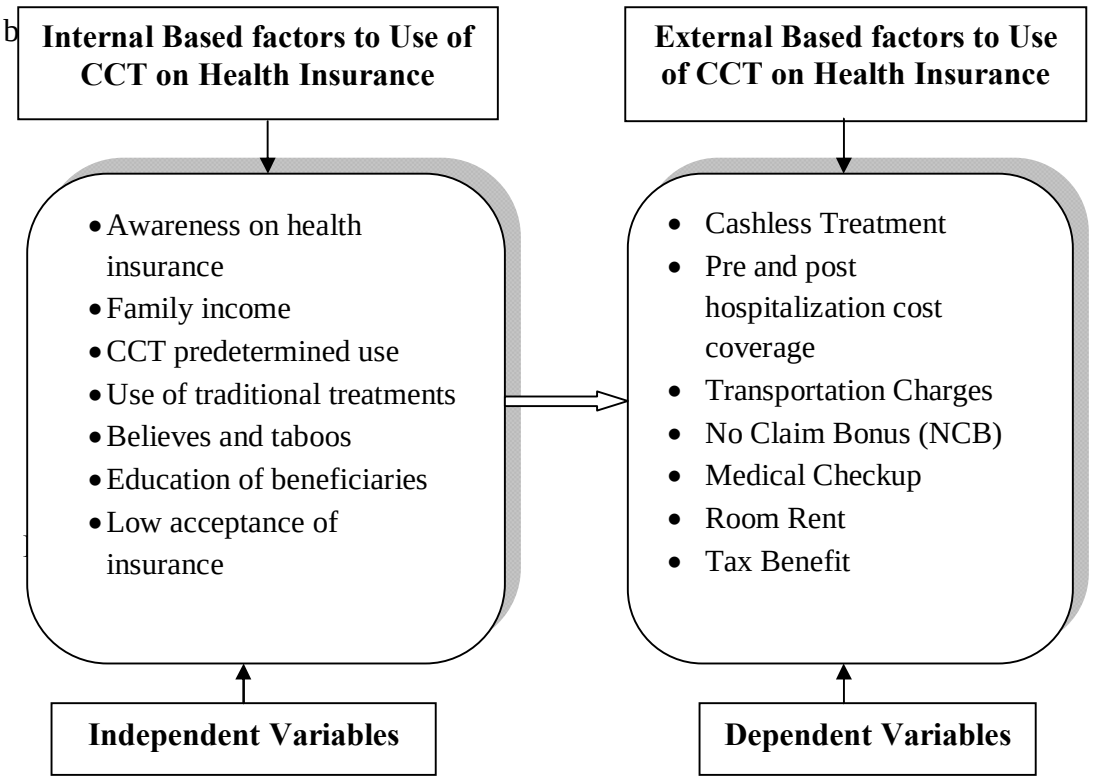

Figure 2.1: Conceptual Framework
Source: Researcher, 2019

On the part of dependent variables, the adoption of health insurance from CCT offered by TASAF, there are a number of variables including cashless treatment, pre and post hospitalization cost coverage from the beneficiary. Other variables include

transportation charges coverage, no claim bonus (NCB) as well as medical checkup. Others include room rent during charged treatment and tax benefit by the beneficiary.

CHAPTER THREE

METHODOLOGY OF THE STUDY

3.1 Introduction

Chapter three is aiming at covering a research design, data collection method, research instruments, reliability, validity data, analysis research ethics. It generally deals with data collection and analysis setting.

3.2 Research Design

Due to the nature of the population and the study itself, the research design to be used survey. This method involved selecting small area of population in Dar es Salaam from which the findings from the sampled population of small area was generalized to the entire population of the country from which CCT is used. Therefore under this research design the sample was collected from determined two wards of Ubungo District in Dar es Salam. The data obtained here was generalized to entire population where TASAF beneficiaries of CCT are found in Tanzania.

3.3 Research Paradigm

To begin a research project, the first step is to identify the research paradigm that ýts with your research objectives so that you can narrow down the selection of research methodologies. So, what exactly is a ñparadigm?ò In simple English, it is a basic belief system that guides the investigations. Your chosen paradigm determines the researcherôs role in the research project. Research paradigms address the philosophical dimensions of social sciences and there are five competing paradigms: positivism, interpretivism, critical realism, critical theory and constructivism (Wong, 2014).

The study was conducted based on qualitative method form which interpretive . The study used.

3.4 Area of the Study

The study used two wards found in Ubungo district in Dar es Salaam region. These are Kwembe and Goba. The district was chosen randomly among 5 districts making Dar es Salaam city. Ubungo on the other hand has got 6 wards from which two wards Kwembe and Goba were selected none randomly due to their nature of population in relation to the requirements of this study. On the other hand, the region has so many hospitals and health centers accepting the health insurance.

3.4 Target Population

Ubungo District have 6 wards with around 64 street executive officers as well as 64 local governance chairperson elected authorities and estimated 890 TASAF household beneficiaries. From these 6 wards, two wards were used in the study whereby a sample of 95 respondents was drawn from the given population.

3.5 Sampling Techniques

The sample was chosen using both two sampling procedures of none and probability sampling. The 17 street elected chairpersons as well as 17 street executive directors were included using none randomly with their virtual participation in CCT. On the other hand the 61 household were selected using a random procedure of simple random sampling. A sample of 95 respondents was selected to represent the whole target population.

3.6 Sample Frame

The two wards have 17 street executive offices as well as 17 local governance elected authorities and estimated 122 TASAF household beneficiaries. The study will use all executive officers as well as all street chairpersons and 61 households where the head of a house hold answered a questionnaire. Generally, the sample size of this study will be 95 respondents. These beneficiaries are scattered all over the streets and will be reached by the assistance of the given authorities (i.e street executive offices and local Governance)

3.7 Sample Size

A sample is a subject of the population. It comprises some members selected from it. In other words, some, but not all, elements of the population would form the sample. Kothari, (2004) define sample size as the number of items to be selected from the population to constitute the sample. The researcher selected a total sample of 95 respondents including household beneficiaries, street executive officers as well as all street elected chairpersons of the given two wards found in Ubungo municipal. Therefore, this sample will be used to testify the use of TASAF CCT towards the adoption of health insurance among the beneficiaries.

3.8 Pilot Test

A pilot study was conducted in the study area by administering the questionnaires to respondents of the similar main research. It involved about 12 respondents and the findings were used for the purpose of testing the validity of the results in the actual study findings.

3.9 Research Instruments

This area analyses types of data to be collected and methods to be used which are secondary and primary data. Data was obtained from both secondary and primary sources of information. The information to be involved here was used to obtain accurate information for the study. The primary data will be obtained from the field while secondary data will be obtained from records found in the documents related to adoption of health insurance using CCT.

3.9.1 Primary Data

Since the research was qualitative in nature, a semi-structured interview was used as the main method of data collection to capture primary data on the adoption of health insurance using CCT provided by TASAF. This was the main method of data collection.

3.9.2 Secondary Data

Secondary data was obtained from analysis of data that collected by someone else for another primary purpose. Hence already written documents on the use of CCT to adoption of health insurance will be collected and used for this purpose.

3.10 Reliability and Validity

3.10.1 Reliability

According to Phelan, and Julie (2005) reliability means is the degree to which an assessment tool produces stable and consistent results. This study collected prior data on the same area. The data collected was compared with the final findings of this study so as to test about the consistence of the two results.

3.10.2 Validity of the Study

According to Phelan, and Julie (2005), validity of the study refers to how well a test measures what it is supposed to measure. This study collected prior data on the same area. The data collected will be used to make all corrections which could affect the final findings of the really study. This will make the study to give findings of the objectives of this study.

3.11 Data Analysis

The data collected through the main method of interview and documentary review was analyzed using content analysis method. This was due to the fact that the research findings are based on qualitative research approach.

3.12 Research Ethics

Ethical research principals: honesty, objectivity, integrity, carefulness, openness, respect for intellectual property, confidentiality, competence and legality are important to follow (David and Resnik, 2011) The study deal with the sample of two categories; the 34 street executive officers and street chair persons as a first group while the second involving beneficiaries of CCT from TASAF. The study observed all traditions and norms of the all two groups so as to remove contradictions. Wearing, communication, greetings and other will be observed on the field for both researcher and assistants.

CHAPTER FOUR

FINDINGS, ANALYSIS AND INTERPRETATION

4.1 Overview

This chapter presents the findings of the research, analysis and interpretation of the findings. The findings are analyzed in relation to the objectives of the study and the literatures reviewed earlier.

4.2 Demographic Characteristics of the Respondents

4.2.1 Sex of Respondents

Of the total respondents interviewed, majority were the females reaching 52.6% and the rest 47.4% put were the male. This was caused by the randomly selected families found that most of them being with female head of the households. On the issue of age of respondents, the study grouped them into three categories. The respondents aged less than 30 years old were 10.0%while 46.2% were those aged between 31 to 50 years being the largely represented age group. The respondents aged above 51 years old were 43.8% represented secondly largely age group among the three grouped.

4.2.2 Relationship with TASAF

The study involved majority of respondents who were 61 household beneficiaries and 17 street executive officers as well as 17 streets elected chairpersons of the given two wards Kwembe and Goba.

4.2.2 Education Level

Most of respondents about 53 members have primaryeducationleveland31 members

reached secondary school level whereby these represented secondly category. The last category was11respondents whoôs their education level was above secondary school. The majority of the respondents had this level of education due to the fact that they are lower income families not having opportunities to get or not valuing education.

4.2.3 Gender

The study tested gender of respondents. Majority of respondents were females. Female were 57 out of 95 total respondents. The remaining parts of respondents were the male and this reached 38 of them. This was because during the survey to the household, most of women were at home.

> *"My husband has gone Kisopwa where with other fellows they do work in the gravel extraction mines"*

Said one of the female interviewed in one of the household found in Kingôazi A street in Kwembe Ward.

4.2.4 Years with Benefiting or working being the Secondly with TASAF

The majority of respondents, about three quarters, benefited or were working with TASAF for less than 5 years. Some respondents had more than 5 years and this category included a few of the reaching about one quarter. This could be caused by the nature TASAF policy which was in phases. Most of the respondents were in a new phase hence making the findings to have most of them in about three quarters.

4.3 Specific Findings

This part makes and detailed clarification of the study findings based on research

specific objectives. It specially makes explanations on findings of TASAF beneficiariesô attitude toward adoption of social health care insurance using CCT; factors hindering TASAF beneficiaryôs adoption of social health care insurance using CCT and the strategies that can be used improve TASAF beneficiaryôs adoption of social health care insurance using CCT. It has also a part of discussion of findings of this research study. Both none and structured interview were used to get the information from the sampled respondents. The study also used the relevant materials to reach about its conclusion.

4.3.1 TASAF Beneficiaries Attitude toward Adoption of Social Health Care Insurance Using CCT

Most of the respondents indicated having the need for health insurance using TASAF CCT. These respondents were estimated to be more 90% of the entire study respondents. The findings showed that health insurance would be the first option for them from the money they receive from TASAF. Almost all of the` interviewed respondents had a concern on investing the money to health insurance.

> *"Need for health insurance is inevitable. Suffering from diseases comes at any time while a person has no cash to pay for treatments"* Said the respondent at Msakuzi Street in Kwembe Ward.

Majority of respondents reaching about 70% of the sampled population, on the other hand, thought that health insurance was more important comparing on how the money given by TASAF as CCT was used. Some respondents indicated that though it was very important to use the CCT provided by TASAF the way it was used including making some investments to raise the life standard of the beneficiaries, the money would rather be used to make a reliable health insurance for beneficiaries.

They pointed out that it was difficult for them to access the good hospitals especially the private hospitals such as Hagakan or Bochi hospitals instead they simply attend the government health centres. Respondents were asked if having health insurance would assist the family recovery from lower income situation they had. Their responses provided shown that there were a need for a reliable health insurance to save time, energy and money for the better investments progress. They pointed out that they take more time roaming for treatments and using little cash they have for treatments in instead of dealing with other investments.

> *"Yes of course. If people are not sure of their treatment and life security in case of diseases and sicknesses lead to reduce morale to deal with developmental activities……. Having health insurance to the poor must be taken with great ambition so has to make them think of developmental investments."*

Proclaimed the Ward Executive Officer at Kwembe Ward when responding an addition question aimed at checking the absence of health insurance would be the cause of poverty among the beneficiaries of TASAF CCT.

Most of the respondents reaching about 95%, generally mentioned that the other benefits they could get from TASAF CTT on health insurance. Some of the benefits were easy access to counseling and guidance which was said to be expensive for them to afford as individual family. They pointed out that they need accessing reliable treatments instead of keeping most of the time accessing the medicines and drugs which were not directed by the physicians or doctors.

> ñ*Having the health insurance would rather protect my young children who suffer from malarial and breathing related infections. At least now we take them at Mloganzila new nearby hospital. I was having a*

> *frequent travel to Mwananyamala, Amana or Muhimbili hospitals."*Said one of the respondents at Mjimpya Street in Kwembe Ward.

Below are the reviewed literatures about attitude toward adoption of social health care insurance using CCT from different sources; Conditional cash transfers are about more than just handing out funds. Conditional cash transfers (CCT) are a stepping stone to universal health coverage, not just help for individual families. ADB recently approved a $400 million loan for the Philippine government to expand the CCT program, which started in 2008 and has since expanded to become the third largest such program in the world after Mexico and Colombia, covering more than 4.4 million poor households in under a decade (Banzon, 2016).

Achieving universal health insurance coverage is a goal for many developing countries. Even when universal health insurance programmes are in place, there are significant barriers to reaching the lowest socio-economic groups such as a lack of awareness of the programmes or knowledge of the benefits to participating in the insurance market. Conditional cash transfer (CCT) programmes can encourage participation through mandatory health education classes, increased contact with the health care system and cash payments to reduce costs of participating in the insurance market (Biosca,2014).

On the basis of Hausman test, fixed effect modelôs results are presented. Results revealed that life insurance has positive and a significant relationship with economic growth for developed countries when measured through net written premiums and

density while it is significant for developing countries when the insurance industry was measured through penetration proxy. Moreover, results also confirmed that non-life insurance plays more significant role in promoting economic growth for developing countries for all three proxies while it is significant for developed countries only when measured through density (Regupathi, 2017).

4.3.2 The Factors Hindering TASAF Beneficiaries Adoption of Social Health Care Insurance Using CCT

The study tested if low income of the families were the factor that used the money provided by CCT instead of health services. This was one of the concerns due to the fact that the CCT beneficiaries are households with low earning in terms of income. Most of the respondents interviewed, reaching about 90% of the entire study respondents, showed that due to poverty problem, facing most of the families, they were forced to use CCT for substances matters lather than opting using it for health insurance. The study then found that the beneficiaries were mostly interested on the subsistence use of TASAF CCT instead of opting for health insurance.

> ñ*We really need these services but the money we get to tell the truth, we would lather need to clear other needs we have as a family. We need to fulfil our daily needs; especially family daily needs."* Said on one of the respondents from Muungano in Goba Ward.

Study also assessed if CCT provided by TASAF had predetermined uses which could be likely to limit adoption of health insurance. I understood that there were directions and conditions given by TASAF to CCT beneficiaries on how to use the money they provided whereby beneficiaries were insisted on investments and not for insurance. The use of traditional treatment was tested if was applied instead of health

insurance. The findings showed that there were incidences of using traditional herbs as the source of treatment but was not the main cause for not adopting the health insurance through the CCT provided by TASAF. Though it wasnôt the majority on this variable but about 30% of the interviewee valued the traditional herbs and other ways. The study then found that, beneficiaries prefer to use herbs/traditional medicines because it was cheap rather than opting for health insurance, however they sometimes obtained herbs or traditional medicine freely.

> *"My family sometimes uses traadditional medicine collected from my mother in Kagera region. The medicine is known as 'mshana' (traditional malaria medicine used by Haya) we use it as prevention and cure for malaria.* Said one of the respondent interviewed in Kibululu Street in Goba Ward.

The study tested if there was low acceptance of health insurance. It was found that the majority of respondents who volunteered for this study accepted and seeing the importance of health insurance to human life. The challenge was not affordable.

> *"They need and they know the importance of the health insurance, the problem includes both ignorance on the importance and affordability of it."* Said the Street Chair person of Matosa in Goba Ward.

The study also tested if the believes and taboos among the factors limiting the adoption of health insurance. It was found that, generally in some cases people believed that when you have insurance you welcome health problem. Most of the respondents preferred to use health insurance instead of their taboos. They know the value of health insurance instead of their traditions. The study tested if the education level of beneficiaries limited the motive for adoption of health insurance using the CCT provided by TASAF. It was found that education was not the key factor limiting the adoption health insurance using CCT provided by TASAF shown by

about 80% of the respondents who were interviewed. All respondents with all levels of education interviewed pointed out their concern on the importance and the need for health insurance. Under this study the majority of respondents reached primary school, secondary school and those above secondary school level.

> ñ*We are six in my family from which four of them are our children. We think it much better if the money we are given to be used for health insurance. We have been suffering from various diseases especially malaria of which we use the family income for treatment especially buying drugs from the pharmacy"* responded one of the respondents from Kwembe Street in Kwembe Ward.

Respondents provided their suggestions on willingness and awareness being some other factors for adoption of health insurance. They generally mentioned that the majority of the people were not taking in consideration of health insurance because they have good health so they donôt see the need for it. This was indicated by many of the respondents reaching about 85% of the entire study respondents.

Below are the literatures investigated on the factors hindering beneficiaryôs adoption of social health care insurance using CCT from different sources. Community Savings and Investment Promotion is a new initiative being implemented under TASAFII aimed at promoting the culture of saving among the poor individuals and groups. COMSIP enables poor people to form groups and mobilize savings from their owner sources and intestine come generating activities.

A total of 1,778 voluntary savings groups have been formed with a totalo f21,712 individuals. saver sin the targeted 46 LGAs. Some groups have invested in other income generating subprojects, like rice production, Vegetables growing, Poultry keeping, Kiosks, etc(TASAF, 2011). However, one-third of the population of

Tanzania lives below the basic needs poverty line. People living in poverty struggle to provide their families with the things they need. They canôt invest in improved seeds or fertilizer and therefore increase the amount of food their families have to eat, and there is very little access to local employment opportunities which might help them to earn enough money to purchase food, buy other necessities and find it difficult to afford basic health care and havenôt adopted a routine of taking children regularly to clinics (TASAF, 2018).

It came out that many countries particularly developing countries still struggle in their attempt to achieve a well-functioning healthcare provision system like the developed nations. Issues such as bad infrastructure, poor management and poor staffing were major hindrance to them, they are also dogged by political power games and lack of goodwill from the government to fully devolve the authority and resources to the regions, corruption and favoritism in appointments is also a major setback in their quest to achieve a good healthcare system. This points out to the fact that more studies need to be carried out on how to address these challenges (Zedekiah, 2017).

Firstly, the uptake of health insurance and utilization of NHIF membership cards in settling hospital bills is low compared to health needs of the community and as a result many people are resorting to out-of-pocket payments and other alternative health financing systems that may lead many in rural communities failing to access to healthcare and falling further into poverty. There is therefore an urgent need to promote viable health financing schemes, including National Health Insurance ,to ensure that the healthcare needs of the poor and the 68marginalized especially in the

rural areas are catered for. Secondly, although there is some awareness of NHIF registration procedures, premium payment mechanisms and the benefit packages, the awareness has not been translated into increased uptake of the health insurance by potential contributors (Ndungôu, 2015).

4.3.3 The Strategies for Improvement of TASAF Beneficiaries Adoption of Social Health Care Insurance Using CCT

The respondents have seen the value of having education as an advantage of health insurance. Education to their children would be much better if they were sure of their health security and this was supported by the majority of respondents about 95% of them. Diseases and period of treatment make improper education provision as the patient waste time and lose concentration on studies. The study tested if there was a need for increasing of CCT to health insurance. Most of the respondents about 80% supported the need for TASAF to increase the CCT provided to poor peopleôs so as they can adopt the reliable health insurance. They pointed out that the money provided now were not enough to meet their needs to the families and at the sometimes to adopt for health insurance.

There was a need to found out whether there should be improvements on CCT to promote income for future CCT health insurance. About 90% of the interviewed respondents accepted this and recommended that changes of TASAF CCT policy would assist of what to be provided can be also used for health insurance instead of mainly focussing on investments and generation of family income which has a little impact.

The respondents were asked if all health services based accepted the health insurance. Accessibility of health insurance services was not on all health services-based institutions. This was shown by the majority of respondents reaching about 95% of all interviewee. It was accepted mostly by government based and some private health insurance while the majority of the institutions did not. This was likely to make difficult environment for adoption of the CCT health insurance.

The respondents point out the need for other donors to provide CCT on health insurance. The TASAF based CCT was intended on promoting several issues instead of health insurance to all beneficiaries. Therefore, because these beneficiaries are low income families hence the there was a need for other donors to invest on CCT which could be aiming at provision of health insurance. The respondents suggested other strategies that could be help to improve TASAF beneficiariesô adoption of social health care insurance using CCT was to have the alternative sources of health insurance sponsors who could donate the service.

As you discussed, the use of conditional cash transfers (CCTs) to improve population health has become increasingly common, with the scope and spread of CCTs growing significantly in the past 10 years. In addition to the programs implemented in Latin America discussed above to incentivize use of preventative health services through conditional payments from the government, CCTs and other forms of incentivizing changes in behaviors, including health behaviors such as utilization of health services, and improved health outcomes have been explored in a variety of contexts.

Generally, CCTs are understood to buffer the poor from sudden income shocks and encourage behavior change at an individual level by redistributing wealth and eliminating challenges in access and/or utilization, and by essentially paying people to enact beneficial behaviors. Overall, these programs have had strong impacts on proximal outcomes, such as school enrollment, vaccination, and use of other preventative health care (as discussed above), but the impacts on final outcomes such as the achievement levels of children and changes in health at the population level are less clear. And while they can reduce poverty and increase agency for beneficiaries (including empowering women), there have been instances where CCTs have unexpected and undesirable outcomes.

Despite this, the array of evidence showing the impacts of CCTs on proximal factors and their potential to positively affect population health means that they were only become more widespread as the focus of health intervention increasingly shifts from the individual to the system and social determinants of health.1,2 But in the design and implementation of CCTs programs the intent of such programs must not be forgotten CCTs programs are meant to break the links between poverty and poor health across generations. To realize this goal, programs must be conceived and implemented in local collaboration, strategic and aware of the potential synergies and antagonisms always present in addressing social determinants of health, and focused not just on reducing poverty and improving health but on increasing equity and removing barriers (Pleasants,2017).

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Over View

This chapter presents summary of the findings, conclusion and recommendations of the study conducted. Furthermore, the chapter presents limitation of the study and areas for further studies.

5.2 Summary of the Findings

The study tested TASAF beneficiariesô attitude toward adoption of social health care insurance using CCT. It has been proved that there was a need for using TASAF CCT to cover for health insurance .On the other hand, health insurance founded more important than the CCT provided by TASAF as the way it has been used. The study also founded that having health insurance would assist the family recovery from lower income situation they had. It was then found that beneficiaries could have several advantageous issues including easy access to counseling and guidance which was said to be expensive for them to afford as individual family.

One of the specific objectives tested if there were factors hindering TASAF beneficiaries ón adoption of social health care insurance using CCT. It has been shown that due to poverty and the way these CCT were used mostly to support daily basic needs to their families, therefore the money has not enough to pay for health insurance.Also there were directions and conditions given by TASAF to CCT beneficiaries on how to use the money they provided, due to that scenario limited them to opt for health insurance. However, it has been founded that the use of traditional treatment/medicine to some extent because it cheaper instead of applied

health insurance. The study found that there was no low acceptance of health insurance among the families. It was also found that believes and taboos were among the factors limiting the adoption of health insurance to some extent. The education level of the respondents on the other hand limited the motive for adoption of health insurance using the CCT provided by TASAF. Lastly, there was a willingness and awareness being some other factors for adoption of health insurance.

Lastly the study examines what strategies that can be used to improve TASAF beneficiaries in adoption of social health care insurance using CCT. It seems that education about health insurance was very important to them so that they understand well about importance of having health insurance to their families in order to leave better life with good health. Also, it understood that there was a need for TASAF policy to be improved in order for CCT provided can also support on health insurance. They should plan to engage various sponsors/stakeholders to contribute on this program so that many people can have the ability to seek for health insurance. Continue to increase the accessibility of health insurance in many health facilities including private hospitals at all levels.

5.3 Implication of the Study Findings

It was generally found that TASAF beneficiariesô had a positive attitude toward adoption of social health care insurance using CCT. Instead of their low income ability, they realize the need of health insurance using CCT. The governments then using these findings should incorporate the regulations and policies to make the majority of the poor access the CCT hence access the health insurance. There were several factors hindering TASAF beneficiaryôs adoption of social health care

insurance using CCT according to the findings. This implies of having the need for strong policies on training and increasing of awareness on adoption of health services using CCT. It was found that respondents indicated several strategies that can be used to improve TASAF beneficiariesô adoption of social health care insurance using CCT. This implies that there is a need to incorporate the regulations to assist many poor families adopt the CCT hence health services.

5.4 Conclusions

The study tested TASAF beneficiariesô attitude toward adoption of social health care insurance using CCT. It could then be concluded that the respondents had the positive altitude on the adoption of health insurance using the CCT provided by TASAF. It was found that what limits the services were the challenges which need to be electrified for the betterment of health insurance using CCT. The other objective was to analyses the factors hindering TASAF beneficiariesô adoption of social health care insurance using CCT. The study would conclude that there were several factors hindering the health insurance using TASAF CCT. These include education, traditional and beliefs and TASAF policies. Whereby for education it has shown most of beneficiaries have little education about health insurance, they believe it expensive so itôs better to use traditional treatment/medicine with the beliefs that its treat well, cheap and easy to access.

Also, TASAF policies encouraged their beneficiaries to use the money provided to fulfill their basic needs and send their children to school. Therefore, with these challenges in one way or another, these consequences have predetermined the

adoption of health insurance. Lastly the study tested the strategies that can be used improve TASAF beneficiaries adoption of social health care insurance using CCT. There is a need for education about health insurance so that people can understand well the importance of having health insurance whereby in case of diseases/sick a person can get health services without any difficult. There a need to improve policies on provision of CCT in order to increase the accessibility for beneficiaries to have health insurance where they can easy access for health service.

5.5 Recommendations

The study tested TASAF beneficiariesô attitude toward adoption of social health care insurance using CCT. On this objective, the study would suggest that because most of beneficiaries have a big positive attitude of using CCT provided for health insurance, the program can engaged various stakeholders/donors and plan for improving these CCTôs by providing enough money to their beneficiaries so that they can able to obtain health insurance and support other basic needs.

On the factors hindering TASAF beneficiariesô adoption of social health care insurance using CCT provided by TASAF. There were several factors which made the health insurance not well successful. The study recommend on having several health insurance accepting service providers. These studies lastly tested on strategies that can be used improve TASAF beneficiariesô adoption of social health care insurance using CCT. It recommend that, the program has to improve its policies either by increasing on what has been provided so that they should also be used for health insurance rather than only depending on supporting for basic needs.

5.6 Suggested Areas for Further Studies

The study suggests three areas to be studied; an assessment on the way to improve lower income families having investment through uniting together so as to make them contribute for their health insurance. This increased the ability to access the health insurance as the lower based families had the positive perception and attitude on health insurance. An assessment on the strategies to be done so as to adopt health insurance using CCT; this assisted the improvement of the service. Health insurance was very crucial to all human kinds. This made the poor to have this valuable service. What strategies to be made to improve health insurance donation; since the study recommends that there was a need of engaging various stakeholders/sponsors who contributed their views and plan to improve the program.

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APPENDICES

Appendix 1: Interview

The Open University of Tanzania

Dear respondent, the purpose of this survey is to understand role Conditional Cash Transfer (CCT) in Promoting Health Insurance demand among TASAF Beneficiaries Data given will be secret and usefully for academic purpose for Open University of Tanzania. Kindly, you are requested to respond these questions below carefully using only approximately five minutes to facilitate information so that to be analyzed to fulfill the requirements of the study.

Section A: General Information:

Age		Gender		Education level		Relationship with TASAF	
Years with benefiting or working with TASAF							

Section B: Specific Information onthe role of conditional cash transfer in promoting health insurance demand among TASAF beneficiaries

TASAF beneficiaries' attitude toward adoption of social health care insurance using CCT

1. Is there a need for having health insurance using TASAF CCT?
2. Do you think the health insurance is more important than how the money given is used?
3. Do you think having health insurance would assist the family recovery from lower income? Explain in short.
4. Mention the benefits you think you will have due to having TASAF CTT health insurance.

Factors hinder TASAF beneficiary's adoption of social health care insurance using CCT

5. **Are the following the factors limiting the health insurance up taking?**

i. Low family income use the money provided by CCT

ii. The CCT predetermined CCT uses limit adoption of health insurance

Use of traditional treatments is enough instead of health insurance

iii. There is low acceptance of insurance

iv. The believes and taboos limit the adoption of health insurance

v. Education of beneficiaries limit the adoption of health insurance

6. Suggest other factors experienced

7. How are these factors experienced?

Strategies that can be used improve TASAF beneficiary'sadoption of social health care insurance using CCT

8. Are the following strategies that can be used improve TASAF beneficiaryôs adoption of social health care insurance using CCT?

i. There should be education on advantages of health insurance

ii. There should be increase of CCT to health insurance

iii. There should be improvements on CCT to promote income for future CCT

iv. There is a need for all health services based to accept the health insurance

vi. There is a need of other donors to give CCT on health insurance

9. Suggest the other strategies that can be used improve TASAF beneficiaries adoption of social health care insurance using CCT

Thanks for your corporation