FACTORS AFFECTING ENROLMENT OF IMPROVED COMMUNITY HEALTH FUND MEMBERS IN MBARALI DISTRICT COUNCIL

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CERTIFICATION

The undersigned certifies that he has read the whole work and hereby recommends for acceptance by the Open University of Tanzania a dissertation entitled: ***"Factors Affecting Improved Community Health Fund Members in Mbarali District: A Case of Mbarali District Council in Mbeya Region (Tanzania)",*** is partial fulfilment of the requirements for the degree of Master of Arts in Monitoring and Evaluation of the Open University of Tanzania.

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DECLARATION

I, **Anthony Apolinary Mhimbira**, 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 partial fulfillment of the requirement for the Degree of Master of Arts in Monitoring and Evaluation (MAME) of the Open University of Tanzania.

……………………………………

Signature

……………………………………

Date

DEDICATION

To my lovely wife and my beloved two children, as well as my father and my family member, who were without me for the duration of the program. May God continue to bless them in life.

ACKNOWLEDGEMENT

I am grateful for God's tender love and grace, because without Him, I would be without a soul. The progress of this project has been made possible thanks to the support and understanding of a variety of organisations and individuals to whom I am grateful Dr. Hamidu Shungu (My Supervisor) of the Department of at the Open University of Tanzania deserves my sincere appreciation for his insightful remarks, professional assistance, and suggestions. Furthermore, he was a huge supporter of mine and was always there for me when I needed him, providing moral support that was extremely motivating.

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ABSTRACT

The study on Improved Community Health Fund (iCHF) is aimed at looking into the factors affecting low number of iCHF enrolment. This study was guided by three specific objectives. The objectives were: To examine the socio-cultural practices that affect enrolment; To assess the perception of both beneficiaries and non-beneficiaries on affordable health care services and to determine how the national health policy of 2007 affects affecting enrolment Improved Community Health Fund in Mbarali District council. Data collection, presentation, and interpretation were done using both qualitative and quantitative approaches, as well as focus group discussions and in-depth interviews. Purposive sampling was used for in-depth interviews, and basic random sampling was used for social survey and focus group participants. The sample size for social survey respondents was calculated using Yamane's formula and distributed using Wilinkison and Bhandarkar's formula, while respondents for in-depth interviews were purposefully chosen. For qualitative and quantitative data analysis, content analysis and SPSS Version 20 were used, respectively. The study's key findings showed that people's willingness to enrol in iCHF is influenced by their awareness, cultural aspects of life, and policy implementation. Although the group is hesitant to enter iCHF, there is an urgent need for affordable healthcare that is provided by prepayment plans rather than out-of-pocket payments. Enrolment in iCHF is often subject to other factors such as a lack of knowledge about iCHF, insufficient resources in government facilities, the proliferation of alternative healing solutions, and people's perceptions of the prepayment scheme.

Keywords: Enrolment, Community Health Fund and Tanzanian Health Insurance Plan

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LIST OF ABBREVIATIONS

AAR	African Air Rescue
ACCORD	Action for Community Organization
CBHI	Community Based Health Insurance
CHE	Catastrophic Health Expenditure
CHI	Community Health Insurance
CHRCS	Centre for Human Relations and Community Studies
CHSB	Council Health Service Board
FBOs	Faith-Based Organizations
CHF	Community Health Fund
iCHF	Improved Community Health Fund
MEDEX	Medical Excellence
MHISs	Micro-Health Insurance Schemes
MoH	Ministry of Health
MOHSW	Ministry of Health and Social Work
NHI	National Health Insurance
NHIS	National Health Interview Survey
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NHSO	National Health Security Officer
NIHF	National Health Insurance Fund
OOP	Out of Pocket
PMI	Private Medical Insurance
PO-RALG	Regional Administration and Local Government

RSTGA	Rungwe Tea Growers Association
SEWA	Self Employed Women’s Association
SHI	Social Health Insurance
TNICHFs	Tanzania Network of Community Health Funds
UHC	Universal Health Coverage
UMASIDA	Umoja wa Matibabu Sekta Isiyo Rasmi Dar es Salaam (Mural Health Scheme)
URT	United Republic of Tanzania
USA	United States of America
VIBINDO	Vikundi vya Biashara Ndogo Ndogo (Health Insurance Scheme Program)
VSSC	Village Social Services Board
WHC	Ward Health Committee
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Overview

The aim of this study is to investigate the factors affecting enrolment of Improved Community Health Fund (iCHF) members' in the Mbarali District Council. The history of the study, the statement of the problem, the study's objectives, research questions, the study's scope, and the study's significance are all covered in this chapter.

1.2 Background of the Study

Health care funding is a worldwide concern as the world moves closer to universal health coverage (Byrd et al., 2015). Universal health coverage (UHC) has the ability to provide populations with life-saving healthcare Acharya, D. R., Bell, J. S., Simkhada, P., Teijlingen, E.R.V., Regmi, P. R. (2010). The Community Based Health Insurance (CBHI), which is funded by voluntary donations, has been selected as part of a wider solution to the informal sector's healthcare financing problems (White, 2015).

This has piqued the interest of low- and middle-income countries to expand their current health-care coverage to reach their entire populations (Feng, 2016). According to Kutzin, (2016), what remains a mystery is how these countries can effectively shield their populations from the risks of rising health-care costs.

According to Amporfu, E. (2013), the performance of CBHI stems from the state's determination to improve communities' positions in healthcare management and co-

financing. Thailand, Nepal, and Vietnam all have voluntary Social Health Insurance (SHI) programs. Other popular initiatives include private health insurance (PHI), which has been widely introduced in Brazil, Chile, and South Africa (McIntyre, D., 2010).

In Sub-Saharan African countries, universal health coverage through is limited by rural poverty Barasa, E.W, Ayieko, P., Cleary, S. (2012), with the exception of Rwanda, where 85 percent of the population is covered by a collective insurance scheme known as “mutuelles” (Buyene, 2016). In Tanzania, the Community Health Fund (ICHF) was established as part of the Ministry of Health and Social Welfare's effort to make health care more affordable and accessible to the rural population and informal sector. ICHF was founded in 1996 with the aim of improving access to health care for the approximate 85 percent of the population in rural areas who work in the informal sector. In 1998, ICHF was piloted in Igunga District before being extended to nine other districts, including Singida Rural District. The ICHF Act was passed by parliament in 2001, enabling ICHF to be enforced in all districts (Basaza, R., 2002).

The ICHF is a voluntary organization, and each household in the district pays the same amount of fees as decided by the community's beneficiaries, who are then given a health card (URT, 2001). Throughout the year, the card entitles the household to a simple bundle of curative health services. Typically, coverage is limited to the household head and other beneficiaries under the age of eighteen. Households who do not participate in the ICHF program must pay individual user fees at the time of care at the health facilities. Tanzania initiated consumer fees in 1993 as part of broader

health-care funding reforms. Other funding strategies have been added over time, including prepaid insurance-like schemes like the National Health Insurance Fund (NHIF), ICHF, and its urban counterpart, TIKA; and various Micro Health Insurance Schemes (MHIS) like UMASIDA and VIBINDO.

The National Social Security Fund (NSSF) has recently launched the Social Health Insurance Benefit, a health-care benefit plan (SHIB). User fees, ICHF, drug revolving fund (DRF), national health insurance fund (NHIF), and re-enactment of private for-profit health facilities are some of the government's funding options (MOHSW, 2007).

1.3 Statement of the Problem

Following the generally recognized challenges in health funding, community-based health insurance (CBHI) is seen as a step toward universal coverage (Verguet et al., 2015). However, as with ICHF in Tanzania, the CBHI's long-term viability is hindered by uneven enrolment and member dropout (WHO, 2010; Borghi et al., 2013).

The Tanzanian government developed the Community Health Fund (CHF) scheme in 1994 to achieve universal health coverage, piloting it in Magu in 1995 before rolling it out across the country in 1999, (URT, 1999). Several strategies have been devised to boost ICHF members enrolment. Continuous group sensitization and lobbying meetings on the merits of mutual pre-payment, as well as optimizing service delivery at facilities to retain members, are among the strategies.

Despite the initiatives and the perceived advantages of pre-payment to the general public, the iCHF continues to have low enrolment and eventual member dropout.

However, research to enhance comprehension of perceived socio-cultural variables that have a direct effect on enrolment in the system has remained inadequate. This knowledge gap caused this study to be conducted in order to close the gap. As a result, the aim of this study was to look into the factors that affect iCHF enrolment in Mbarali District.

The results of previous studies have focused on assessing the CBHI's success in terms of enrolment patterns, financial management, and long-term viability, all of which are quantifiable (Ekman, 2004; Jakab et al., 2004; Sinha et al., 2006). In countries like South Africa, Ghana, and Rwanda, these studies have adequately informed decision-makers and policymakers on issues related to the health of the population in the informal sector or the disadvantaged. In several developed countries, however, socio-cultural factors have remained indefinite in community-based health insurances (CBHI).

1.4 Research Objectives

1.4.1 General Objective

The main objective of this study was to explore the factors affecting enrolments of I Improved Community Health Fund members in Mbarali District Council.

1.4.2 Specific Objectives

(i) To examine the socio-cultural practices that affect enrolment of Improved Community Health Fund member in the Mbarali District Council

(ii) To assess the perception of both beneficiaries and non-beneficiaries on affordable health care services in Mbarali

(iii) To determine how the national health policy of 2007 affects enrolment of Improved Community Health Fund member in the Mbarali District Council.

1.4.3 Research Questions

(i) How do the socio-cultural practices that affect enrolment of Improved Community Health Fund member in the Mbarali District Council?
(ii) What is the perception of both beneficiaries and non-beneficiaries on affordable health care services in Mbarali District Council?
(iii) How does the current National Health Policy from 2007 affects enrolment of Improved Community Health Fund member in the Mbarali District Council?

1.5 Significance of the Study

The results of this study would demonstrate whether a lack of understanding of socio-economic and technological factors, which are major barriers to accessing quality health care services, has a significant impact on the delayed implementation of the ICHF insurance scheme. The results will raise awareness among ICHF implementers about the rural community's understanding and acceptance of this insurance scheme. Issues facing ICHF will be brought to light for intervention by appropriate authorities, enabling ICHF to achieve its goals as outlined at its inception. The findings of this research can also be used as a source of knowledge for researchers, as well as local governments, NGOs, and government agencies.

1.6 Organization of the Study

The study has been organized in five chapters. **Chapter One:** includes the reason for the researcher's decision to do this research rather than another. The first chapter includes background information about the research's purpose and methodology.

Chapter Two: reveals the literature sources that the researcher used to come up with his research concept. With the goal of fully comprehending the research issue, other people's ideas were included. The goal was to learn what other researchers, readers, organizations, and governments had to say about the issue at hand.

Chapter Three: Methodology part. This section explains the way the research has been conducted. The methods and techniques adopted.

Chapter Four: The findings are presented and discussed in this chapter. To display the similarities and differences of the research findings, instruments such as charts, percent, tables, and figures were used. The results' similarities, differences, and magnitude are discussed.

Chapter Five: The study's summary, conclusion, recommendation, and limitations, as well as research areas that need to be looked at further. The researcher summarizes what was done, observed, and presented, as well as the findings' consequences and policymakers' recommendations. The bibliography and appendices are included in the latter part.

1.7 Scope of the Study

The study was conducted in Mbarali district to assess the factors affecting enrolment of community health fund members. Specifically, the study examined the examine the socio-cultural practices that affect enrolment; To assess the perception of both beneficiaries and non-beneficiaries on affordable health care services; To determine how the national health policy of 2007 affects enrolment in the community health fund.

1.8 Chapter Summary

The context to this study has been provided in this chapter, starting with an introduction and background of the study and statement of the problem overview, followed by general objective, specific objectives, and research questions. The importance of the study, organization of the study and its scope are also discussed in this chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

The term literature review refers to the examination of the findings of other studies that are closely similar to the one being discussed (Bennett, S. and Kelley, A. G. 1998), It connects the research to a broader ongoing debate in the literature on the topic, filling in gaps and building on previous research (Berg, 2001). It also acts as a basis for establishing the study's significance and as a benchmark for comparing the results to those of other studies. The chapter begins with a review of the literature on factors that affecting iCHF enrolment of iCHF members, followed by a description of key terms and principles, a theoretical and empirical review, identification of knowledge gaps, and a chapter summary.

2.1.1 Definition of Key Terms

2.1.2 Enrolment

Individuals apply to become members of a specific scheme through the method of enrolment. Individuals join based on a set of agreed-upon and suitable standards.

2.1.3 Improved Community Health Fund (iCHF)

The improved Community Health Fund (iCHF) is a Tanzania-based voluntary pre-payment program that aims to complement government healthcare efforts by addressing the informal and/or unemployed population. The iCHF is a community-based, voluntary pre-payment scheme developed to allow access to affordable healthcare, according to the NHIF report (2014). According to these concepts, the

iCHF is promoted as a way to reduce government responsibility, thus lowering deficits and increasing productivity in providing access to quality health care, paving the way to universal coverage. For the purposes of this report, the term is used since it defines the essentials of universal healthcare.

2.1.4 Tanzanian Health Insurance Plans

Health insurance programs were launched in Tanzania in 1996 as a new source of funding for health care. The ultimate aim of these initiatives is to close the country's health-care funding and universal-health-care coverage gaps (CHRCS, 2005; MOHSW, 2007; Shaw, 2002; URT, 2001). Tanzania is listed as a low-middle-income region. Tanzania's health insurance policies also have a poor coverage rate. This is shown by data on the coverage of leading schemes in Tanzania, which show that NHIF has insured 7.1 percent of those eligible for those funds, while ICHF has insured 7.9 percent of those eligible for those funds (Humba, 2011).

In Tanzania, there are three types of health insurance schemes: SHI, CBHI, and PHI. In this country, the NHIF is the only SHI scheme. ICHF, VIBINDO, and UMASIDA are CBHI schemes, while AAR, MEDEX, and Strategis are PHIs (MOHSW, 2007; Temba and Leonard, 2013).

In 2001, the NHIF began operations with employees from the central level. Other classes were later included, including city government workers, public institution employees, police, jails, fire departments, and immigration; teachers, retirees, and spiritual leaders. The contribution rate is 6% of the monthly gross wage, with both the

employer and the employee contributing 3% each. Beneficiaries of the National Health Insurance Fund (NHIF) are known as principal beneficiaries and their legal dependents by NHIF identification cards (Humba, 2011; MOHSW, 2007). The NHIF benefits package is extensive and evolving; it currently includes appointment fees, outpatient and inpatient facilities, and pharmaceuticals.

The National Health Insurance Fund (NHIF) has accredited 80 percent of all health facilities in the United Republic of Tanzania, including public, faith-based organizations (FBOs), and private facilities of all levels, as well as pharmacies and accredited drug dispensing outlets (ADDOs) that offer the aforementioned services to their beneficiaries (Humba, 2011; MOHSW, 2007). By the competition among providers and allowing beneficiaries to access services from the best providers, the NHIF was able to increase access to health care services while also improving quality. The presence of few pharmacies and ADDOs, as well as a shortage of medications, supplies, and personnel in rural hospitals, are among the NHIF's problems in terms of access to health care services.

Individual salaried workers or employees of licensed employers are the beneficiaries of private health insurance plans, which are voluntary insurance schemes. AAR, MEDEX, and Strategies are private insurance firms that work in Tanzania. Private insurance providers primarily operate in urban areas and with private health care services. Their advantages are risk-rated, and they obey the equivalence principle rather than the solidarity principle. Beneficiaries are chosen based on an individual's age, gender, and level of risk exposure (MOHSW, 2007).

Micro-health insurance schemes (MHISs) are voluntary schemes for people in the informal sector or groups of common interest. UMASIDA and VIBINDO are examples of successful MHISs in Tanzania. MHIS are set up and run by co-operatives, churches or local communities. They have a support network, the Tanzania Network of Community Health Funds (TNICHFs) which helps them in their set-up, operation, organization and management. Benefits package and contributions are set and agreed by the respective beneficiaries (MOHSW, 2007; Temba and Leonard, 2013).

2.1.5 Community Health Fund (CHF).

CHF is described as a "voluntary community-based financing scheme in which households pay contributions to fund a portion of their basic health-care services in order to supplement government-funded health-care efforts" (URT, 2001). ICHF's objectives, according to CHRCS (2005) and URT (2001), are:

To raise funds from the government in order to provide health care services to the community's beneficiaries; To provide high-quality, low-cost health-care services through a long-term financial model; To strengthen the management of health care services in communities by decentralization, through encouraging communities to make decisions and contribute to issues that affect their health.

CHF was founded in 1996 with the aim of improving access to health care for the approximate 85 percent of the population in rural areas who work in the informal sector. In 1998, CHF was piloted in Igunga District before being extended to nine other districts, including Singida Rural District. The CHF Act was passed by

parliament in 2001, enabling CHF to be enforced in all districts (CHRCS, 2005; Shaw, 2002).

CHF is a district-based scheme whose beneficiaries are households who pay an agreed-upon annual contribution and are given a CHF card that allows them to receive basic curative and preventive health care services from a designated health facility for a period of one year. The CHF scheme established an exemptions and waivers mechanism to ensure that the poorest members of the community who cannot afford to pay a premium may receive health insurance. When community members who are neither disadvantaged nor CHF beneficiaries become ill, they must pay a user fee to receive health care facilities at the health care center (CHRCS, 2005; Sendoro, 2007; Shaw, 2002; URT, 2001).

2.2 Socio-cultural Practices that affect Enrolment

According to Bernard, H.R. (2002), in a well-functioning health care system, health value should always be established around the client, and the growth of value for patients should determine the benefits for all other actors in the system. Because value is cantered on results rather than inputs, value in health care is decided by the outcomes attained rather than the number of services offered, and shifting the emphasis from volume to value is a major difficulty associated to social cultural practice.

While process review and improvement are important, they aren't a substitute for assessing outcomes and costs. Performance is included in value since it is measured in terms of outcomes vs expenses. Cutting costs without taking into account the

outcomes is hazardous and self-defeating, as it can lead to misleading "savings" and potentially impede beneficial therapy.

Study by Guldemont (2001), family involvement in health-related issue as the strongest predictor of child health and educational outcomes. Children's motivation to study, attention, task persistence, receptive vocabulary skills, and low conduct problems were all linked to this component. Family participation in schooling has been found as a positive component in the learning of young children (National Research Council [NRC], 2001; U.S. Department of Education, 2000). According to the findings, it is primarily the job of the family to socialize children in order for them to become useful members of society.

According to Desimone (1999) and Van der Warf, Creamers and Guldemont (2001), parental involvement is not only necessary but it is also one of the most cost-effective means of improving quality in health services. Parental involvement in their children's educational experiences at home (e.g., supervision and monitoring, daily chats about school) has been linked to greater reading and writing achievement scores, as well as higher report card grades (Epstein, 1991; Griffith, 1996; Sui-Chu & Willms, 1996; Keith, 1998).

Girls' engagement and level of achievement in both health and education are heavily influenced by parental attitudes and support. Traditional views about the ideal roles of women and girls in society impact parents' and communities' attitudes the most. Wives and mothers were traditionally the sole roles accessible to women. As a result, women

were viewed as nurturers and primarily as support for males who worked to maintain the family.

Different study by King (1991) parents who are not aware of the benefit of health education are intergenerational, and in fact accumulate over time. Or families may not appreciate the benefits of health education. A country in which the "suitability" of better educated women to be decent brides is questioned. According to the same survey, highly educated women's marital options are limited. When curricula are unrelated to the mother-wife role or contradict the values, they desire to teach their children, parents struggle to see the usefulness of education (King 1991).

These cultural influences range greatly between and within countries, as well as in parental education levels, and hence have an impact on female health enrolment. Families may differ in their priorities for schooling children and their judgments of the propriety of child labor due to parental education and cultural influences (World Bank 2004).

According to Hill and King (1993), and Hyde (1993), African women bear large part of the burden of educating health related matter their children. Their capacity to keep their children in school normally influenced by their own level of health education and resource management. According to the studies, homes led by educated females are more likely to send both girls and boys to school and to keep them there longer than households led by uneducated females or males. This shows that a mother's education has a significant impact on her daughters' school attendance. The mothers may also act as role models for their daughters.

2.3 Perception of both Beneficiaries and Non-Beneficiaries on Affordable Health Care Services

Study in United States of America (USA) as the exceptional because PHIs are the only schemes that are operating in that country (Colombo and Tapay, 2004). The examples of health insurance schemes operating in these countries are Landwirtschaftliche Kranken kassen (LKK) which is SHI in German and Medicare PHI scheme found in USA (Baribault and Cloyd, 1999; Bidgood, 2013; Colombo and Tapay, 2004).

Study by Carrin., (2005) analysed the performance of CBHI schemes in developing countries and came up with the following challenges on accessibility to health care services: Poor health-care services, a lack of complete benefits, a lack of provider choice, rigorous gatekeeping and referral policies, and the presence of co-payments are all factors to consider. Low- and middle-income nations must devise strategies to overcome the issues that have been identified in order to enhance access to health-care services. Furthermore, best practices should be communicated because it has been discovered that the impacts created vary.

Study by Micahel E. Porter (2010) health value perception should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system. Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge. Nor is value measured by the process of care used; process measurement and improvement are important tactics but are no substitutes for measuring outcomes and costs.

Study by Msuya., (2004) observed that CHF perception has raised demand for health care services among beneficiaries in Igunga District. Because they are covered, beneficiaries have sought medical help as necessary. Another conclusion was that CHF protects recipients financially by covering the costs of health care services, which are covered in the benefits package. CHF recipients, on the other hand, have had to pay out of pocket for covered health care treatments that are not available in recognized health facilities, as well as transportation charges. Moreover, income has been found to determine CHF beneficiary membership since an individual is required to pay for premium and extra costs that might arise. This has affected poorest participation in the scheme.

Another study by Mtei and Mulligan (2007) reported perception and low CHF enrolment which is contributed by low income, low user fees, high premium, and poor knowledge on CHF, lack of comprehensive benefits package, poor quality of health services, poor health providers' attitude and broad exemption policy. When it comes to reaching the poor, it's been discovered that they can't afford premiums and that the exemption policy is inadequately applied. As a result, iCHF does not benefit the vast majority of the impoverished. In addition, the study found that management and accountability were lacking due to a lack of understanding and minimal community involvement. Furthermore, there was an increase in access to and usage of services, as well as some improvement in service quality.

However, the quality of treatments supplied to iCHF beneficiaries is jeopardized by a lack of comprehensive benefits package, insufficient medical supplies and equipment at health institutions, insufficiently skilled and motivated health personnel, and a lack

of provider freedom of choice. Low enrolment and a high dropout rate have been determined to jeopardize the iCHF's long-term viability. The two factors have an impact on contribution collection, which is one of iCHF's primary sources of revenue.

2.4 National Health Policy of 2007 affects Enrolment in Improved Community Health Fund

The National Health Policy aims to promote and sustain people's health by lowering disability, illness, and mortality, improving nutrition, and increasing life expectancy. Around 20% of the population lives in cities, with the remaining 80% living in rural areas. The population structure reveals that 46.8% of the population is under the age of 15, 49.1% is between the ages of 15 and 64, and 4.1 percent of the population is 65 years and older. By 1999, the total dependency ratio had risen to around 104. By 2000, the newborn mortality rate is expected to be 99 per 1000, down from 115 per 1000 in 1988. Although fertility rates have remained high, these statistics show that health services have improved. The overall fertility rate is 5.6, whereas the crude birth rate is around 41 per 1,000.

As a result, the Ministry of Health will continue to assist and facilitate the implementation of preventative, promotive, curative, and rehabilitative health services at the council level through the Regional Secretariat. The Ministry of Health will also continue to support worldwide and national special health services and activities.

Primary Health Care has been the cornerstone of Tanzania's National Health Policy since its adoption by the government. In order to ensure the successful delivery of essential health care in the country, the government emphasizes community

involvement and ownership through active participation in problem identification, planning, implementation, monitoring, and evaluation of health care services, as well as empowerment through decentralization of health services to regions, districts, and communities to ensure effective coordination, implementation, and monitoring and evaluation of health care services.

2.5 Theoretical Literature Review

2.5.1 Human Capital Theory

Theories give a firm foundation with supporting theory for explaining, guiding, and predicting the research study and the influence of independence variables on dependent variables. However, the study examined the elements that impact sociocultural practices on health involvement in Mbarali district using the Theory of Human Capital and Socio-Cultural Theories. Schultz's notion of human capital is used to drive this research (1971). Human capital, according to Theodore Schultz, is a measure of an employee's skill set's economic value. This measure is based on the basic production input of labor, which assumes that all labor is equal. Human capital understands that not all labor is created equal, and that investing in people can increase their quality. Employers and the economy as a whole place a value on an employee's health education, experience, and abilities (Schultz, 1971).

According to the hypothesis, an individual endures the expenses of health care (both direct and indirect costs, such as the opportunity cost of accessing health services over time) because he or she expects that this investment will provide a future stream of benefits to him or her (higher productivity and thus higher wages). This fact is supported by a substantial body of literature and research: For example, according to

Psacharopoulos and Patrinos' study (2004), health quality has a significant impact on individual incomes, and health quality also has a significant and robust impact on economic growth, with "really causative links." "The bulk of the variation in earnings dispersion was caused by skill dispersion between sexes," Ersado (2011) concluded after looking at how disparities in the distribution of incomes were affected by the distribution of health care. The importance of human capital theory to this study of girls' accomplishment is that after graduation, the girls will have acquired information and skills that they can employ for productivity.

2.5.3 Socio-Cultural Theories

The second theory that guided this investigation is socio-cultural theory. Social Constructivism Paradigm, Social Learning Theory, and Cognitive Learning Theory are all incorporated into this theory. These theorists are familiar with the methods through which children acquire gender appropriate conduct in the same way they learn in general. Gender Schema theory, for example, focuses on explaining gender development and differentiation, whereas psychoanalytic theory stresses the unconscious processes involved in forming gender identity. Likewise, social Constructivism asserts that gender is best understood through a cultural perspective (Kukla, 2000 & Vygotsky, 1978).

In the constructivist theory of education, social constructivism is one of the three primary schools of thinking. Many educational social constructivism thinkers, such as Kenneth Gergen and John Dewey, have endorsed Lev Vygostsky, a Russian psychologist and philosopher who lived in the 1930s and is best identified with social constructivism theory. He emphasizes the importance of cultural and social

environment in learning and advocates for a learning discovery approach. Social constructivism's primary premise is that knowledge is created via social interaction and is the consequence of social processes. Gergen, (1995).

Reality is generated by a social consensus and is based on social interaction in the social-cultural perspective model. For information to be true, it must conform to social consensus and be useful (Bandura, 1977) School learning, and particularly female academic success, is predicated on what the community already knows about women based on cultural expectations. This idea will assist in explaining how the gender gap in schooling occurs. Teachers, students, parents, and religious leaders' perceptions of clever girls' cultural values, as well as the overall view of community expectations of girls, influence female performance and underperformance.

2.6 Knowledge Gap

The application of social theories has been limited in different research on the factors affecting enrolment in the Community Health Fund. Again, most studies have focused on using quantitative methods of data collection, which has resulted in quantification of the results on the topic under review, leaving the group members' extensive qualitative expertise on iCHF. Furthermore, in my field of study, there has been no recent analysis and documentation on the iCHF. As a result, in order to fill the above gape, this research aims to dig down the perceived factors affecting community health fund insurance enrolments of community health fund members.

2.7 Conceptual Framework

According to Nkechi et al. (2016), perception has emerged as a significant determinant of health-care use. Patients can opt not to use services even though they

are available, so utilization of health services is only a partial representation of successful availability." People's perceptions of available health services, as well as their availability, influence their decision to use them. Assessing factors contributing to their level of satisfaction with the health service, as well as their evaluation of the behaviour of health workers, affect people's attitudes and decisions.

The evolution of the studied phenomenon is best explained by this conceptual structure. A conceptual structure, according to Kombo and Tromp (2006), is an abstract representation of basic concepts and structures that are supposed to interact in real-world settings and experiences to form the basis of a successful research study. There were two types of variables in this study: independent and dependent variables.

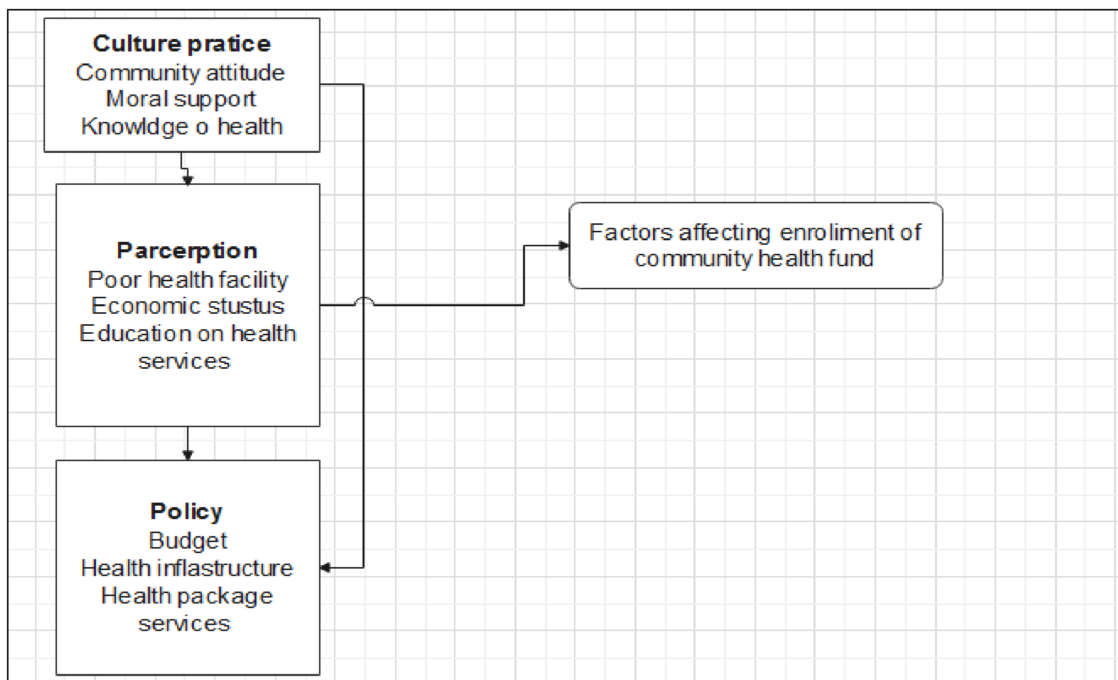

Figure 2.1: Conceptual Framework

The conceptual framework for this study was based on a brief description of a literature review that aimed to explain how technical and social economic aspects as independent variables affect affordable health care services for the rural community,

which is considered as a dependent variable for the current study on Beneficiaries and Non-Beneficiaries' Perceptions on iCHF a. The availability of affordable health care services (dependent variable) is expected to adjust as a result of the independent variables' perceptions.

The research idea has been divided into two sections, which are the causative factors, namely the technical and economic variables, in order to draw relevant conclusions (independent variables). Finance, facilities, information systems, and the technological capability of health workers are the technical variables. Education level, household income, and household size are economic variables. The second aspect of this framework has been labelled as the alleged effects of universal health care on various technological and social economic variables (the effect).

The basic impression of health insurance, as it is for iCHF, is risk sharing and burden bearing, with a good iCHF insurance being viewed as one that helps the rural population to access quality health care services. As shown in Figure 2.1, perception, as one of the important aspects of humans who are among the broad intelligent systems, has been used to differentiate views of iCHF beneficiaries and non-beneficiaries.

2.8 Chapter Summary

This chapter covered the study's key terms and principles, as well as a theoretical and empirical literature review, the knowledge gap and conceptual flamework that this study would fill, and a chapter overview. So far, the next chapter (Chapter III) has dealt with the data collection and analysis methods used in the report.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

According to Kothari (2009), research methodology is a method for solving a research problem in a systematic manner. It explains the different steps that a researcher takes to examine a research issue, as well as the reasoning behind them. Furthermore, research methodology refers to an analysis of the research process in all of its complexities and breadth, as well as the different methods and techniques used in the research process (Kombo, D. and Tromp, D. 2006).

As a consequence, discussing research methodology involves not just discussing research methods, but also considering the reasoning behind the methods used in the context of the research study, as well as explaining why a specific method or procedure is used and why not others, so that research findings can be evaluated by the researcher or others. As a result, research methodology, as described by Kaufman (1944), is the theory of correct scientific decisions. As a consequence, this chapter provides an overview of the study's research nature, venue, sampling procedures and sample size, data collection techniques, data analysis and interpretation, validity and reliability.

3.2 Research Design

The structure for a study that determines how and operation will be carried out to achieve the research objectives, such as determining the information needed, designing the instruments, choosing the sample, and collecting and analysing the data

is known as research design (Robson, 2002). A cross-sectional research design was used in this study.

According to Bordens et al., (2005), a cross-sectional analysis helps the researcher to gather valuable data in a limited amount of time and is more suitable when the participants share a broad variety of common characteristics, such as socio-cultural and socio-economic context. This structure allows for the use of multiple data collection techniques, such as face-to-face interviews and surveys (Walliman, 2011). As a result, the researcher chose to use a cross-sectional design because of its potential for integrating multiple data collection methods.

3.3 Area of Study and Its Characteristics

3.3.1 Selection of the Study Area

The research was carried out in the Mbarali district council in Mbeya Region. The area was chosen because of the district's low enrolment in the Improved Community Health Fund (iCHF), despite the scheme's lengthy implementation period. In addition, unlike other districts, no recent scientific study has been conducted in the field of factors affecting iCHF enrolment. The District Council, once again, is made up of all of the dominant ethnic groups found in all of the Mbeya Region's districts.

As a result, researching the socio-cultural patterns of the District Council citizens can be used to lay the groundwork for increasing enrolment in neighbouring Districts. Three wards have low enrolment, with the largest having the lowest. Three wards having low enrolment, with the largest number of populations in the informal sector were involved in the study (SCSP, 2016-2021). These are Chimala Ward, Itamboleo Ward and Igawa Ward.

3.3.2 Description of the Study Area

3.3.2.1 Location of the Study Area

The Mbeya Region was once part of the Southern Highlands Province. The Southern Highlands Province was divided into two parts, Mbeya and Iringa, in 1963. Mbeya Region was expanded in 1972 to include Sumbawanga District, which had previously been part of the Western Province.

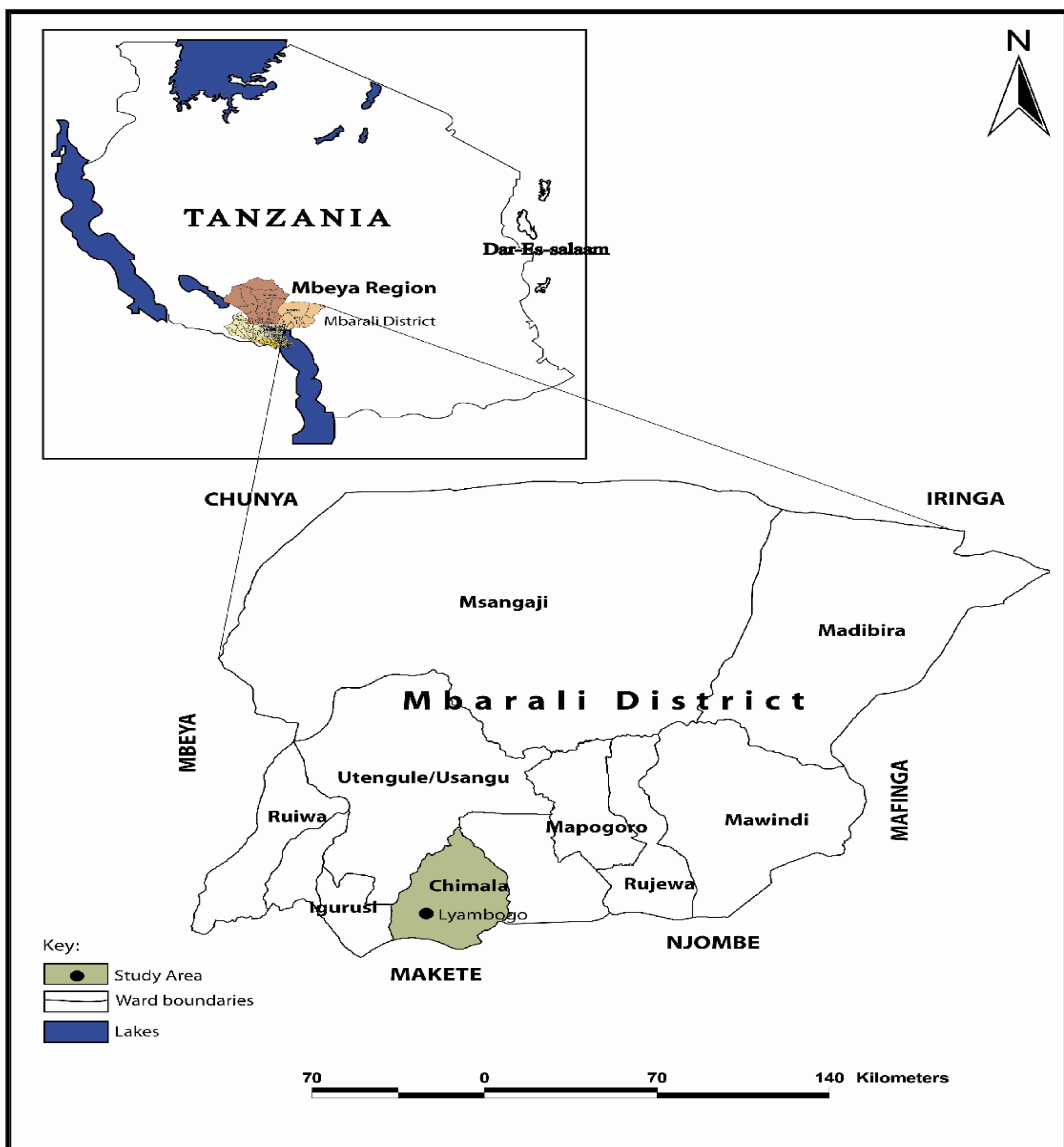

Figure 3.1: A Map of Mbarali District Council

Source: Mbeya Municipal, 2016-2021

Sumbawanga District's inclusion in Mbeya Region, however, did not last long, as the district was divided and granted full regional status in 1974. It is found in Tanzania's Southern Highlands, in the south-western corner.

The area is located between latitudes 7o and 9o 31 degrees south of the Equator, and longitudes 32o and 32o and 35 degrees east of Greenwich. Mbeya shares boundaries with Zambia and Malawi to the south, Rukwa Region to the west, Tabora and Singida Regions to the north, and Iringa Region to the east, with Tunduma and Kasumulu in Mbozi and Kyela districts, respectively, serving as key entries and/or exit points into Malawi and Zambia.

3.3.2.2 Major Economic Activities

Tanzania's Mbeya region is one of the country's major food surplus areas. The region covers 6,362,200 hectares, with 3,960,000 hectares suitable for agriculture and livestock. However, just about a third of the time, just about a quarter of the time. A total of 1,300,000 hectares are cultivated each year for both food and cash crops. Approximately 80% of the population relies on agriculture for their survival. Means of survival Food surpluses (maize, paddy, etc.) are also produced in the area. 350,000 tons of potatoes, pulses, and green vegetables are produced each year. year, which the country, in most cases, exports to other regions such as Dar es Salaam, Dodoma, Singida, and the Lake Regions are all places worth visiting.

3.2.2.3 Major Crops Grown

The major crops cultivated in Mbeya Region include maize, Paddy, Beans, Bananas and Sweet Potatoes, with maize being dominant. Farmers also keep livestock such as cattle, goats and poultry (SMCSP, 2016-2021).

3.3.2.4 Climate

Rainfall is plentiful and consistent in the area. The annual rainfall ranges from 650mm to 850mm. 2600mm in the Usangu Plains and Chunya. Kyela District's northern shores of Lake Nyasa, as well as the Rungwe and Ileje District's highlands and southern portions. The rainy season usually starts in October and lasts until May, with a dry and cold duration between June and September. In most parts of the country, the crop growing season starts in November and lasts until May.

3.3.2.5 Administration

Mbeya Region is divided in seven Administrative districts namely Kyela DC, Busokelo DC, Mbeya rural DC, Chunya DC, Rungwe DC, Mbeya City Jiji, Mbarali DC. However, the official establishment of the seventh district of Mbarali (curved from Mbeya District) is soon to be affected. The districts are further divided into 25 divisions, which are subdivided into 135 wards and 577 villages.

3.3.2.6 Target Population

A population, according to Mugenda et al. (1999), is a group of persons, cases, or artifacts that share certain measurable characteristics. A population, according to Parahoo (2006), is the total number of individuals from which data can be obtained and a researcher can draw a general conclusion. The informal sector/unemployed population in the four-street selected from three wards in Mbarali District served as the study's target population.

3.4 Research Approach

A qualitative method of data analysis was used in this study. The use of a hybrid method aids in the collection of both qualitative and quantitative data, allowing for a

more accurate view of the topic (Kothari, 2004). According to Gay & Airasian (2000), the qualitative are complementary components of empirical and disciplinary investigation rather than adversarial bodies. The qualitative approach, on the other hand, dominated the analysis because the researcher wanted to examine and explain knowledge and socio-cultural behaviours related to the iCHF. A qualitative approach is appropriate for eliciting a person's perceptions as well as additional information about phenotypes.

3.5 Sampling Design

According to Kothari (2004), sampling design is a research strategy that specifies how respondents or sample materials will be selected for the study. It also applies to the procedures for choosing a group of people from a large group of people (Cohen et al, 2000). In both qualitative and quantitative studies, sampling is used to select participants that are best able to provide the researcher with a unique viewpoint and explanations of a situation. The following sampling methods were used by the researcher in this analysis.

3.5.1 Sampling Frame

The sampling frame is a list that contains all of the sampling units from which the sample will be taken (Kothari, 2009). It includes the total number of products in the population. The list of all those working in the informal sector and the unemployed (18 years and older in the study area) obtained from the respective Street Offices served as the sampling frame for this study. The District Medical Officer of Health Office, health services, and the selected street provided the list of main informants.

3.5.2 Sample Size

The study included 105 respondents, with 99 being members from selected wards with 6597 households and 6 being main informants who were classified as follows: 1 Medical Officer, 3 health-care professionals from the study areas' health-care facilities (2 male doctors and 1 female nurse), and 2 community members (1 male and 1 female).

While the sample size for the in-depth interview and focus group, discussion was purposefully chosen from the municipality, population, and survey respondents, the sample size for the social survey respondents was calculated using Yamane's (1967) formula: n =N/ 1 + [N (e*e)] Where N denotes the total population estimate. = Sample size desired; e = standard error (1-10%); 1 = constant Using a population of N = 8270 and an e of 10% (0.01), the estimated sample size is n= 99 Yamane, Taro. (1967).

3.5.3 Sample Size Distribution

Using a formula invented by Wilinkison and Bhandarkar (1979), I = (Pi*n)/p, a proportionate sampling approach was used to allocate the sample size of 99 respondents. (See Table 3.1 for more information.) The number of respondents in each Mtaa was proportioned to its size based on the available population using this process. P = total population; n = total sample size; ni = strata I sample size; Pi = population for strata i

Table 3.1: Sample Size Distribution

Ward name	Number HHs	Number HH surveyed
Chimala	2,199	33.3
Itamboleo	2,300	34.8
Igava	2,098	31.8
Total	**6597**	**99.9**

3.5.4 Sampling Procedure

The method of selecting objects or individuals from a population is referred to as a sampling technique (Orodho and Kombo, 2002). To obtain a sample of 105 respondents for this analysis, researchers used both probability and no-probability sampling methods, specifically simple random and purposive sampling. During the study, the researcher developed a sampling frame consisting of 300 female-headed households and 250 male-headed households, from which a sample of 52 females and 47 males was randomly selected. This sampling frame was derived from a total of 6597 study areas sampled. The aim of creating a separate sampling frame was to get a better idea of what was going on.

Simple random sampling, according to Kothari (2004), is a method of selecting subjects in which every member of the population has an equal chance of being chosen. To obtain the 99 respondents, the lottery method was used to randomly pick them from the constructed sampling frame. Each household was given a unique number on a piece of paper and put in a box, which was then thoroughly mixed. The analysis included any household whose number was chosen.

Purposive sampling was used to pick 6 primary informants once more. These are members of the community of interest who are observant and thoughtful, know a lot about the subject, and are both capable and willing to share their knowledge (Bernard, 2002). Purposive sampling, according to Kothari (2004), is ideal when the universe is small and a known feature of it needs to be examined in detail. As a result, key informants were chosen for this research based on their knowledge, experience, and expertise in the study area and topic.

3.6 Data Sources and Collection Methods

The process of collecting information/ data, which can be qualitative or quantitative, is known as data collection (Jupp, 2006). This research used both primary and secondary data sources in the data collection process. Respondents provided primary data, while secondary data was gathered from a variety of sources, including books, reports, and the internet. The use of several approaches allows data to be triangulated and helps to prevent bias, which can skew the overall image of truth that the researcher is examining (Cohen et al., 2000). As a result, data was collected through interviews, surveys, and focus group discussions.

3.6.1 Primary Data Collection

Primary data are those that are collected for the first time and are thus unique in nature (Kothari, 2004). Primary data, according to Dodge (2003), is knowledge gathered directly from first-hand (original) experience. The interview was conducted using a check list, and the social survey was conducted using questionnaires.

3.6.1.1 Social Survey

For data collection, the study used a social survey, in which questionnaires of both closed and open-ended questions were distributed to 99 households. Surveys are appropriate for studies with a large sample size and a large geographic region, but they are relatively inexpensive (Kothari, 2002). According to McNabb (2002), survey findings are both accurate and reflective of a much broader population if they are well coordinated. After obtaining informed consent from respondents, the researcher administered questionnaires to the households in this sample, which were written in

Swahili to reduce the chance of misunderstanding. The questionnaire was subjected to pre-testing.

3.6.1.2 In-Depth Interviews

A process consisting of conversation or verbal answers between two or more people is referred to as an in-depth interview (Mugenda et al, 1999). According to Kothari (2004), this approach includes the researcher asking oral questions and engaging with the respondents face-to-face. The in-depth interview was perfect for capturing rich and accurate information from respondents on the topic under review because the study required comprehensive information about the perceived factors affecting enrolment in iCHF. The discussion was supported by the use of a checklist. As a result, six separate people, including one Municipal official, were interviewed in detail.

The main informants who were selected for interviews were contacted by phone and a physical visit to the locations where they were available. The interviewees were told about the study's goal and the type of information the researcher needed from them before the interview, and they were encouraged to allow audio recording because it was difficult to listen and write all on the spot. The interviewees were also told that the interview would last approximately twenty to thirty minutes and were asked whether they had any scheduling conflicts. During the interview, the researcher spoke with each informant at a health facility for twenty minutes and the influencer for thirty minutes.

3.6.2 Focus Group Discussion

A focus group discussion (FGD), according to McNabb (2002), is a researcher's own coordinated group of resource persons aimed at discussing topics of interest to the

researcher through which he or she is capable of assembling the necessary data. For this approach, a discussion guide was used as a data collection tool. Four focus groups with a total of eight participants were held in the study's street locations: Ndilima Litembo, Londoni, Mletele, and Subira Kati. All four focus groups were held in May of 2021. Three focus groups were held on the grounds of the primary school, and one was held under a mango tree, with the aim of limiting the participants' independence in the event that the public was informed.

The focus group was used to harmonize the meanings provided in questionnaires that were vague or difficult to interpret. The aim of the focus group was to see if the answers to the open and closed ended questions were shared by the majority of people. As a result, the data gathered through focus group discussions replaced the data gathered through questionnaires.

3.6.3 Secondary Data Collection Methods

The secondary data were collected from journals, articles, from other people’s work, which were relevant to the research at hand (Kombo et al., 2006), (Kombo et al., 2006). The form of data was useful primarily when a study on how the health policy affects enrolment and implementation of the iCHF was completed.

3.6.3.1 Documentary Review

Documentary review, according to Kothari (2004), is the process of reading documentary materials such as books, magazines, newspapers, and the contents of all other verbal materials that can be spoken or printed. A review of iCHF documents

from important sources such as the Library, National Health Insurance Fund (NHIF) National Health Policy, journals, internet and annual Council Health Reports was conducted for this study. These documents extensive information on enrolment, procedures, and the Community Health Fund's policy and legal structure. However, this was a continuous phase that enriched and solidified the results.

3.7 Data Reliability and Validity

3.7.1 Reliability of the Data

The degree to which repeated measurements under similar conditions produce the same results is referred to as reliability (Roger, 1999). It implies that when a research instrument is used at different times in the same study field, it should produce the same results. The researcher pre-tested the questionnaire and other data collection instruments, as well as qualified research assistants, to ensure the research data's reliability.

3.7.2 Validity of the Data

Validity refers to a research instrument's ability to quantify what it's supposed to measure and have generalized research results (Kothari, 2004). Validity, according to Kumar (2005), is the degree to which an empirical measure accurately represents the true sense of the concepts being studied. The researcher used research assistants from the local community within the study area to ensure data validity by explicitly explaining the study's goal to the respondents. This helped to establish confidence with the respondents, allowing them to provide relevant information while being assured of the researcher's confidentiality.

3.8 Ethical Considerations

Before collecting data, the researcher obtained permission from all relevant authorities in the research sites in question. To begin, permission was obtained from the Open University of Tanzania, which issued a letter authorizing the researcher to conduct the research, which was then presented to the authorities in the study area. The participants were invited to engage in the study willingly and were assured of confidentiality. Furthermore, the researcher followed all human rights laws and regulations, ensuring that the respondents' privacy and security were not violated.

3.9 Data Analysis Procedures

Editing, coding, classification, and tabulation of collected data are also part of data processing (Kothari, 2004). Content analysis was used to interpret qualitative data in this study, which entailed coding and classifying data, as well as categorizing and indexing it. The primary objective of content analysis was to make sense of the information gathered and to highlight the most relevant messages, attributes, and conclusions from the respondents.

The qualitative data from the interview and focus group was analysed and presented using content analysis. The quantitative data was analysed with SPSS version 20 to produce frequencies, percentages, tables, and graphs, and a chi-square test was used to determine the results.

3.10 Chapter Summary

The methodology used in the analysis has been mentioned in this chapter. It explicitly covers the study's research nature, study venue, sampling procedures and sample size,

data collection methods, data analysis and interpretation, research validity and reliability, and ethical concerns. Eventually, it includes a brief overview of each chapter. The following chapter (Chapter IV) provides a summary of data presentation as well as a brief discussion of the research findings.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

The findings, analysis, and discussion of the factors affecting improved Community Health Fund enrolment are presented in this chapter. The research was carried out in the Mbarali District Council in Mbeya region. The findings are based on a field study that included 99 participants. The study included three wards, namely Chimala, Itombelo, and Igawa, with respondents ranging in age from 18 to over 60 years old and five (5) key informants, four (1 Medical Officer, two male clinicians, and one female nurse) from the District Council and two (1 male and one female) from the community member

4.2 Characteristics of the Respondents

This section looked at the respondents' biographical information as well as the patterns of relationships within their families. The features of the respondents are critical tools for acquiring insight and knowledge of the respondents' attitudes about the topic under investigation.

4.2.1 Age of the Respondents

The age of the respondents is an important demographic factor in any study since it provides insight into the dependability of the data collected and presented for public consumption. Each age group's (cohort) respondents were meticulously gathered without bias, resulting in each age group's (cohort) own distinct subculture. As a result, the knowledge provided by such groups reflects the social meanings they

ascribe to certain events. The age distribution of the respondents in this study was divided into seven groups, with 18-25 years accounting for 12 percent of all respondents, 26-33 years for 23 percent, 34-41 years for 18 percent, 42-49 years for 15 percent, 50-57 years for 24 percent, 58-65 years for 6 percent, and 66 years and above for 2 percent (2 percent).

Table 4.1: The Age Distribution of the Respondents

Responses	Frequency	Percent
18-25	12	12
26-33	23	23
34-41	18	18
42-49	15	15
50-57	24	24
58-65	5	5
66 +	2	2
Total	**99**	**100**

Source: Field Data Survey, 20121

In order to extract meaningful and reliable information on factors affecting enrolment in the iCHF. The study took into account the existence of all age groups above 18 years old. More respondents in this study were between the ages of 42 and 49, and they were between the ages of 19 and 25 in 1998, when CHF was created, making them eligible members of the program.

The rationale for the higher number of responses in this group was due to socio-cultural factors such as the fact that more people at that age are autonomous and mature enough to choose their own path in life (Tyler, 2002). These are also the

people who are directly involved in the administration of society as home heads, Street (village) leaders, and religious leaders, therefore health insurance is intended for their lives.

4.2.2 Sex of the Respondents

This study involved both male and female respondents and this was done purposefully because both categories have roles either in decision making or economic position in the household. Findings from the fieldwork survey as indicated in Table 4.2 elucidate that out of 99 respondents, 38 respondents (38%) were males, while 62 respondents (6 %) were females.

Table 4.2: Sex of the Respondent

Responses	Frequency	Percent
Male	38	38
Female	61	62
Total	**99**	**100**

Source: Field Data Survey, 20121

The disparity between male and female respondents, on the other hand, was attributed to equal participation by both sexes in the study. In low and middle-income countries, such as New Zealand in 2013, females outnumbered males in all age categories, resulting in males and females making up 48.7% and 51.3 percent of the population, respectively (Zealand, 2013). The respondent's gender is an important feature since it allowed the researcher to categories males and females' knowledge and power relations in household decision-making. Males and females are socialized differently in Mbeya's ethnic groups, as they are in many other African cultures.

According to statistics, the respondent's gender plays a considerable effect in household decision-making. A chi-test was used to prove this, with the findings indicating that when chi-square= 67.254, p=0.000, there is a strong statistically significant relationship between the respondent's sex and the power to make decisions in the household. The significance value must be 0.05 or less for the findings to be statistically significant. Because the correlation between the two variables is statistically significant at 0.0000.05, the researcher can conclude that the relationship between variables is statistically significant.

4.2.3 Level of Education of the Respondents

Education has a significant impact on an individual's thinking, judgment, interpersonal interactions, as well as the ability to make decisions in daily life. Figure 4.1 shows that approximately 8% of respondents had never attended school, 78 percent had received primary education, 14 percent had received secondary education.

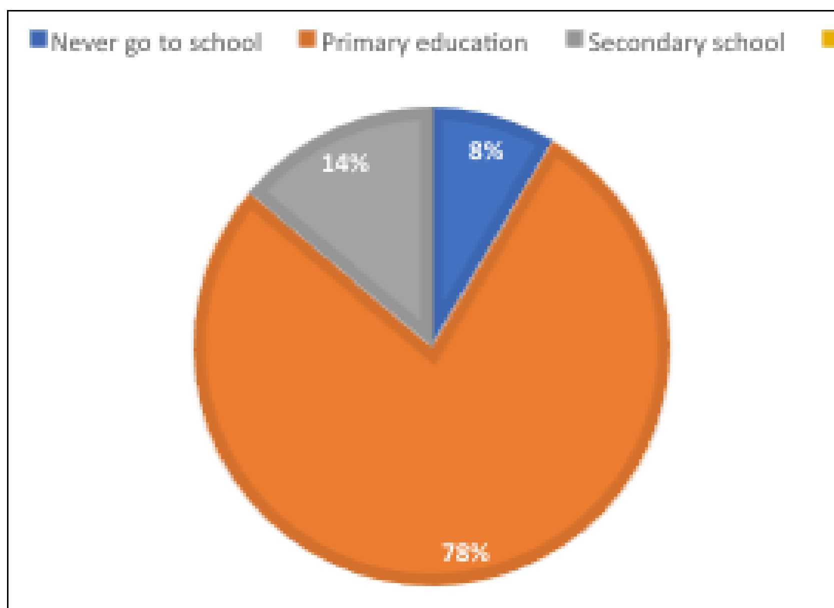

Figure 4.1: Level of Education of the Respondents

Source: Field Data Survey, (2021)

Understanding respondents' educational levels aided in determining their level of knowledge about the topic under investigation.

4.2.4 Occupation of the Respondents

Occupation refers to the sort of labor done by an individual in a certain job, regardless of the economic activity branch. According to Farooq and Ofosu (1992), the type of occupation is determined by the sensitivity of persons in society, which is primarily concerned with making money on a daily or monthly basis.

Table 4.3: Occupation of the Respondents

Responses	Frequency	Percent
Peasant	63	64
Self employed	15	15
Other	21	21
Total	**99**	**100**

Source: Field Data Survey, 2021

Table 4.3 shows that 64 percent of the 99 respondents were peasants, 15 percent were self-employed, 21 percent were working in other fields, and none were formally employed. Those who were fully involved in the cultivation and sale of crops as a means of subsistence were classified as peasants. Agriculture is the backbone for the majority of people in the research region, as seen by the large number of respondents who are involved in agricultural production.

This position is comparable to that of most South Asian indigenous peoples, who grow rice as a staple agricultural product while also lifting people out of poverty and food insecurity (Bishwajit et al., 2013). This variable assisted the researcher in

determining levels of choice making among the youngsters and their ability to pay for health care because occupation influences decision making, confidence, and self-independence.

4.2.5 Marital Status of the Respondents

Marital status of the respondents was investigated because it contributes to an understanding of the nature of the responses given. As demonstrated in the Table 4.4, 19(19%) respondents were single, 60(61%) respondents were married, 5(5%) respondents were divorced, and 15(15%) respondents were widows/widowers.

Table 4.4: Marital Status of the Respondents

Responses	Frequency	Percent
Single	19	19
Married	60	61
Divorced	5	5
Widow/widower	15	15
Total	**99**	**100.0**

Source: Field Data Survey, 2021

Furthermore, because health is a human issue, it was critical to make use of the respondents' appropriate knowledge of their marital status. Thus, whether or not you are married can affect your freedom of choice and power to choose a particular path in life (Carlsson, He, Martinsson, Qin, & Sutter, 2012).

Out of the 99 people who responded, 60 were married and 19 were single. As a result, married folks made up 61 percent of those who filled out the surveys. The research area's location in the municipality's periphery, where peasant’s production is

predominant and family is the source of labor, was ascribed to the higher number of married people. As a result, knowing the respondents' marital status was an important variable since it allowed the researcher to establish the extent of relationships and influence in the household decision-making process.

4.3 The Perception of both Beneficiaries and Non-Beneficiaries on Affordable Health Care Services

The Improved Community Health Fund (iCHF) has the ability to provide life-saving healthcare to Tanzanians, particularly those working in the informal sector. Because of the population's potential for iCHF, the researcher felt compelled to investigate community knowledge among Mbarali people. Their responses are featured in the next section.

4.3.1 Understanding of iCHF

Implementation of iCHF in Tanzania has faced several hurdles including issues of awareness and understanding. In this study, respondents were asked to reveal their understanding about iCHF. Field findings indicated that 70(71%) respondents were sure and had a clear understanding on the iCHF that it is a prepayment scheme, 4(4%) respondents were not sure about iCHF, 26(26%) respondents could not give any answer or what they knew about ICHF. Figure 4.2 condenses the study findings.

According to the findings, a considerable majority of the respondents, almost 71%, had sufficient and appropriate knowledge on the subject under investigation. Similarly, these findings are consistent with Marwa (2009)'s findings in Magu

District, where the majority of respondents were found to be unaware of the subject matter, resulting in a CHF enrolment rate.

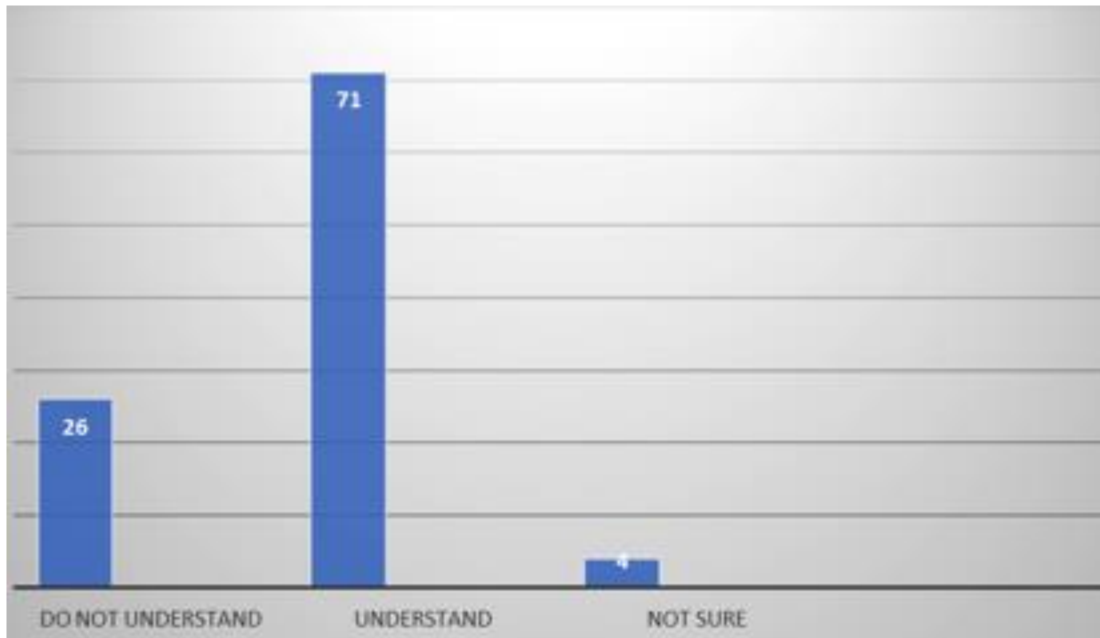

Figure 4.2: Understanding of ICHF

Source: Field Data Survey, 2021

The excerpt above demonstrates that community (26%) members had a no clear idea of what iCHF was, relying on a kind of created reality based on what was conveyed in the community, vertically or horizontally, depending on their experience with various stigmas associated with impoverished households. The researcher is confident that a thorough understanding is critical to increasing enrolment in the program. This is due to the fact that iCHF is a public voluntary prepayment in all contexts, including all classes of individuals as long as they are not covered by other health insurance plans.

4.3.2 Community Acquisition of iCHF Information in Mbarali DC

According to Figure 4.3, roughly 34 percent of respondents said they learned about iCHF through the health facilities in-charges, 24 percent said they learned about iCHF

in a public gathering, and 14 percent said they learned about iCHF through friends. Again, 25 percentage of respondents were informed via radio/TV 3 percentage respondents claimed to have received information from other means (newspaper). According to the research, health facility in-charges were the most common source of information, followed by public meetings and friends.

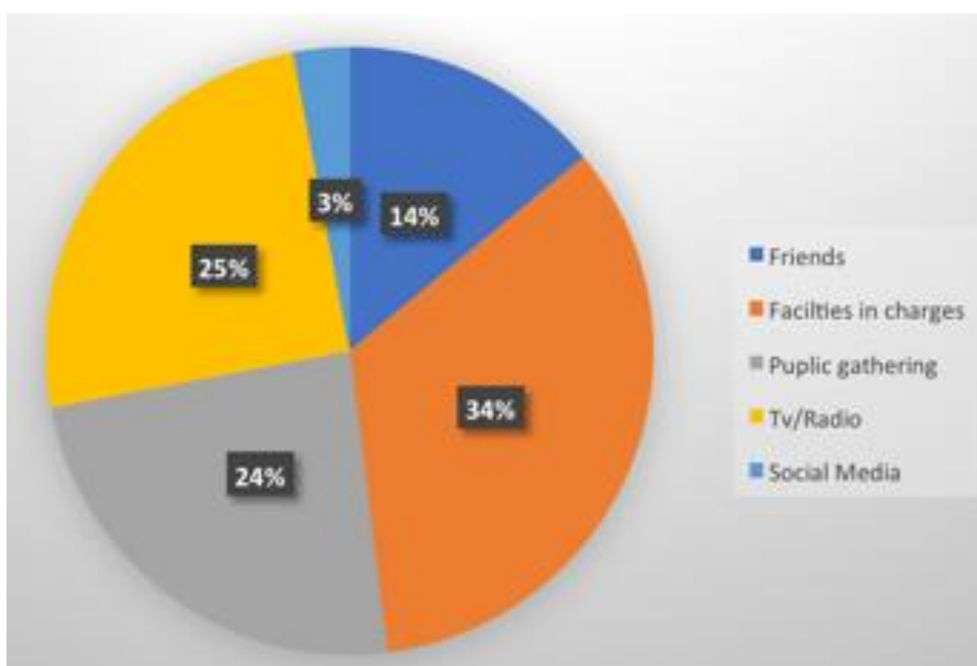

Figure 4.3: Community Acquisition of iCHF Information

Source: Field Data Survey, 2021

Service providers, on the other hand, reported to have been delivering education to community members while they were visiting their health facilities, despite having limited time to speak about the iCHF due to patient wait times.

During the interview, one of the in-charges of a health center said:

> *"We've been told to encourage our clients to join the iCHF, but there's no time set out for it." What I do is spend a few minutes while attending to the client to educate them on iCHF; at the same time, customers who are outside frequently begin to complain about the delay in receiving medical care."*

The findings of this study corroborate those of Marwa, (2009), who found that health staff, village leaders, and posters were the most common sources of CHF information in Magu District.

4.3.3 Frequency of Attending Health Facility for Medication

Table 4.5 shows that 69 (71 percent) of respondents visited the health facility regularly, 28 (28 percent) of respondents visited the health facility only occasionally, and only 2 (2%) of respondents did not visit the health institution for treatment. Nonetheless, the majority of those who said they went to the health facility on a regular basis said the government facilities were their favorites since they were less expensive than private facilities. Again, government facilities are scattered across the city, close to where the majority of the people live.

Table 4.5: Frequency of Attending Health Facility for Medication

Responses	Frequency	Percent
Frequently	69	71
Rarely	28	28
Do not attend at all	2	2
Total	**99**	**100**

Source: Field Data Survey, 2021

According to the findings of the study, the majority of the community members were reliant on health facilities for survival. As a result, providing the community with accurate information about iCHF can help to increase membership.

4.4 Socio-Cultural Practices Influence on Enrolment into iCHF

In a certain social environment, socio-cultural practices are essential parts of human life. Examining the impact of socio-cultural practices on iCHF enrollment is thus an

exploration of the particular human being, who is both a social and biological creature. As a result, individual health is affected by the social context in which socialization occurs, which is influenced by a variety of factors. This is what prompted the researcher to look into the impact of socio-cultural behaviors on iCHF enrollment in the study area. The information was summarized using tables and figures.

4.4.1 Respondents' Attitudes towards Service Delivery

Figure 4.4 shows that 10% of respondents said the services offered were fair, 3% said they were good, 35% said they were bad, and 52% said they were poor.

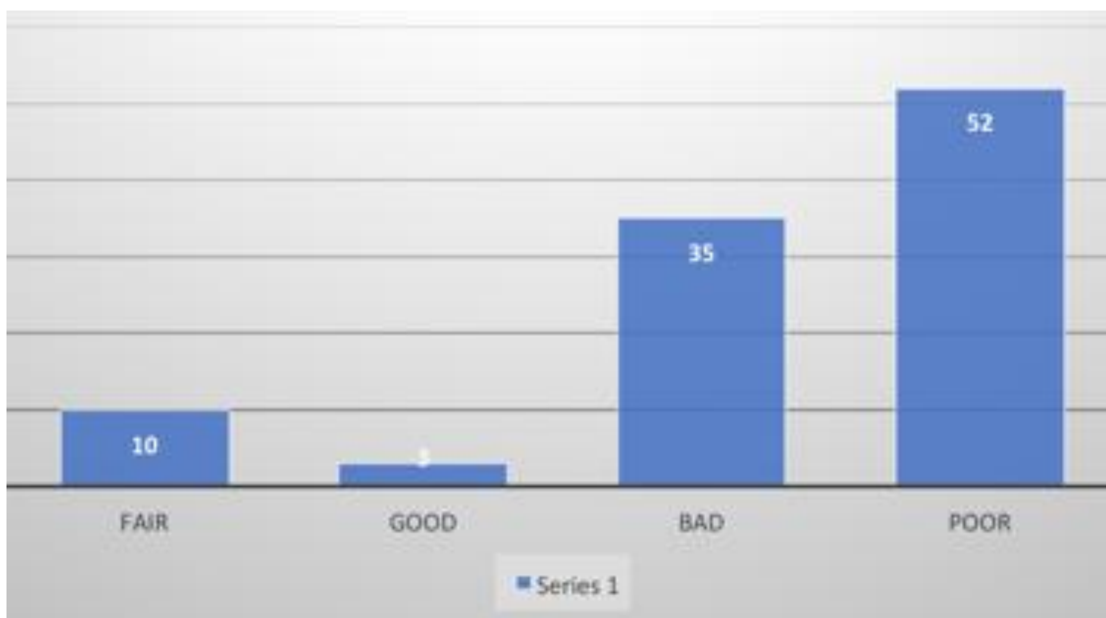

Figure 4.4: Respondents' Attitudes towards Service Delivery

Source: Field Data Survey, 2021

This study's findings are comparable to those of Beraldes and Carreras (2003) and Marwa (2003). (2009). These studies also revealed a variety of service gaps that CHF may fill. Members in Mtwara rural, for example, were willing to enlist but were put off by the poor level of service provided (Beraldes and Carreras, 2003)

4.4.2 Options to Alternative Healing

According to Table 4.6, around 75 percent (76 percent) of respondents indicated they chose alternative healing for medication and therapy, whereas 24 percent (24 percent) indicated they did not choose alternative healing other than hospitals. People were depending heavily on traditional healing due to insufficient medical care in public health facilities, according to the report. Such data show that community members' inclination to join iCHF is impacted to some extent by their beliefs, which require them to rely on conventional treatment and conventional therapies.

Table 4.6: Options to Alternative Healing

Responses	Frequency	Percent
Yes	75	76
No	24	24
Total	**99**	**100**

Source: Field Data Survey, 2021

4.4.3 Respondents' Opinion/Perception towards Prepayment System

As shown in Table 4.7, about 45(46%) respondents acknowledged that prepayment was very important but suggested for service improvement, 14(14%) respondents revealed that prepayment system is not desired as it may cause burden of diseases to the household, 32(32%) Respondents expressed concern about losing money if no one in their homes became ill throughout the year, while 8% of respondents were undecided about whether prepayment was good or not.

The findings of the study show that people's perceptions of the occurrence can readily influence their decision to enroll in iCHF. It also shows that the majority of

respondents were dissatisfied with the service offered, with even those who were enrolled suggesting ways to enhance the service.

These views, on the other hand, prevented people from enrolling in prepayment plans. These data support Bonu. (2003)'s claim that low enrolment rates in many CHF may be linked to persons' understanding of paying before being sick and the reflection of healthcare quality. As a result, those who join the scheme early on may drop out fast and pass on their knowledge of the phenomena to others.

Table 4.7: Respondents' Opinion/Perception towards Prepayment System

Responses	Frequency	Percent
Very important but services be improved	45	46
Not desired, may cause burdens	14	14
Worry of getting loss if not fallen sick	32	32
Not sure	8	8
Total	**99**	**100**

Source: Field Data Survey, 2021

4.5 Health Policy Influence on Enrolment into CHF in Mbarali DC

Tanzanian residents' access to affordable healthcare is under the jurisdiction and direction of the Ministry of Health, which is regulated by the National Health Policy. Explicitly, health policy is designed to lay out priorities and the expected roles of various players, as well as inform and establish consensus and estimate the resources needed to fulfill goals and priorities (WHO, 2010). With this viewpoint, the researcher was motivated to investigate how policy implementation influenced iCHF enrolment, the results of which are provided in Tables and figures.

4.5.1 Respondents' Knowledge on iCHF Management

The majority of those polled did not know who was in charge of the iCHF's day-to-day operations, according to the findings. Only 10 (10%) respondents said iCHF management was under the control of the health facility committee, while 14 (9%) said they didn't know, 35 (20%) said the government was in charge, and 40 (65%) said the health facility in-charge was in charge of iCHF management. This information is summarized in Table 4.8.

Table 4.8: Respondents' Knowledge on iCHF Management

Responses	Frequency	Percent
Do not know	10	10
Health facility in-charge	40	40
Health facility committee	14	14
The government	35	36
Total	**99**	**100**

Source: Field Data Survey, 2021

This suggests that the directives in the National Health Policy (2007) were not well understood by community members who were meant to benefit from health services while also participating in prepayment schemes. Such findings may imply that mobilizing people to be members of a program that is not clearly defined and known to them is nearly impossible. These findings, however, are in line with Macha et al. (2012)'s proposal for sensitizing the community to better understand the management chain and the benefits of voluntary schemes in order to promote a sense of ownership and responsibility.

4.5.2 Community Opportunities to Participate in the iCHF Implementation

The field results show that only 32 (32 %) respondents had the opportunity to participate in the implementation of the iCHF through election of community representatives to the health facility governing committee and providing feedback to service providers during public meetings and 67(68) do not participate as shown in figure percent of respondents claimed they didn't get a chance to participate in the implementation, claiming that health providers already knew what patients needed and planned accordingly.

That's in contrast to global health strategies, ranging from the 1978 Alma Ata Declaration's primary care (PHC) approach (Wass, 2000) to the more recent focus on health in many of the Millennium Development Goals (MDG), which emphasizes community involvement in health financing through maximum community participation in primary health care organization.

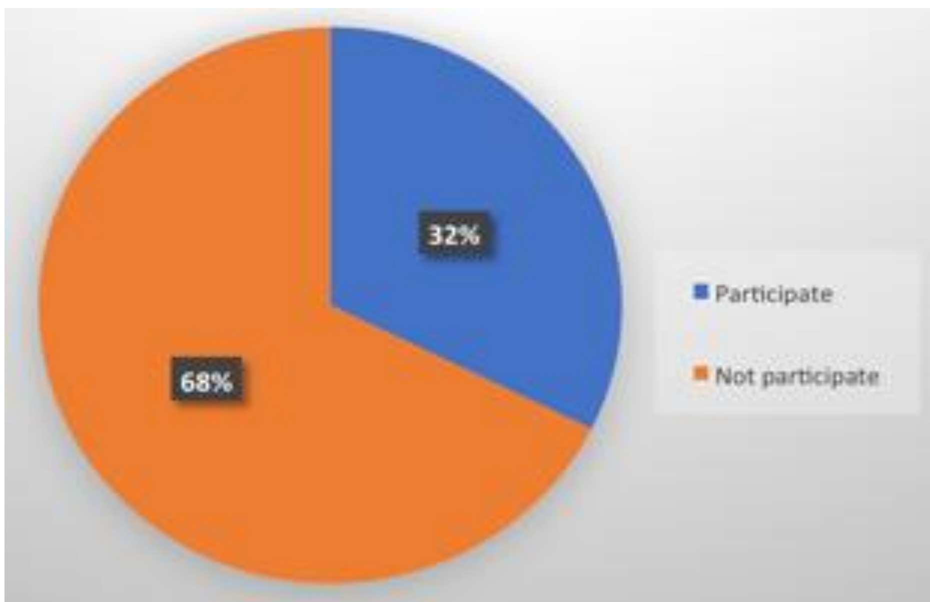

Figure 4.5: Community Opportunities to Participate in the iCHF Implementation

Source: Field Data Survey, 20121

According to Buyene (2016), community involvement in healthcare funding has the potential to increase program acceptance and sustainability, including voluntary and co-funding for health. At the same time, if you're well-versed in health finance, you'll find that managing community financing arrangements is a breeze.

4.5.3 Respondents' Awareness on Service Packages Covered By iCHF

Table 4.9 shows the respondents' awareness of iCHF's healthcare packages and perks, revealing that. 47(47%) respondents were unsure what services were covered by iCHF, 52(53%) respondents claimed that iCHF covered all services dependent on the client's needs. People who are unaware of the benefits offered by the programme are likely to have a restricted possibility of joining, according to the study's findings.

Table 4.9: Respondents' Awareness on Service Packages Covered by iCHF

Responses	Frequency	Percentage
Not sure	47	47
I think all services	52	53
Total	**99**	**100**

Source: Field Data Survey, 2021

4.6 Chapter Summary

The display, analysis, and discussion of data were the topics of this chapter. The majority of community members are unfamiliar with the subject, but are aware that it is useful during times of uncertainty, according to the findings of the investigation. The in-charges of the health institutions were depicted as the primary source of information on the subject, which is only available to individuals who visit the health institutions.

Similarly, community members are especially sensitive to judgmental or pushy attitudes about what they receive, which makes them hesitant to participate in the program. Statistical significance tests of selected variables in the chapter. The next chapter (Chapter V) presents summary of the study, conclusion and recommendations.

CHAPTER FIVE

CONCLUSION AND RECOMEMNDATIONS

5.1 Introduction

Following the discussion in the previous chapter (chapter four), this chapter gives the study's conclusion and suggestions based on what was discussed in chapter four. The chapter concludes with a suggestion for future research.

5.2 Summary of the Findings

The Improved Community Health Fund (iCHF) is considered as beneficial to the majority of uninsured people, particularly those who are struggling financially. However, the majority of community members are unaware of the iCHF and are unable to explain what it means, but they are aware that it aids in times of uncertainty. Health facility in-charges, on the other hand, were mentioned as the primary sources of information about the iCHF, whereas the scheme management, which was intended to be the driving force behind getting individuals to join the iCHF, lagged behind.

5.2.1 Socio-cultural Practices that affect Enrolment In Community Health Fund

The study found that poor service delivery, a lack of referral system, a lack of knowledge about the iCHF, a negative perception of prepayment, and the availability of other healing options, primarily alternative healing, where all reasons why people were not interested in enrolling in the iCHF. Community members were not active in management and implementation once again, indicating that they were unaware that they were a part of the administration of primary healthcare and its related financial

mechanisms While everyone has the freedom to express their thoughts, especially in healthcare, the majority of respondents said they were afraid to confront health practitioners about the flaws they saw for fear of offending them. Furthermore, community members were acutely aware of any judgmental or dominating attitude toward the services they were receiving. As a result of their attitude and judgment, they were hesitant to join the plan and even share with other members, who were also hesitant.

5.2.2 The Perception of both Beneficiaries and Non-beneficiaries on Affordable Health Care Services

This study sought to establish the perception of beneficiaries and non-beneficiaries on iCHF as a sustainable family health insurance scheme in Mbarali District. Specifically, the study aimed to assess the perceptions on iCHF scheme and investigate its sustainability in Mbarali District. In order to draw valid inference, the study research case was to examine the influence of Technical and Demographic/Socio economic variables (Independent variables) on access to affordable health care services under iCHF insurance scheme.

An assessment on individuals' perceptions has shown that despite the delayed implementation of iCHF in Mbarali District a large number of the beneficiaries of iCHF are positive to implementation and sustainability of iCHF scheme. The findings reveal that this is mainly through facilitation of improved finance for procurement and supplies of medical packages, tools and equipment, improvement of infrastructures for provision of quality services, information system and technical capacity of workers in

provision of efficient health services, which are in line with iCHF objectives. Moreover, it is evident that iCHF insurance is expected to continue being a major contributor to meeting both technical and socio-economic needs for access to affordable health services in the district.

5.2.3 National Health Policy of 2007 affects Enrolment in Improved Community Health Fund

The Tanzanian government places a high priority on health, as seen by the annual growth in budgetary allocation to the sector. The present percentage of the budget dedicated to health is 11%, with a target of 14%. In accordance with the Government Development Vision 2025 goals, the Ministry of Health will work to raise and improve Tanzanians' health status and life expectancy by ensuring the delivery of effective, efficient, and high-quality curative, preventive, promotive, and rehabilitative health services at all levels.

Reduce the burden of disease, maternal and infant mortality, and enhance life expectancy by facilitating the development of environmental health and sanitation, appropriate nutrition, the control of communicable diseases, and the treatment of common conditions as policy objectives. The vast majority of the poor, particularly the rural poor, are affected by the aforementioned and other preventable conditions.

The Ministry will boost budget allocation to address these cost-effective interventions while also working with other stakeholders, communities, and development partners

to reorient services to be more responsive to the needs of the population, with a focus on the poor and vulnerable.

5.3 Conclusion

Based on the findings, it can be stated that a well-managed improved community health fund (ICHF) is a beneficial tool for impoverished and uninsured community members. Individual experience, the mushrooming of healing alternatives, understanding, attitude, and practice of the iCHF are all elements that impact low iCHF uptake. However, best practices that will encourage individuals to join the iCHF should include the provision of adequate and dependable information, as well as widespread improvements in service delivery while taking into account contemporary social developments.

5.4 Recommendations

Several recommendations have been made based on the goals of this study on the factors that influence enrolment in the Improved Community Health Fund. These suggestions are for district iCHF administration, service providers, policymakers (Ministry of Health, Community Development, Gender, Elderly, and Children), and future research. The Council iCHF management should continue to educate the community on the iCHF so that everyone understands it. Again, community participation in the day-to-day operations of primary healthcare and benefit packages must be a continuous initiative. To keep enrolled members in the scheme, the management should ensure that medication is available and that a defined referral procedure is in place.

Health care providers, including clinicians, physicians, nurses, and their assistants, should adhere to the basic principles outlined in the criteria for providing health care, as well as create a welcoming environment for clients to express their opinions. Furthermore, health providers should operate in the best interests of the client's welfare and uphold the basic requirement of doing no harm while adhering to the non-discrimination principle. Furthermore, health-care providers should work to educate the public about participatory health management while protecting the confidentiality of the clients' ideas. This will help raise community awareness and trust in the health-care system.

According to the conclusions of the study, the ministry in charge of health should implement a mechanism through policy reform that requires mandatory enrolment in health insurance in order to lessen the burden of out-of-pocket payments at health facilities. This will put pressure in the direction of universal health care. Furthermore, the ministry should endeavor to integrate the iCHF's health services with those provided by the National Health Insurance Fund (NHIF), allowing members to receive services from a variety of locations rather than relying on a single place of registration.

5.5 Recommendation for Further Research

The focus of this study was on the factors that influence iCHF enrollment in Mbarali district. So, in order to have a robust comparison base and, if possible, statistical evidence based on factors impacting enrolment along the path to universal health care, other studies may be done to cover other locations. However, the study did not go

deep enough to better understand the drivers of enrolment, necessitating additional research into enrolment determinants.

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APPENDICES

Appendix I: Questionnaire for Community Respondents (Members and Non-Members)

Introduction This questionnaire is meant to collect information on ""Factors affecting community health fund insurance enrolment of community health fund members in mbarali district council". The information collected through this questionnaire will be treated with confidentiality and used for academic purpose only. Kindly take a moment to answer all the questions as accurately as possible.

Questionnaire No…………….

Instruction: Insert response of your choice in the box or fill in the blanks as required.

Part A: Introductory part

Questionnaire Number…………………
Date …………………………
District/Council ……………………… Ward…………………… Mtaa…………………………

1. How old are you? ……………… (Years).

2. What is your sex?

i. Male [ ]

ii. Female [ ]

3. What is the level of your educational?

i. Not gone to school [ ]

ii. Primary level [ ]

iii. Secondary level [ ]

iv. Others (specify) ……………………..

4. What is your occupation?

i. Peasant [ ]

ii. Self-employed [ ]

iii. Employed [ ]

iv. Other………………………………...

5. What is your marital status?

i. Single [ ]

ii. Married [ ]

iii. Divorced [ ]

iv. Widow/widower [ ]

6. What is your economic activities? …………………………………………….…………...

7. Who makes decision in your household.……………………………………….…..……..

1. Have you ever heard of Community Health Fund?

   a) No b) Yes

2. If Yes, what was the source of information?

   a) friend b) neighbor c) village meeting d) place of worship e) radio f) TV g) printed media (e.g., newspapers) h) clinic day i) while on treatment in hospital/ health center/ dispensary j) while attending a seminar k) ICHF workers awareness visits in your area l) other (state)………………

3. Have you ever joined/registered with the ICHF

1. Have you ever heard of Community Health Fund?

   a) No b) Yes

1. If Yes, what was the source of information?

a) friend b) neighbor c) village meeting d) place of worship e) radio f) TV g) printed media (e.g., newspapers) h) clinic day i) while on treatment in hospital/ health center/ dispensary j) while attending a seminar k) ICHF workers awareness visits in your area l) other (state)………………

2. Have you ever joined/registered with the ICHF

a) Yes b) No

3. If Yes, when did you join the ICHF?

4. State the year/month …………………….

5. Who persuaded you to join? ....

6. Was joining the community health insurance of any benefit to you and family?

a) Yes b) No c) Little d) Not at All

7. If the answer is Yes, what were the benefits?

a. Received medical treatment without bother

b. Received medical treatment at all times even when I had no money

c. Medical treatment to me and my household members has been simplified

d. All the benefits listed above appl

1. Circle one number basing on whether you strongly agree (SA), agree (A), Undecided (UD), disagree (DA), or strongly disagree (SD) on role played by ICHF insurance under the following statements.

Items	**SA**	**A**	**UD**	**DA**	**SD**
i. Finance for ICHF insurance is improved • Improved health package					
• Improved medical supplies					
ii. Infrastructure for ICHF insurance is improved • Improved roads/access to Health services					
• Improved Health service buildings					
iii. Information system Improved • Improved record keeping • Improved ICT					
iv. Technical capacity/skills of workers Improved					
• Number of competent workers					

2. If you are happy (or somehow happy) with ICHF insurance, how many times have you renewed?

b) Just joined b) once c) twice d) three times

3. If no, what are in your view, challenges of this type of insurance?

a. Medical treatment not availed smoothly

b. Even if you see the doctor, no medicines

c. Some diseases or ailments are not treated by ICHF insurance

d. Availability of medicines is not satisfactory

e. Few treatments center

f. Poor service by ICHF providers

g. All responses above appl

4. Have you ever convinced other village community members to join ICHF?

a. Yes…………b) No….. How many…...

5. What does the community you live say or comment on ICHF?.

a. Helpful to the community and households as health insurance

b. NHF is of no assistance to the community

6. For those who are not yet members of the ICHF, what are their main complaints?

a.……………………………………………………………………………

b. ………………………………………………………………………………

c. ………………………………………………………………………………

d. ………………………………………………………………………………

7. What are your views on the sustainability of ICHF in Mbarali if all challenges put forward area addressed ....?

………………………………………………………………………………………..

Part B: Examining Socio-cultural practices influencing enrolment into ICHF

16. What is your opinion regarding the following services provided to the Community Health Fund (ICHF) members at the health facility?

i. Reception……………………………………………………………

ii. Communication…………………………………………………

iii. Is there any form of discrimination? (1) Yes (2) No []. If YES, explain ……………………………………………………………

iv. Health workers attitude towards Community Health Fund (ICHF) members? ………………………………………………………………

v. Availability of medication services …………………………………

17. Do you go for alternative medicine?

i. Yes [ ]

ii. No [ ]

If YES, what type of alternative medicine do you go? ....

18. Why do you go for alternative means?
…………………………………………………………………………………………

19. How often have you opted for the alternative medicines?

……………………………………………………………………………………………

20. What is your perception on prepayment scheme?
………………………………………………………………………………………

21. Do you agree that "it is important to be enrolled into ICHF to enable access to quality and affordable health care services?"

i. Strongly agree [ ]

ii. Agree [ ]

iii. Neutral [ ]

iv. Disagree [ ]

v. Strongly disagree [ ]

PART C: The perception of both beneficiaries and non-beneficiaries on affordable health care services

22. Have you ever heard of Improved Community Health Fund?

a) No b) Yes

23. If Yes, what was the source of information?

a. friend b) neighbor c) village meeting d) place of worship e) radio f) TV g) printed media (e.g., newspapers) h) clinic day i) while on treatment in hospital/ health center/ dispensary j) while attending a seminar k) ICHF workers awareness visits in your area l) other (state)………………

24. Have you ever joined/registered with the ICHF

a. Yes b) No

25. If Yes, when did you join the ICHF?

26. State the year/month ……………………

27. Who persuaded you to join? ....

28. Was joining the community health insurance of any benefit to you and family?

a. Yes b) No c) Little d) Not at All

29. If the answer is Yes, what were the benefits?

a. Received medical treatment without bother
b. Received medical treatment at all times even when I had no money
c. Medical treatment to me and my household members has been simplified

PART C: **The perception of both beneficiaries and non-beneficiaries on affordable health care services**

22. Have you ever heard of Community Health Fund?

a) No b) Yes

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26. State the year/month …………………….

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30. Was joining the community health insurance of any benefit to you and family?

a. Yes b) No c) Little d) Not at All

31. If the answer is Yes, what were the benefits?

a. Received medical treatment without bother
b. Received medical treatment at all times even when I had no money
c. Medical treatment to me and my household members has been simplified

d. All the benefits listed above apply

30. Circle one number basing on whether you strongly agree (SA), agree (A), Undecided (UD), disagree (DA), or strongly disagree (SD) on role played by ICHF insurance under the following statements.

Items	SA	A	UD	DA	SD
i. Finance for ICHF insurance is improved • Improved health package					
• Improved medical supplies					
ii. Infrastructure for ICHF insurance is improved • Improved roads/access to Health services					
• Improved Health service buildings					
iii. Information system Improved • Improved record keeping					
• Improved ICT					
iv. Technical capacity/skills of workers Improved • Number of competent workers					

31. If you are happy (or somehow happy) with ICHF insurance, how many times have you renewed?

a. Just joined b) once c) twice d) three times

32. If no, what are in your view, challenges of this type of insurance?

a. Medical treatment not availed smoothly
b. Even if you see the doctor, no medicines
c. Some diseases or ailments are not treated by ICHF insurance
d. Availability of medicines is not satisfactory
e. Few treatments center
f. Poor service by ICHF providers
g. All responses above apply

33. Have you ever convinced other village community members to join ICHF?

a. Yes…………b) No…. How many…...

34. What does the community you live say or comment on ICHF?

a. Helpful to the community and households as health insurance

b. NHF is of no assistance to the community

35. For those who are not yet members of the ICHF, what are their main complaints?a.

a …………………………………………………………………………………

b. …………………………………………………………………………………

c. …………………………………………………………………………………

d. …………………………………………………………………………………

36. What are your views on the sustainability of ICHF in Mbarali if all challenges putforward area addressed

....?

………………………………………………………………………………………..

Part D: Analysis of how the health policy influences enrolment into ICHF

30. Who do you think is responsible for day-to-day operation of the ICHF?

....

40. Are you given opportunities to participate in the ICHF implementation at your area?

i. Yes [ ]

ii. No [ ]

If yes, explain how? If No, explain how?

41. What are the healthcare services covered by the ICHF in your area?

25. In your opinion what do you think could be the best practice so as to attract members?

Thank you for your cooperation

Work Plan

ACTIVITY	1st 30days	2nd 7 days	1day	23days	15days	5days
Proposal preparation	■					
Proposal submission		■				
Data collection			■			
Data analysis and Presentation				■		
Report writing					■	
Finalization						■

BUDGET PLAN

S.NO	DESCRIPTION	AMOUNT
1.	**RESEARCH PROPOSAL AND PREPARATION**	
2.	Stationary (pens, drafting paper	250,00
3.	Secretarial services	10,000
4.	Photocopying	5000
5.	**SUB TOTAL**	**40, 000**
6.	**QUESTIONNAIRES PREPARATION**	
7.	Drafting paper 1 ream	10,000
8.	Printing and Typing	100,000
9.	Photocopying	10,000
10.	**SUB TOTAL**	**30,000**
11.	**PRIMARY DATA COLLECTION**	
12.	Transport cost from home to Mbarali district	20,000
13.	**SUB TOTAL**	**20,000**
14.	**DATA ANALYSIS**	
15.	Secretarial services	10,000
16.	Soft binding 4 copies	10,000
17.	**SUB TOTAL**	**20,000**
18.	**MEAL COST**	**40,000**
19.	**GRAND TOTAL**	**150,000**

Appendix II: Research Clearance Letter

THE OPEN UNIVERSITY OF TANZANIA

DIRECTORATE OF POSTGRADUATE STUDIES

P.O. Box 23409
Dar es Salaam, Tanzania
http://www.openuniversity.ac.tz

Tel: 255-22-2668992/2668445
ext.2101
Fax: 255-22-2668759
E-mail: dpgs@out.ac.tz

Our Ref: PG201900763,

28th April 2021

District Executive Director (DED),

Mbarali District Council,

P.O.Box 237,

MBEYA.

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 **Mr. MHIMBIRA, Anthony, Reg No:PG201900763** pursuing **Masters of Arts in Monitoring and Evaluation (MAME).**We here by grant this clearance to conduct a research titled **"Factors Affecting Community Health and Insurance Enrolment of the Members in Mbarari District Council"**. He will collect his data at your Area from 1st May 2021 to 30th May 2021.

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.

Yours,
THE OPEN UNIVERSITY OF TANZANIA

Prof. Magreth Bushesha
DIRECTOR OF POSTGRADUATE STUDIES.

THE UNITED REPUBLIC OF TANZANIA

PRESIDENT OFFICE
REGIONAL ADMINISTRATION AND LOCAL AUTHORITY
MBARALI DISTRICT COUNCIL

REF.NO. MDC/R.40/VOL.V/II/02 ***Date. 06/05/2021***

THE OPEN UNIVERSITY OF TANZANIA,
DIRECTORATE OF POSTGRADUATE STUDIES,
P.O Box 23409,
DAR ES SALAAM.

REF: ACCEPTANCE OF REASERCH CLEARENCE FOR MR. ANTHONY APOLINARY MHIMBIRA

Reference is made to the heading above,

I like to inform that, your request to conduct a research in Mbarali District Council is accepted . Whoever Mr. Anthony Apolinary Mhimbira is obligated to report to DED Office for further support.

Thanks.

Anyagile A Mwanayamaki
For: District Executive Director,
MBARALI.

MKURUGENZI MTENDAJI
HALMASHAURI YA WILAYA
MBARALI

Copy to;

District Executive Director
MBARALI

District Executive Office, Mbarali District Council, Mpungarelini Street, P.o.Box 237, Rujewa.
Phone; 252957440/252957447, Fax 025-2590089/2590108, Email: ded@mbaralidc.go.tz, info@mbaralidc.go.tz,
Website: www.mbaralidc.go.tz