EVALUATION OF FACTORS AFFECTING COMMUNITY HEALTH FUND GROWTH IN TANZANIA: A CASE OF ILALA DISTRICT

KHADIJA MOHAMED KASSANGA

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the Open University of Tanzania a dissertation titled; ***"Factors affecting community health fund growth in Tanzania. A case of Ilala distric***t**"** in partial fulfilment of the requirements for the award of Master's Degree in Business Administration - Marketing (MBA-Marketing) of the Open University of Tanzania.

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DECLARATION

I, **Khadija Mohamed Kassanga**, do hereby declare that the work presented in this dissertation is original. It has never been presented to any other University or institution. Where other people's works have been used, references have been provided. It is in this regard that I declare this work as originally mine. It is hereby presented in particular fulfilment of the requirements for the Degree of Master of Business Administration - Marketing (MBA-Marketing) of the Open University of Tanzania.

DEDICATION

I dedicate this study to the Almighty God, my husband and children. I could not have done without them.

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ABSTRACT

The study objectives were to assess the socio-demographic, socio-economic as well and socio-cultural factors affecting CHF scheme growth in the Ilala district. The study population for this research comprised both members and non-members of the CHF scheme, staff members of CHF institutions and local government officials from four wards (Ilala, Kisutu, East and West Upanga). The sample size of 400 respondents was considered to be reasonable and affordable. The study used a cross-sectional design, where quantitative data was collected at a single point. The cross-sectional design took the form of a questionnaire survey, with participants selected using random sampling processes. Quantitative data collected using questionnaires was analyzed using descriptive statistics while multiple linear regression was carried out to determine the general relationship between independent and dependent variables. The findings showed that the majority of the surveyed households had a sufficient education level and ages of more than 50 years. A higher number of the households had unreliable jobs that gave them no option to join the CHF scheme. The majority of the surveyed households mentioned traditional healing to be the most appropriate way to treat their health implications. Based on the study findings, the researcher recommends the following in order to improve the performance of the implementation of the CHF scheme: Households have to be categorized by authorities into strata of different income levels and geographical locations premiums determined according to their ability to pay. Timings for revenue collection are to be designed in such a way to suit the situation of different members, for example during harvest, by two equal instalments, or through peer members.

Keywords: *Community Health Fund, Tanzania*

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LIST OF ABBREVIATIONS

CBHI	Community-based Health Insurance
CHF	Community Health Fund
CHI	Community Health Insurance
CHSB	Council Health Services Board
DMO	District Medical Officer
HBM	Health Belief Model
iCHF	Improved Community Health Fund
LMICs	Low- and Middle-Income Countries
MOH	Ministry of Health
MOHCDGEC	Ministry of Health, Social Development, Gender, Elderly and Children
NBS	National Bureau of Statistics
NGOs	Non-government Organizations
NHIF	National Health Insurance Fund
PORALG	President's Office, Regional Administration and Local Government
RCMS	Rural Cooperative Medical Systems
SDG	Sustainable Development Goals
SPSS	Statistical Package of Social Science
TIKA	Tiba kwa Kadi
UHC	Universal Health Coverage
URT	United Republic of Tanzania
WTP	Willing to Pay

CHAPTER ONE

INTRODUCTION

1.1   Background of the Study

The earliest Community Health Insurance (CHI) initiatives in Asia were rooted in deliberately political processes (Witter & Ensor, 1997). In China, the first Medical Cooperatives saw the light of day in a few communist-controlled rural areas as far back as the 1940s (Yip, 2008). Once an isolated innovation, these schemes eventually led to the nationwide implementation of the Rural Cooperative Medical System (RCMS) in the 1960s. By the 1970s, RCMS covered 90% of China's rural population. However, the RCMS collapsed following the market-oriented reforms of the early 1980s. A new RCMS was created in 2003 and is in expansion (Werner *et al.,* 2010).

In recent years, community based health financing reforms in many developing countries, as a mechanism for raising additional funds for essential public health services, enhancing access to care and reducing out-of-pocket payments (Diop & Ba, 2010).According to the study conducted by Macha *et al.,* (2014), community based health insurance is usually organized and managed by local government institutions, local health facilities, or non-government organizations, with significant community involvement. Despite the proven effects of community-based health insurance schemes in enhancing access to services and financial protection, in many developing countries there has been limited population enrollment in such schemes (Abel, 1992).

Indeed, in Sub-Saharan Africa coverage rarely attains more than 10 percent of the target population with some exceptions in countries such as Rwanda and Ghana (Vogel, 1990). In many developing countries, initiatives are underway to implement community-based health insurance as a means of expanding access to affordable care among the informal sector (Normand and Weber, 1994). However, increasing coverage with voluntary health insurance in low income settings can prove challenging. In the United Republic of Tanzania, user fees have progressively replaced financing from general taxation since 1993. From 1996 on, the Tanzania government introduced Community Health Fund (CHF) schemes, essentially a district-based Community Health Insurance (CHI) arrangement (Mtei and Mulligan, 2007). Alongside, a dozen provider-driven CHI schemes originated. A 2001 CHF made the creation of a CHF obligatory for every rural district within a two-year span and introduced state subsidies for CHF schemes, member fees are matched by a 100% government grant. Tanzania introduced the Community Health Fund (CHF), a voluntary community-based health insurance for the rural informal sector in 2001 (Ramadhani & Stephen, 2021). Enrollment in such schemes is voluntary, and premiums tend not to be according to ability to pay, nor are they risk rated, with schemes often running on a non-profit basis. Revenue collection mechanisms vary from place to place. In some cases, contributions are collected at a specific period in the year, such as during the harvest season, in other cases people can join year-round (Beraldes & Carreras, 2003).

A number of studies have examined and reviewed the constraints to increasing enrollment. Ndomba & Maluka, (2019) assert that among the potential barriers to

enrolment in Tanzania are affordability of premiums, poor quality of health care services offered to members and limited referral services. Poor management (unfavorable scheme design) and lack of trust were also reported in some studies to affect the coverage of community-based insurance schemes (Kamuzora & Gilson, 2007). Concerns about the lack of inclusion of referral care and associated transport costs in the benefit package have also been reported elsewhere. Recent moves in Tanzania to promote engagement with the private sectors in the provision of quality health services in areas with the limited public facilities through service agreements (or contracts) should facilitate a widening of the benefit package (Catherine, 1998).

1.2   Statement of the Problem

Health care service is among the most important services that are to be accessible in human life. The lack of it may lead to various problems in social, economic as well as political spheres. In many countries access to health care services is not free but rather it initiated and run by the government, NGOs and individuals. In countries where majority of its citizens can't afford health care services, various schemes are introduced in order to help its citizens acquire good health care services. Globally such schemes are known as Community Based Health Insurance (CBHI). CBHI refers to voluntary, non-profit health insurance, normally organized at local level where formal health insurance does not provide protection against the cost of illness (Muluka & Ndomba 2019).

The implementation of CBHI in Tanzania is done through the Community Health Fund (CHF), which was introduced in 1996 as a pilot study and adopted in 2001 by

the CHF Act. CHF in Tanzania refers to voluntary health prepayment mechanism that enable households to access health care services when they fall sick based on the health insurance package opted by the beneficiaries. The scheme was identified as a possible mechanism granting access to basic health care services to populations in the rural areas and the informal sector in the country. Its aim was not primarily to raise additional funds but rather to improve access to health care for the poor and vulnerable groups (Mtei *et al*., 2007).

CHF was developed among many reasons to help the community members to access quality and affordable health care services. According to the CHF Act of 2001, the objectives of the CHF included-: mobilizing financial resources from the community for provision of health care services to its members; (ii) providing quality and affordable health care services through sustainable financial mechanism and (iii) improving health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health (URT 2001).

However, despite the government effort in insuring the health scheme succeed among majority of its citizens, there has been low enrollment rate of the community members into the CHF and high rate of dropout among the registered members. Moreover, even in the areas that where there was once high enrollment in the scheme, they have recorded tremendous decrease in enrollments. Kamuzora and Gilson (2007) investigated the causes of low enrollments and came up with findings that poor inability to pay membership contributions was the most important barrier,

whereas poor quality of care, non-acceptance of the need to protect themselves against the risk of sickness and lack of trust in CHF managers mattered more to average and wealthy community members.

In responding to the weaknesses of the CHF, the NHIF (National Health Insurance Fund) advised the government to establish an Improved Health Insurance fund (iCHF) 2016 and it was officially adopted in 2018. The aim was to ensure that, funds collected through iCHF are utilized effectively for the intended purpose and ensure service availability to the community as promised. In addition, the National Health Insurance Fund would only assist Council Health Services Boards(CHSBs) in sensitization activities in order to increase membership enrolment in the informal sector ("Improved Community Health Funds" (ICHF): Third-party relationships improving health service provision and members' recruitment A case of the National Health Insurance Fund, 2022).The success of the iCHF is expected to increase enrollments of the community members in the non-formal sector as well as those in the rural areas in accessing the affordable and quality health services from up to referral hospitals depending on their subscription package. Therefore, this study intends to evaluate the factors affecting community health fund (CHF) growth in Tanzania.

1.3   Objectives of the Study

1.3.1 Main Objective

To examine the factors affecting community health fund (CHF) growth in Tanzania. A case of Ilala District

1.3.2 Specific Objectives

The following specific objectives support the general objective**:**

i) To examine the socio-demographic factors affecting CHF scheme growth in Ilala district.

ii) To determine the socio-economic factors affecting CHF scheme growth in Ilala district.

iii) To examine the socio-cultural factors affecting CHF scheme growth in Ilala district.

1.4 Research Hypothesis

The following research hypotheses are used to test the specific objective**s**

i) Socio-demographic factors affect positively CHF scheme growth

ii) Socio-economic factors affect positively CHF scheme growth

iii) Socio-cultural factors affect positively CHF scheme growth

1.5 Significance of the Study

The findings of this study are expected to help the government, health care providers and other stakeholders in the health sector to understand about the community perception on the Improved Health Care Fund. Moreover, it will provide health care researchers with a data that may be useful in writing more studies on the Improved Community Health Fund in Tanzania.

1.6 Organization of the Study

This study is organized into three chapters. The first chapter presents background information, statement of the problem, objectives of the study, research questions,

and significance of the study and organization of the proposal. Chapter two presents literature review where the chapter covered introduction, definition of terms, and empirical literature reviews. Other sections covered in chapter two includes conceptual framework, research gap and chapter summary. Chapter three presents the study area, research design, and target population, sampling procedure and sample size. It also covered data collection methods, data analysis, processing and interpretation, and validity and reliability, ethical issues and chapter summary. Chapter four provides findings and discussion and chapter five provide summary, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter captured what others wrote with regard to the perceptions of the community members towards the Improved Community Health Fund in Tanzania. The chapter compiled and documented individual studies as well as institutional studies, experiences and reports with regards to the community health fund in Tanzania. However, theoretical literature reviews and empirical literature reviews are also discussed. The same information is further used as part of the study analysis and thus making it easy to determine research gap for this study as well as giving the comparative views with regard to the study parameters.

2.2 Definition of Key Terms

2.2.1 Community Health Fund

The Community Health Fund (CHF) is a type of Community-Based Health Insurance (CBHI) scheme which is being implemented in Tanzania (Macha and Maluka, 2019). CHF is a voluntary health insurance scheme mainly targeting informal and rural population; and it was first piloted in Tanzania in 1996. Later, the government made CHF a voluntary prepayment health financing mechanism by 2001 CHF (URT, 2001). The CHF membership is for the entire household members. At the district level, the CHF is overseen by the Council Health Services Board (CHSB) which comprises representatives from the district authorities, public health care providers, private healthcare providers and the community at the ward level, the Ward

Development Committee and the Health Facility Committee are responsible for mobilizing people to join the CHF, tracking the membership base, overseeing premium collections, evaluating CHF operations, providing recommendations and granting exemptions (URT, 2016).

2.2.2 Community-Based Health Insurance (CBHI)

Community-Based Health Insurance (CBHI) is a form of micro health insurance targeted to low-income people (Odeyemi, 2014). The specific feature of CBHI is the community involvement in driving its setup and its management. According to Macha & Maluka (2019), Community-Based Health Insurance (CBHI) schemes are usually voluntary and characterized by community members pooling funds to offset the cost of healthcare. Despite much hope in these systems, evidence suggests the impact of CBHI on financial protection and access to needed health care are moderate for those enrolled.

2.2.3 Health Care Services

Health care is the maintenance or improvement of health via the prevention, diagnosis, treatment and cure of diseases, illness, injury or other physical and mental impairment in people. Health care services are delivered by health professionals and allied health fields. Access to health care may vary across countries, communities and individuals influenced by social and economic conditions as well as health policies. Healthcare services mean the medical and related healthcare services provided by physician to patients. CBHI schemes are usually voluntary and characterized by community members pooling funds to offset the cost of healthcare.

2.3 Theoretical Review

2.3.1 The Health Belief Model (HBM)

A theory is a set of interrelated concepts, definitions, and propositions that explains or predicts events or situations by specifying relations among variables. Theory presents a systematic way of understanding events, behaviors and/or situations (DiClemente, 2002). The Health Belief Model was developed in the 1950's by social psychologist Hochbaum Rosenstock who was working in the US Public Health Services to explain the failure of people participating in programs to prevent and detect diseases. The Health Belief Model has provided a useful framework for investigating health behaviors and identifying key health beliefs and it has been widely used and has met with moderate success in predicting and changing a range of health behaviors (McLeroy, 1988).

According to McLeroy (1988), the Health Belief Model is another extensively researched model of health behavior attempting to predict health-related behavior in terms of certain belief patterns. A person's motivation to undertake a health behavior can be divided into three categories: individual perceptions, modifying factors and the likelihood of action. Individual perceptions are factors that affect the perception of illness and with the importance of health to the individual, perceived severity and perceived susceptibility. Modifying factors include demographic variables, perceived threats and cues to actions. The likelihood of action is the perceived benefits minus the perceived barriers of taking the recommended health action. The combination of these factors causes a response that often manifests into the likelihood of that behavior occurring (DiClemente, 2002).

The key strength of Health Belief Model lies in the fact that it was developed by researchers directly working with health behaviors and so many of the concepts possess face-validity to those working in health behavior. This common-sense operationalization of a number of cognitive variables relevant to the performance of health behavior partly accounts for the model's popularity. The Health Belief Model (HBM) was developed to help understand why people did or did not use preventive services offered by public health departments, and has evolved to address newer concerns in prevention and detection (e.g., mammography screening, influenza vaccines) as well as lifestyle behaviors such as sexual risk behaviors and injury prevention. The HBM theorizes that people's beliefs about whether or not they are at risk for a disease or health problem, and their perceptions of the benefits of acting to avoid it, influence their readiness to act (Abel, 1992).

However, compared to other similar social cognitive models of health behaviors, the Health Belief Model suffers from a number of weaknesses. The way in which the variables in the Health Belief Model combine to produce behaviorhas not been precisely specified and, as a result, it is frequently tested as six independent predictors of behavior (DiClemente, 2002).

The relevancy of Health Belief Model to this study lies upon the fact that community's knowledge, perception, preferences participation or involvement in decision making to join CHF scheme depends upon many factors that, this study intends to explore in order to achieve the universal coverage of CHF scheme in Tanzania, specifically Ilala district.

2.4 Empirical Literature Reviews

2.4.1 Socio-demographic Factors Affecting CHF Scheme

The socio-demographic characteristics of clients and their perception of quality of care play a major part in people's decision-making process especially in-service utilization. Policy makers need to recognize community perceptions as potential enablers and barriers to enrolment, and to invest in understanding and addressing them in the design of interventions to stimulate enrolment (Appiah et al., 2012). Study on Kenya show that perceived poor quality of care in public health system can be a major hindrance of Universal Health Coverage. Good quality services, particularly related to drug availability and interpersonal relationship between clients and health provider can boost trust in the public system and in so doing encourage people to belong to health insurance (Mulupi *et al*., 2013).

Moreover, the study included the following other factors that the literature has also mentioned as important in determining joining or not joining health insurance programs: demographic variables such as age was assumed that middle aged people enroll more compared to other groups; on sex it was assumed that females enroll more on CHF than males; in occupation, marital status, level of education, size of the household influence CHF enrolment.

Not only that, but also households with elderly members or children under-five years. Joining or not joining CHF members depend more in involvement from the beginning of the formulation of the scheme in order to make them feel part of the initiative. This study was also conducted in Tanzania. If members are more involved,

the potential for membership fees to be set at an affordable rate is much higher and the benefit package will be clear to all members, avoiding the possibility of over expectations of the benefits package (Mtei & Mulligan, 2007).

In addition, there are many studies, conducted in different settings, to evaluate the factors that determine enrolment into CBHI or people's willingness to pay (WTP) for CBHI these potential factors include age, income, education and distance to health facility (Adebayo at el, 2013). The association between age and WTP has been mixed in the literature. Respondent's age is found to have a positive effect on WTP in some studies, while in others it is the opposite.

2.4.2 Socio-economic Factors Affecting CHF Scheme

In India it was observed that the main barriers for the subscription of health insurance were low income or uncertainty of income, not adequate knowledge regarding its benefits and do not feel the need (Madhukumar & Gaikwad, 2012). Also, for economic variables that involve distance to health services and availability of transport are related with joining or not joining CHF. In their study in Tanzania Msuya, Jütting, & Asfaw (2004) reveal that more than 60% of the households that were considered to be either rich or normal had joined the scheme compared to only about 33% of the poor ones; also, village of residence was one of the significant variables that affect the decision of households to join the CHF scheme.

Macha *et al*., (2014) in their quantitative analysis in Tanzania have revealed that the three middle income quintiles were more likely to enroll in CHF than the poorest and

the richest. CHF members were more likely to be big, and headed by a male than uninsured households from the same area. Also poorest were more likely to join as were large families and of greater risk of illness with disabilities or persons with chronic diseases.

Similarly, high membership fees set by some council are also were barrier to enrolment. For instance, the MOH, CHF Facilitative Supervision report noted that Karagwe had proposed an annual fee of 30,000 Tshs. per household to those currently paying 15,000 Tshs, a figure already above the average in comparison to much other district council contributions (Abel, 1992).

Several scholars found that, low income and income unreliability has influenced low enrolment. For example, 60% of richer households in Igunga district joined the CHF scheme compared to 33% of the poorest households (Msuya *et al*., 2007). Other reasons include inadequate information due to insufficient sensitization to the community; introduction of NHIF which took out public servants who were potential members of CHF, non-coverage of referral care; perceived poor quality of health care services at public health facilities. Similarly, to what other reports which has reported poverty, limited coverage package of the scheme has made many individuals not to decide to join.

2.4.3 Socio-cultural Factors Affecting CHF Scheme

On socio cultural variable that include attitudes and practice of the people towards CHF and health insurance in general were assumed that people have positive attitude

towards CHF enrolment as it will help them to access improved health services. Furthermore, the communities perceive CBHI as a crucial healthcare services which is relevant to use at a later point in time during the time of illness or any physical impairment. On the other hand, the different logic of traditional networks sometimes induces misconceptions of CBHI and disappointment, because people have expectations based on their experience with traditional institutions that are not fulfilled by CBHI, for instance, that the money paid into common fund accumulates over time and that the benefits will correspond to the contributions made (Doris & Johannes, 2000).

There are well-documented experiences in community participation and engagements in the health sector, not all of them were successful. The term community engagement, as opposed to participation, emerged from the field of health research and focused on the deliberate integration of communities into the design and implementation of research activities (Kishole & Nalini, 2019). Community engagement and participation have the same goal- i.e. improving public health service deliveries and policy projects. However, both are not initiated by the same actors. Indeed, community engagement is a *top-down* initiative. Hence, it is implemented by a governmental body such as a city /town/ village. The government officials are the ones encouraging citizens/communities to discuss, assess policies and contribute to the projects. On the contrary, citizens implement community/citizen participation which is a *bottom-up* initiative (Olushayo & Pamela, 2019).

Apart from the community participation and community engagement, the term community mobilization is also an attempt to attain Sustainable Development Goal (SDG) by bringing both human and non-human resources together to undertake developmental activities (Sharma & Sobito, 2017). In their literature, they asserted that community mobilization is a process through which action is stimulated by a community itself or by others, that is planned, carried out and evaluated by a community's individuals, groups, and organizations on a participatory and sustained basis to improve the health, hygiene and education levels so as to enhance the overall standard of living in the community.

We have seen examples in the past that participatory approaches always have a positive health impact (Olushayo & Pamela, 2019). It is essential to have involvements of communities, local elected leaders, Civil Society Organizations to make communities aware about their rights thereby reducing asymmetries and inequalities. It's also necessary for equitable access to healthcare and to make health services accountable and responsive towards community needs.

Participatory approaches contribute to increased uptake and quality of health services, financial protection for individuals and communities accessing health care, improving health behavior and health awareness in communities as well as strengthening social capital and deepening democratic processes (Kishole & Nalini, 2019).

In the study conducted by Kishole & Nalini (2019), it concluded that, to facilitate local health planning, implementation and monitoring, the role of both the local

elected bodies and civil society has been critical. The success of participatory planning platforms globally depends upon the central role of civil society organizations and upon adequate investment of time and resources in capacity building. NGOs play critical roles in handholding and training and as interlocutors between communities and governments (URT, 2001).

2.5 Conceptual Framework

The conceptual framework is a figure typically presented as a concept map that summarizes all key information presented in the literature review of the study (Antonenenko 2014). This study is guided by the conceptual framework consisting of independent, dependent and moderating variable. The universal CHF scheme coverage and enrollment is the independent variable; mass media campaigns, advice from others as well as illness of family members and friends are the moderating variables while socio-economic, socio-demographic and socio-cultural factors are the dependent variables.

The interpretation of this approach is that the primary goal and focus of the improved community health insurance fund is to reach the Universal Health Coverage (UHC) objectives. These goals will not be successfully achieved without proper implementation of strategic initiatives in this study referred to as moderating variables such as mass media campaigns, advice from others as well as illness of family members and friends. Moreover, the growth of CHF scheme is constrained with various factors collectively known as socio-cultural, economic and demographic factors.
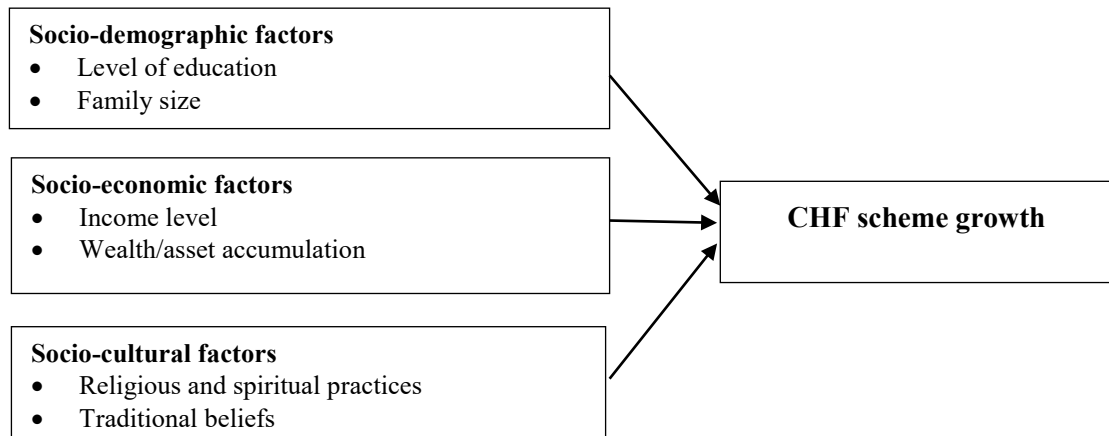
Figure 2.1: Conceptual framework

2.6   Research Gap

Despite the fact that there are a number of literatures assessing the community members' perception towards the improved community health insurance fund in Tanzania such a Macha *et al.,* (2019) who focused on the challenges facing the implementation of the scheme in Tanzania. A study conducted in Kenya show that perceived poor quality of care in public health system can be a major hindrance of Universal Health Coverage. Good quality services, particularly related to drug availability and interpersonal relationship between clients and health provider can boost trust in the public system and in so doing encourage people to belong to health insurance (Mulupi *et al.,* 2013). Abel (1992) argues that the priorities of the government is to ensure that all citizens receive treatments through health insurance systems, especially those in the informal sector to achieve the goal of universal health coverage, as well as to manage the collection, access to quality services, low cost and improve community health services.

However, there are numerous studies that have assessed the community members' perception towards improved community health insurance fund (ICHF) in Tanzania.

In particular there are less studies to my knowledge that has been done on evaluating the factors affecting community health fund (CHF) growth in Tanzania, based in Ilala municipal. Therefore, this has created an information gap which this study aimed at filling.

CHAPTER THREE

THE STUDY AREA AND RESEARCH METHODOLOGY

3.1   Introduction

This chapter presents the research methodology. The study area, data sources, data collections techniques, research design, sampling procedures and sample size are covered. Other areas covered are data analysis and presentation, data validity and data reliability and finally ethical consideration.

3.2   Research Design

The study used a cross-sectional design, where by quantitative data was collected at a single point in time. Cross sectional design takes the form of questionnaire survey, with participants selected using random sampling processes (Matthews & Ross, 2010). This design was preferred as in addition to its simplicity it allows determination of relationship between variables (Kothari, 2009). The design was further considered favorable in situations of limited resources and time as the case for the present study.

3.3   Study Area

Ilala municipal council is one of the four municipalities of Dar es Salaam city; other municipal councils include Temeke, Kinondoni and Dar es Salaam city council. According to the recent census of 2012 the total population of the district is 1,195,936 people while male are 581,184 and female 614,752 (NBS, 2015). The municipal is divided into 26 wards. Ilala municipality has an area of 210 km^2, it lies

between longitude 39° and 40° East, between 6° and 7° South of the equator. On the Eastern part it borders Indian Ocean for a distance of 10 km. On its Southern part it borders Temeke municipality, while in western it borders Kisarawe district and in northern part it borders Kinondoni municipality. Ilala municipal council is selected as a study area because of its strategic location and it is highly populated area. It is the residence of most government ministries and institutions. National referral hospital (Muhimbili), Dar es Salaam international airport, High court of Tanzania and some universities campuses. Furthermore, it is the city center which comprises business centers of the countries such as Kariakoo, kivukoni, Mchafukoge, Buguruni, Upanga, Vingunguti and Kisutu. Moreover, the researcher herself works in Ilala municipal council thus this study was made less expensive in terms of accommodation, transportation and other costs.

3.4   Study Population

Based on 2012 National Census, Ilala Municipal Council has a population of 1,505,181. The study population for this research comprised of both members and non-members of CHF scheme, staff members of CHF institutions and local government officials from 4 wards (including Ilala, Kisutu, East and West Upanga) with the total population of 64,034 (NBS, 2012).

3.5   Sampling Procedure and Sample Size

3.5.1 Sampling Procedure

Simple random sampling was used as a probability sampling method. Here respondents are expected to have equal chance of being selected. The procedure

involved listing clients of CHF scheme and writing them on pieces of paper which amounted to the population of study. The papers were tossed and selected randomly to amount to a sample size of 400 respondents. Those selected were corresponded with names in the list and were picked for the study. Probability sampling was very suitable for quantitative data in this research.

3.5.2 Sample Size

Sample size included 400 people at the community. Sample was divided into two, those who joined CHF and those who are not CHF members. The researcher sought information to those who are enrolled in CHF and those who are not, that's those who receive treatment out of pocket when they fall sick. Information concerning CHF enrolment for the district was also obtained through documentary review and interview with responsible person in the DMOs' office.

A complete and update list of CHF members and non-members in Ilala municipality was provided and used to select the most appropriate respondents for the study. Sample size was calculated by the following formula;

$n = N/1+N.e^2$

$n = 64,034/1+64,034×0.05^2$

$n = 400$

Where n = number of samples, N = total population=64,034; e = standard error of sampling (0.05)

For the purpose of this study, the sample size of 400 respondents was considered to be reasonable and affordable.

3.6   Sources of Data

3.6.1 Primary Data

Sekaran (2003) contended that primary data is the first-hand data that is collected by researcher on variables fulfilling the interest of the particular purpose of the study. All primary data were collected from the selected study area. In this study, data was gathered through structured questionnaire in selected pool of specific beneficiaries and CHF members in Ilala district.

3.7   Data Collection Method

3.7.1 Questionnaire

Primary data for the study was collected using a structured questionnaire with open and close-ended questions. The questions were closed-ended where by responses were provided for the respondent to tick the answers, or open-ended where by respondent provided his/her views. This type of questionnaire was used to standardize the type of data collected and the procedure used in collecting the data. According to Matthews and Ross (2010) this type of questionnaire can be used to effectively gather data from a large number of people or cases in the same way for all respondents and data are easy to code for analysis.

3.8   Data Analysis, Interpretation and Presentation

Quantitative data that was collected using questionnaires was analyzed using descriptive statistics. Descriptive statistics (frequencies, percentages and means) was determined using SPSS and results summarized in Tables with the aid of Statistical Package for Social Sciences (SPSS) software. The multiple linear regression was

carried out to determine the general relationship between independent and dependent variable.

3.9   Model of Multiple Linear Regression

$$Y = \alpha + \beta_1 X_1 + \beta_2 X_2 + \varepsilon$$

Where:

Y = Dependent variable (CHF scheme growth)

β_1-β_2 = Regression coefficient

α = Regression constant

ε = Error term

X1-X2 = Independent variables

3.10   Data Validity and Data Reliability

3.10.1 Data Validity

According to James (1997) validity means the degree to which a test measures what it is supposed to measure. In this study an informal pretest of the survey was carried out with 30 subjects and the data collection tool was structured around the responses derived from the pilot study. A professional translator wasused to translate an instrument from English to Kiswahili before the interviews. Weaknesses detected in the instrument during the pre-testing were corrected in order to refine them so as to enhance validity. In cases of any flaws and bias, the instrument was modified for more clarity and accuracy.

3.10.2 Data Reliability

The reliability of the research instruments concerns the extent to which the instrument yields the same results on repeated trials (James, 1997). In this study, the aspect of reliability was addressed in the current research by ensuring the appropriateness of the research process: rigorous and consistent data collection and interpretation, and transparent process. Further, the reliability of this research was ensured by using standardized social sciences research methods, example; keeping the field record, recording interviews and transcribing them. Data collection was conducted in both Kiswahili and English in order to ensure that the questions are well understood by all respondents. All questionnaire and in-depth individual interviews were audio recorded (to carry out an accurate analysis of the verbal responses) and notes taken.

3.11 Ethical Issues

Research ethics provides guideline for the responsible conduct of research. In addition, it educates and monitors scientists conducting research to ensure a high ethical standard (Jenn, 2006). In this study the research information was gathered and handled confidentially and the participants were informed about the study purpose individually and confidentially. The participants were also informed of their rights to access the results from this study. In the situation where the case of questions that requires mentioning names, letters and numbers were used instead. The study did not intend to cause any harm to the participants in terms of psychological, social, economic and physical aspects.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1   Introduction

This chapter presents the data collected and discusses the findings in relation to the objectives and questions of the study. The chapter is divided into two parts. The first part presents the findings on the demographic characteristics of the respondents of the study. The second part presents results and analysis of the findings with respect to the research objectives and attempts to answer the associated research questions.

4.2   Demographic Characteristics of Respondents

The demographic characteristics of respondents examined were gender, age, and level of education, family size and occupation. These features are essential because they may suggest the possible reasons for the responses from the participants.

4.2.1 Respondents Distribution by Gender

The purpose of obtaining data on the basis of sex was to gain the insights to determine the participation in CHF between male and female participants. The findings in (Table 4.1.1) show that 138 (34.5%) respondents were males and 262 (65.5%) were females.

Table 4.1: Gender of the respondent

Gender	Frequency	Percentage (%)
Male	138	34.5
Female	262	65.5
Total	**400**	**100**

Source: Field data (2022)

These findings suggest that the membership of females to CHF was somewhat higher (65.5%) than that of males (34.5%). This result is not surprising given the reality that the number of female members tends to be higher than males due to the fact that female household specifically mothers are the one with the responsibility to take care of the family hence forcing them to seek for health insurance back up.

4.2.2 Respondents Distribution by Age

The age of respondents was divided into four age groups; 20-29, 30-39, 40-49 and 50-above. The findings (See Table 4.1.2) indicated that majority of the respondents were aged between 40 and 49 which constituted 194 respondents (48.5%), followed by 106 respondents aged 50 and above (26.5%). About 57 respondents were aged between 30 and 39 (14.25%) while 43 (10.75%) respondents had the age limit of 20-29.

Table 4.2: Age of the respondent

Age category	Frequency	Percentage (%)
20-29	43	10.75
30-39	57	14.25
40-49	194	48.5
50 and above	106	26.5
TOTAL	400	100

Source: Questionnaire data (2022)

The findings in Table 4.1.2 suggest that most of the respondents (75%) were adults (ranging from 40-49 and above 50 years) and were capable of expressing their experiences with regard to access to health care under CHF scheme in Ilala district. It is also a case that adults are likely to take health care matters particularly accessing quality health care for their own sake and of their families.

4.2.3 Respondents Distribution by Level of Education

The level of education of respondents was categorized into five levels; college (certificate and diploma level), degree level (including bachelor, masters and PhD), Primary and secondary education level as well as non-formal education. Findings (See Table 4.1.3) show that 67 respondents (16.75%) had attained college (certificate and diploma level), 28 (7%) had attained degree level, 77 (19.25%) had attained primary education and 205 (51.25%) attained secondary education (o-level and high-level education) while the rest 23 (5.75%) had non-formal education.

Table 4.3: Education level of respondents

Level of education	Frequency	Percentage (%)
Non-formal education	23	5.75
Primary education	77	19.25
Secondary education	205	51.25
College	67	16.75
University/Degree level	28	7
TOTAL	400	100

Source: Field data (2022)

The findings suggest that the respondents were sufficiently educated and therefore they were in a position to assess performance of CHF against their expectations including whether they adequately accessed health care services under CHF considering their level of understanding. The findings suggest that the respondents were sufficiently educated and therefore they were in a position to assess performance of CHF against their expectations including whether they adequately accessed health care services under CHF considering their level of understanding.

Table 4.4: Occupation of the respondents

Occupation	Frequency	Percentage (%)
Peasant	68	17
Employed	20	5
Entrepreneur	194	48.5
Jobless	118	29.5
TOTAL	400	100

Source: Questionnaire data (2022)

4.2.4 Occupation of the Respondents

Most of the respondents were jobless and entrepreneurs while others are peasants. This implies that the level of income is directly proportional to CHF scheme growth, meaning that most people without a reliable source of income could not access health services easily compared to those with reliable income. Those who are employed could have their health services access through National Health Insurance Funds and other insurance schemes provided for those employed in a private sector. According to the study conducted by Stephen (2015), people who are richer in rural areas are those who engage in multiple occupations like small business/trade owners of small shops, keeping animals as well as farming can easily afford to pay for the CHF membership fee.

Table 4.5: Respondents' family size

Family size	Frequency	Percentage (%)
1-3	168	42
4-above	232	58
Total	400	100

Source: Questionnaire data (2022)

4.2.5 Family Size of the Respondents' Households

The findings indicated that the majority had the household family size of 4 and above

which has the close relationship with the likelihood of households to not join the CHF scheme due to having a big burden to the heads of the family to enroll each individual in his household. Similarly, Macha *et al.,* (2014) disclose that a large family size of more than 7 people was the reason for enrolment, other reasons included a male headed household, having completed secondary education and being married. CHF accept membership of only one wife, the second wife will be considered another household and they have to pay membership premium. This is becoming a big burden to poor families.

4.3 Factors Affecting Community Health Fund Scheme Growth

4.3.1 Socio-Demographic Factors Affecting CHF Scheme Growth

4.3.1.1 Number of Dependent Children

Respondents were also asked to indicate their highest number of dependent children. About 31 respondents (7.75%) indicated 1-3, 69 respondents (17.25%) indicated that their highest number was 3-5, 185 respondents (46.25%) recorded that their highest number of dependent children was 5-8, while 115 (28.75%) respondents recorded to have 8-above dependent children.

Table 4.6: Number of dependent children

Number of dependent children	Frequency	Percentage (%)
1-3	31	7.75
3-5	69	17.25
5-8	185	46.25
8-above	115	28.75
Total	**400**	**100**

Source: Questionnaire data (2022)

The findings indicated that the majority had the highest number of dependent children of 8 and above and 5-8 dependent children with 28.75% and 46.25% respectively. This has the close relationship with the likelihood of households to not join the CHF scheme due to having a big burden to the heads of the family to enroll each child into the CHF scheme. Msuya *et al.,* (2004) found that a household with many family members were more likely to join the scheme than the small family size. He further suggested that households with less than 5 family members have a great chance to enroll in CHF schemes compared to large size considering that current CHF membership fee is too high.

4.3.1.1.1 Family Size

Respondents were also asked to indicate their family size (the size of their households). 45 respondents (11.25%) indicated 1-3, 81 respondents (20.25%) indicated that their highest number was 3-5, 156 respondents (39%) recorded that their highest number of dependent children was 5-8, while 118 (29.5%) respondents recorded to have 8 and above household size.

Table 4.7: Respondents' family size

Family size	Frequency	Percentage (%)
1-3	45	11.25
3-5	81	20.25
5-8	156	39
8 and above	118	29.5
Total	**400**	**100**

Source: Questionnaire data (2022)

The findings indicated that the majority had the household family size of 8 and above which has the close relationship with the likelihood of households to not join the

CHF scheme due to having a big burden to the heads of the family to enroll each individual in his household. Msuya *et al.,* (2004) found that a household with many family members were more likely to join the scheme than the small family size. He further suggested that households with less than 5 family members have a great chance to enroll in CHF schemes compared to large size considering that current CHF membership fee is too high.

4.3.2 Socio-economic Factors Affecting CHF Scheme Growth

4.3.2.1 Occupation

Respondents were asked to record their job categories. Out of 400 respondents surveyed, 68 (17%) recorded that they were peasants, 20 (5%) recorded that they were employed (either civil servants or private institutions' workers), 194 (48.5%) recorded that they were entrepreneurs, while 118 (29.5%) recorded that they were jobless.

Table 4.8: Occupation of the respondents

Occupation	Frequency	Percentage (%)
Peasant	68	17
Employed	20	5
Entrepreneur	194	48.5
Jobless	118	29.5
TOTAL	400	100

Source: Questionnaire data (2022)

Most of the respondents were jobless and entrepreneurs while others are peasants. This implies that the level of income is directly proportional to CHF scheme growth, meaning that most people without a reliable source of income could not access health services easily compared to those with reliable income. Those who are employed

could have their health services access through National Health Insurance Funds and other insurance schemes provided for those employed in a private sector.

4.3.2.2 Income Level

Table 4.2.2.2 shows the income levels of respondents at Ilala District Council. It indicates that 185 (46.25%) of respondents were earning less than 30,000/= per month, 125 (31.25%) earned 30,000 to 100,000 while 64 (16%) respondents earned 100,000 to 300,000. The rest 26(6.5%) earned above 300, 000 per month.

Table 4.9: Income levels of respondents

Income levels (Monthly in TShs)	Frequency	Percentage (%)
Less than 30,000	185	46.25
30,000-100,000	125	31.25
100,000-300,000	64	16
More than 300,000	26	6.5
TOTAL	400	100

Source: Questionnaire data (2022)

These results suggest that the majority 310 (77.5%) did not get reasonably good income and one would expect the majorities of the household to have little chance to afford CHF scheme payment. In India it was observed that the main barriers for the subscription of health insurance were low income or uncertainty of income, not adequate knowledge regarding its benefits and do not feel the need (Madhukumar & Gaikwad, 2012).

4.3.3 Socio-cultural Factors Affecting CHF scheme growth

4.3.3.1 Traditional Beliefs

Respondents were asked to indicate the extent to which they believe on traditional

healings. The majority, 178 (44.5%) indicated the highest beliefs on traditional

healing followed by 130 (32.5%) who indicated that they rarely rely on traditional

healing while 92 (23%) indicated to not believe on traditional healing at all.

Table 4.10: Beliefs on traditional healing

Extent of traditional healing beliefs	Frequency	Percentage (%)
Very much	178	44.5
Rarely	130	32.5
Not at all	92	23
TOTAL	400	100

The majority of the respondents mentioned traditional healing to be the most

appropriate way to treat their health implications due to various reasons including

uncaring attitudes of most of the healthcare personnel while others reported that they

have been bewitched hence thinking that traditional healing were the better option.

Some respondents also mentioned commercially available remedies including

"forever living" health products as the alternative medicine to treat their health

problems. A recent study in the Hai district conducted by Hindley (2017) found that

most people with dementia had visited Christian faith healers and traditional healers

for diagnosis and treatments. In rural Tanzania, where most people live far from

health centers often rely on traditional healers to treat their various health problems.

Unfortunately, patients only turn to modern health care services only when

traditional healing treatments fails.

4.4   Regression Analysis on Factors Affecting CHF Scheme Growth

4.4.1 Multicollinearity Test

Before multiple regression was performed multicollinearity, test was carried out.

Multiple regression model normally faces multicollinearity problem for independent

variables. Tolerance and Variance Inflation Factor (VIF) were used for testing multicollinearity in the model (Table 4.3.1). Gujarati (2007) asserted that when the VIF value is less than 5 it indicates no multicollinearity in the model. Since all VIF results of all variables under this study were less than 5, it is concluded that there was no multicollinearity problem.

Table 4.11: Multicollinearity Test

Variables	Tolerance	VIF
Level of education	0.397	2.519
Family size	0.577	1.734
Income level	0.741	1.350
Occupation	0.653	1.532
Beliefs on traditional healings	0.302	3.313

Table 4.12: Regression summary

VARIABLES	B	Std.Error	P.value
Socio-demographic factors	0.178	0.065	0.033
Socio-economic factors	0.250	0.141	0.000
Socio-cultural factors	0.145	0.114	0.061

($R^2 = 0.51$, F = 10.41, P = 0.00)

4.4.2 Multiple Regression Results

Based on the findings in the table 4.3 above, all variables included in the model (Socio-demographic, socio-economic and socio-cultural factors) predicted 51% of variations in community health fund scheme growth (Nagelkerke $R^2 = 0.51$). Therefore, all variables included in the model had significant effects or relationship on community health fund scheme growth.

Furthermore, socio-demographic factors and socio-economic factors had positive significant relationship of community health fund scheme growth (B = 0.178, P =

0.033) and (B = 0.250, P = 0.00) respectively while socio-cultural factors had no significant relationship on community health fund scheme growth (B = 0.145, P = 0.061).

The findings and results from table 4.3 agree with those reported by Stephen (2015) who assumed that affordability of premiums or contributions is a main determinant of membership to any CBHI. The results indicated that people who are richer are more likely to join CHF schemes because they can afford pre-determined premiums. These people who are richer in rural areas are those who engage in multiple occupations like small business/trade owners of small shops, keeping animals as well as farming. In his study, Stephen (2015) revealed that most of rural households and urban households declared that they were not able to pay CHF premiums because of an unstable income. Mushi (2007) found that many people consider the premiums to be too high for them, while others said that lack of money and the premium being too expensive was their first reason for not to joining the CHF. Households that depend on small scale farming, also known as subsistence agriculture, are disadvantaged; they also find it difficult to pay CHF premiums. Msuya *et al.,* (2004) found that a household with many family members were more likely to join the scheme than the small family size. He further suggested that households with more than 5 family members have a great chance to enroll in CHF schemes compared to small size considering that premiums are flat rate, and average contribution becomes less in large families. Similarly, Macha *et al.,* (2014) disclose that a large family size of more than 7 people was the reason for enrolment, other reasons included a male headed household, having completed secondary education and being married. CHF

accept membership of only one wife, the second wife will be considered another household and they have to pay membership premium. This is becoming a big burden to poor families.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1   Conclusion

The general objectives of the study were to assess the factors affecting community health fund (CHF) scheme growth in Ilala district. CHF in Tanzania has several successes and challenges in reaching intended objectives. Some of the success includes; members of CHF do access health care more often, some health facilities improved health care using CHF funds. Some of the challenges are poor households cannot afford annual premiums, limitation on the size of the household's membership, traditional beliefs, quality as well as the majority of the citizens don't have reliable jobs that can enable them to afford paying for CHF membership fee. The contribution and prospect of the CHF in overall health financing is questionable. CHF members are not protected from financial catastrophe and poverty. This is because the population covered is too small, the out-of-pocket expenditure is still very high and CHF does not cover most of the services offered at district and specialized hospitals.

5.2   Recommendations

To improve the performance of the implementation of CHF scheme, the following are recommended:

i)   Households have to be categorized by authorities into strata of different income levels and geographical locations premiums determined according to their ability to pay.

ii) Timings for revenue collection to be designed in such a way to suit the situation of different members for example during harvest, by two equal instalments, or through peer members.

iii) Revenue from alternative sources must be seriously collected from Central or local government.

iv) Social mobilization to be done by specialized people and a relevant department for example the community development to sensitize people on importance health insurance and risk pooling.

v) Improve management of CHF schemes to enhance transparency and accountability.

vi) Community involvement in all stages of CHF implementation to build a sense of ownership and work together with existing community-based solidarity groups.

vii) Integrate all CHF schemes in one pool that will enable the pools to have more funds.

viii) Improve the quality of care provided by public health facilities in rural areas. This can be done by introducing performance-based financing.

ix) Include referral care to the level of consultancy hospitals and fare to the poorest households located in a distant area.

x) Include all facilities in the district in a list of health facilities to be utilized by the CHF beneficiaries

REFERENCES

Abel, S. (1992). Health Insurance in Developing Countries: Lessons from Experience. *Health Policy and Planning*, *7*(3), 215-226.

Appiah, C. J., Aryeetey, G., Agyyepong, I., Spaan E., & Baltussen, R. (2012). Households' perception and their implications for enrolment in the national health insurance scheme in Ghana. *The London School of Hygiene and Tropical Medicine*, *27*, 222-233.

Beraldes, C. & Carreras, L. (2003). Willingness to Pay for Community Health Fund Card in Mtwara Rural District, Tanzania. Mtwara. Retrieved from https://www.semanticscholar.org/paper/ on 24th October, 2022.

Catherine, P. (1998). *An introduction to Health Insurance for Low Income Countries.* London: DFID.

Diop, F. & Ba, A. (2010). Mutual health insurance, scaling-up and the expansion of health insurance in Africa. *Health Systems*, 20:20. Retieved from http://www.healthsystems2020 on 16th October, 2022.

Improved Community Health Funds (2022). (iCHF): Third-party relationships improving health service provision and members' recruitment; A case of the National Health Insurance Fund. Retrieved 1 February 2022, from https://ww1.issa.int/sites/default/files/documents/good-practices/233428-en.pdf

Kamuzora, P. & Gilson, L. (2007). 'Factors influencing implementation of the Community Health Fund in Tanzania', *Health Policy and Planning, 22,* 95–102.

Kibambila, M. (2017). Perception and demand for health insurance services offered under national health insurance fund (NHIF) scheme among civil servants in Tanzania. *Journal of Economic and Sustainable Development. 8*(9), 91- 122.

Macha, J., Kuwawenaruwa, A., Makawia, S. *et al.* (2014). Determinants of community health fund membership in Tanzania: A mixed methods analysis. *BMC Health Serv Res 14,* 538 https://doi.org/10.1186/s12913-014-0538-9

Madhukumar, S., &Gaikwad, V. (2012). Awareness and perception regarding health insurance in Bangalore rural population. *International Journal of Medicine and Public health, 2*(2). 18-22.

Mtei, G., & Mulligan, J. (2007). Community health funds in Tanzania: A literature review. Ifakara Health Research and Development Centre, Ifakara. Morogoro, Tanzania.

Mtei, G., Mulligan, J.A., Ally, M., Palmer, N. and Mills, A. (2007). *An assessment of the health financing system in Tanzani*a. Report on SHIELD Work Package 1. Retrieved on 29th September, 2022 from http://web.uct.ac.za/depts/heu// SHIELD/reports/Tanzania1.pdf.

Mulupi, S., Kirigia, D., &Chuma, J. (2013). Community perception of health insurance and their preferred design features: implications for the design of universal health coverage reforms in Kenya*. BMC Health Service Research, 13,*474. DOI :10.1186/1472-6963-13-474.

Ndomba, T. & Maluka, S. (2019). Uptake of community health fund: Why is Mtwara District lagging behind? *Journal of Global Health Science*, *1*(2). Doi: 10.35500/jghs.2019.1.e50.

Normand, C. & Weber, A. (1994). *Social Health Insurance: A Guidebook for Planning.* Geneva: World Health Organization.

Pope, C. & Mays, N. (1995). Qualitative Research: Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research. *BMJ,* 311(6996), 42-45. Doi: 10.1136/bmj.311.6996.42.

Ramadhani, K. & Stephen, M. (2021). The failure of community-based health insurance schemes in Tanzania: opening the black box of the implementation process. *BMC Health Serv Res* 21, 646. https://doi.org/10.1186/s12913-021-06643-6.

United Republic of Tanzania, (2001). The Community Health Fund act, 2001. Clecky of the National Assembly. Dar es Salaam, Tanzania.

Vogel, R. J. (1990). An Analysis of Three National Health Insurance Proposal in Sub-Saharan Africa. *International Journal of Health Planning and Management*, *5*, 271-285.

Werner, S., Narayanan, D., Durairaj, V. & Bart, C. 2010). *Community Health Insurance and Universal Coverage: Multiple paths, many rivers to cross.* WHO report. Retrievde on 18th September, 2022 from https://www.social-protection.org/gimi/.

Witter, S. & Ensor, T. (1997). *An Introduction to Health Economies for Eastern European and the Former Soviet Union.* Chicester: Wiley and Sons.

Yin, R. K. (2009). *Case study research: Design and methods* (Vol.5). Thousand Oaks, CA: Sage

Yip, W. & Siao, H. (2008). The Chinese health system at a crossroad. *Health Affairs*, *27*(2), 460-468.

APPENDICES

Appendix 1: Questionnaire

Dear respondent,

My name is Khadija Mohamed Kassanga, a student of The Open University of Tanzania. This Questionnaire is administered as part of my research study which is focusing on "Factors affecting community health fund growth in Tanzania. The case of Ilala District". You are kindly asked to spear some few minutes and take part in this study. The participation in this study is voluntary. Therefore, feel free to withdraw if you are uncomfortable. The information collected will solely be used for academic purpose.

Section A: Respondents Demographic Information

1. Gender

    a) Female ( ) b) Male ( )

2. Age

    a) 20 – 29 ( ) b) 30 – 39 ( ) c) 40 – 49 ( ) d) 50 and above ( )

3. Educational background

    a) Non-formal education ( )

    b) Primary education level ( )

    c) Secondary education level ( )

    d) College education ( )

    e) University/Degree level ( )

4. What is your occupation?

    a) Peasant ( )

    b) Pastoralist ( )

    c) Employed ( )

    d) Entrepreneur ( )

    e) Jobless ( )

5. How many are you in the family?

    a) 1- 3 ( )

    b) 4 and above ( )

Section B: Factors affecting CHF scheme growth

1. Are you a CHF member? Yes = 1 ( ) No = 2 ( )
2. If yes, for how long have you been the CHF member? Mention........................
3. If no, why?
4. Have you joined CHF from the time it started? Yes = 1 ( ) No = 2 ( )
5. How many people are covered by CHF in your family?
6. Have you renewed your CHF membership?

   Yes = 1 ( ) No = 2 ( ) Not applicable = 3 ( )
7. Where do you sometimes go when you get ill apart from health care centers?
8. Do you think you can afford to pay for health services at any cost?

   Yes = 1 ( ) No = 2 ( ) Rarely = 3 ( )
9. Do you think at your age you need to have CHF?

   Yes = 1 ( ) No = 2 ( ) don't know =3 ( )
10. Is your family big enough for you to join CHF? Yes = 1 ( ) No = 2 ( ) Not applicable = 3 ( )
11. To what extent do you believe on traditional healing?

    Very much = 1 ( ) rarely = 2 ( ) Not at all = 3 ( )
12. Do you have any comments concerning CHF?

Thank you for your time

Appendix 2: Research Clearance Letter

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Our Ref: PG202000703

Director,   **Date: September 21th, 2022**

Mganga Mkuu

Mnazi Mmoja Hospital
P.O.Box 2541
Dar es Salaam

RE: RESEARCH CLEARANCE

The Open University of Tanzania was established by an Act of Parliament No. 17 of 1992, which became operational on the 1st March 1993 by public notice No.55 in the official Gazette. The Act was however replaced by the Open University of Tanzania Charter of 2005, which became operational on 1st January 2007.In line with the Charter, the Open University of Tanzania mission is to generate and apply knowledge through research.

To facilitate and to simplify research process therefore, the act empowers the Vice Chancellor of the Open University of Tanzania to issue research clearance, on behalf of the Government of Tanzania and Tanzania Commission for Science and Technology, to both its staff and students who are doing research in Tanzania. With this brief background, the purpose of this letter is to introduce to you **Ms.Khadija M. Kassanga, Reg.No: PG202000703** pursuing **Master of Business Administration (MBA).**We hereby grant this clearance to conduct a research titled *"Evaluation of Factors Affecting Community Health Fund Growth in Tanzania.A case of Ilala District".* She will collect her data at your area from 25th, September 2022 to 24th, October 2022.In case you need any further information, kindly do not hesitate to contact the Deputy Vice Chancellor (Academic) of the Open University of Tanzania, P.O.Box 23409, Dar es Salaam.Tel: 022-2-2668820.We lastly thank you in advance for your assumed cooperation and facilitation of this research academic activity.

With kind regards,

Prof. Magreth Bushesha

DIRECTOR OF POSTGRADUATE STUDIES

Appendix 3: Letter of Acceptance

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