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CLIENTS' AWARENESS AND ACCESS TO SERVICES PROVIDED BY IMPROVED COMMUNITY HEALTH FUND SCHEME IN MASEREKA VILLAGE LUSHOTO DISTRICT IN TANZANIA

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ABSTRACT

Tanzania government through Ministry of Health Community Development Gender Elderly and Children has introduced Improved Community Health Fund (iCHF) scheme following operational and financial management challenges which were facing the previous Community Health Fund (CHF) scheme. This study assessed clients' awareness and access to services in iCHF in Masereka village Lushoto District. A cross-sectional survey design was adopted to collect data using questionnaire. The study used stratified random sampling to select 104 head of households from four hamlets namely Masereka, Ludende, Tanda and Yatanga. Descriptive statistical analysis was applied using SPSS version 16 to generate mean, standard deviation, frequencies and percentages. Results showed that few community members are aware of the criteria used to enroll new members to iCHF (50.5%) and other few community members are familiar with health facilities accredited to iCHF scheme (44.7%). The study also revealed that the quality of healthcare services provided through iCHF scheme are perceived to be reliable in respect to fast treatment (Mean score=3.5, SD=1.165), availability of medicines (Mean score=3.3, SD=1.211), accurate medical examination (Mean score=3.4, SD=1.327), accurate treatment (Mean score=3.1, SD=1.336) and easy contact with health workers (Mean score=3.6, SD=1.148). More findings showed that in comparison to health services provided through iCHF accredited health facilities, the community perceived that the costs of enrolment to iCHF is relatively lower (Mean score=3.5, SD=1.066), premium is relatively fair (Mean score=3.8, SD=1.104) and health staff provide good care to clients (Mean score=3.5, SD=1.126). Community members who are non-iCHF members reveal that their reasons for not being enrolled to iCHF were still prefer and trust in traditional medicine (59.2%), and other community members (26.3%) do not afford the iCHF premium. The study recommends that iCHF management and health sector development partners such as Tanzania Social Action Fund (TASAF) and non-governmental organization should increase their efforts in providing clear information to the rural communities and support poor households to enroll to iCHF especially in Masereka village. Clear information and support can motivate many households to enroll to iCHF and leave away their high dependence on traditional medicine which usually lack clear scientific basis in prevention and treatment of diseases.

KEYWORDS: ***community health fund, improved community health fund, awareness, reliability***

1. INTRODUCTION

Universal health coverage (UHC) is one of the United Nations' Sustainable Development Goals (SDGs) which has given a major priority by the government of Tanzania. The UHC agenda aims at increasing mobilization of domestic resources through the initiation of sustainable financing mechanisms for healthcare services (Lee et al., 2018). The UHC will help to end up fragmentation of health insurance coverage, increase healthcare resources, provide all people a minimum benefits for all, and increase the efficiency of health spending (Lee et al., 2018). Community Based Health Financing (CBHF) which contributes to the fulfillment of UHC has emerged in developing countries following existing challenges in the health financing system including low economic growth, constraints on the public sector and low organizational capacity (Carrin, 2003). The CBHF such as Improved Community Health Fund (iCHF) is a mechanism whereby community members at household level finance or co-finance costs associated with health services, and highly participate in the management of community financing scheme and organization of health services (Carrin, 2003).

Tanzania faced economic crisis between 1970s and 1980s which contributed to the failure of national economy to provide essential services like education, water and health services. In order to overcome this

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situation, the government decided to introduce user fees (cost sharing) so that people can assist the government efforts in meeting their needs on health service (Bennett et al., 2004). The introduction of user fees caused many people to rely much on out of pocket payment to acquire health services (Bennett et al., 2004). Later, out of pocket payment had harmful impact to the poor households which are not able to use cash payment for healthcare services. This led Tanzania government to find out a new option of financing the health sector so as to enhance access to basic healthcare services to all citizens particularly the poor (Hinju, 2017).

The government through Ministry of Health Community Development Gender Elderly and Children introduced and operating two major health insurance schemes namely National Health Insurance Fund (NHIF) which mostly covers employees from public sectors and formal private sectors, and Community Health Fund (CHF) which mostly enrolls people working in informal sector from both, urban and rural areas. The CHF has recently undergone a reform and now is known as Improved Community Health Fund (iCHF). The iCHF has extended its healthcare services to regional government hospital level from district level as it was for CHF. Another health scheme known as Social Health Insurance Fund (SHIB) was introduced and operated by National Social Security Fund (NSSF) whereby SHIB members can voluntarily join the fund by allowing deductions of their monthly NSSF contributions. The NHIF was established by the Act of Parliament No.8 of 1999 and began its operation in June 2001.

The CHF was introduced in Tanzania as part of the Ministry of Health's initiatives to make healthcare services affordable and available to the rural population and the informal sector. The scheme was established by Community Health Fund Act, 2001. In the financial year 2016/17, the CHF had an enrollment of over 2.1 million households, covering roughly 12.6 million beneficiaries (Lee et al., 2018). The CHF achieved to pool funds at the district level while iCHF plans to pool funds at the regional level (Lee et al., 2018; URT, 2018). In order for beneficiaries to get access to iCHF services in district and regional hospitals, they are required to have a referral from primary health facilities. There are different premiums which are charged to iCHF members based on locations. For instance, in Dar es Salaam, premiums are set per beneficiary at TZS 40,000 or TZS 150,000 per household of six. In all other urban areas in the country, premiums are set per beneficiary at TZS 30,000. In rural areas, premiums are set per household of six maximum members at TZS 30,000. Each additional adult is set at TZS 30,000 and each additional child is set at TZS 10,000. Alternatively, a household with more than six (6) members can form two iCHF households (URT, 2018).

The reform of CHF was done by the government of Tanzania following various challenges which were constraining its implementation including unclear reporting system, poor management of fund collected and expenditure, poor management by CHF committees of health facilities, little revenue collection, relying on enrolling sick people and lack of access to referrals among CHF members (URT 2018). Based on these challenges, three main operational areas including governance, enrolment and benefit package were included in the reform to iCHF in order to improve the quality of service provided (URT, 2018). In Lushoto District Council iCHF started its operation in 2019. Until May in 2021, the households enrolled to iCHF were less than 5% of 742 total households of Masereka village. However, achievement in the enrolment of members to iCHF in the village depends on community awareness about the fund and service quality offered by accredited health facilities.

The SERVQUAL model developed by Parasurraman et al. (1985), Riono (2017) explained the perceived reliability in service quality of health facilities in providing healthcare to fund members (such as iCHF members). Access to service quality from accredited iCHF health facilities was assessed through clients' perceived reliability using service quality indicators which include; having fast, and accurate examination and treatment services; the patient's examination schedule is performed appropriately; the service procedure is not complicated; and easy to contact the medical staff. The awareness of community members on iCHF scheme has been explained by Theory of Diffusion of Innovation (DOI) pioneered by Rogers (2003). The DOI theory asserts that in order to use new practice such as iCHF, the community should be aware such practice through clear information provided by government and health sector partners such as non-governmental organization (NGOs). Community awareness can be extended through dissemination of iCHF information by using various communication strategies conducting community meetings, seminars and use of media (such as radio stations, television, magazines and newspapers) (Rogers, 2003). Before community members enroll to iCHF services, they usually seek information about the fund operations such as costs, service coverage, benefit packages and management of the fund so that they can be aware about the quality of service provided to relate with alternative healthcare services they are already using. Therefore, the iCHF services are supposed to be less expensive and socially acceptable in comparison to alternative approaches

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payments of healthcare or alternative health care services.

Studies have already been in Tanzania focusing on existed CHF services particularly with respect of packages offered, and implementation and operational challenges (Mtei and Mulligan, 2007; Lee et al., 2018; Hinju, 2017; Mkumbo and Masbayi, 2014). Yet, there is scant information regarding community awareness and service quality offered by improved community health fund scheme in Lushoto District especially for Masereka village. It's through adequate information on community awareness and service quality of the fund, the government and other health sector stakeholders can continue improving iCHF services. In order to address the uncertainty of information, the current study assessed community awareness and perceived service quality in iCHF scheme in Lushoto District Tanzania and Masereka village in particular.

2. METHODOLOGY

2.1 Research design

The study used a cross-sectional design which allowed the collection of data at a single pint in time. Hence, each respondent participated once in the study as a source of information. Through this design, quantitative approach was employed in gathering quantitative data.

2.2 Methods of data collection

Survey was a method of data collection used whereby structured questionnaire was an instrument of data collection which administered to the respondents (household heads). The structured questionnaire comprised of open and close ended questions.

2.3 Data analysis

The study used SPSS version 16 to run descriptive statistical analysis with regard to community awareness, reliability of iCHF services and relative advantage. The analysis revealed descriptive statistics including means, frequencies, percentages and standard deviations which presented in tables and figures.

2.4 Reliability test

Reliability test by using Cronbach's alpha was conducted to verify if there is internal consistency of the measurement instrument. The test revealed that there was internal consistency of measurement instrument with regard to perceived reliability and relative advantage of iCHF service since the Cronibach's alpha values for perceived reliability to iCHF quality services was 0.83. Basing on different studies, the acceptable values of alpha which justify internal reliability are ranging from 0.70 to 0.95 (Nunnally and Bernstein, 1994; Bland and Altman, 1997; DeVellis, 2003). Therefore, the test results of Cronbach alpha revealed in this study justified that there is internal consistency because items of measurement of the instrument generated the same construct or concept.

3. SAMPLING DESIGN

The study used simple random sampling to select four hamlets from seven total hamlets that form the Masereka village. The hamlets selected were Masereka, Yatanga, Ludende and Tanda. The survey population from four hamlets was 345 households. Nard (2003) and Newman (2007) recommend that in a quantitative research, if the population is smaller, the sampling ratio should be larger for the sample to be true representative. For population under 1,000, a minimum ratio of 30% is advisable to ensure representativeness of the study sample (Nard, 2003; Newman, 2007; Suskie, 1996). Basing on Nard (2003), Newman (2007) and Suskie (1996), this study used 30% of survey population to obtain the sample size of 104 households. The sample size was selected by using simple random sampling from four selected villages.

4. GEOGRAPHICAL AREA

The study was conducted in Masereka village, which is one of villages of Lushoto District. The village is located in the West Usambara Mountanis. Administratively, the village is found in Mbaru ward within the Lushoto District Council. It comprises seven hamlets including Masereka, Yatanga, Ludende, Tanda, Kweromo, Chambogho, Ngomei and Kisiwani. The village has a total of 742 households with average household size of 5 and estimated population of 3710 people. Masereka village was chosen because it has very low iCHF household enrolment below 5%, and hence justified the need for research study. Information from this study may help to implement strategies which may help to increase enrolment of community members to iCHF scheme in Masereka village and Lushoto District as a whole.

5. RESULTS AND DISCUSSION

5.1 Demographic characteristics of respondents

The survey assessed demographic characteristics of respondents such as sex, marital status, education, household size and occupation as shown in Table 2. Results revealed that there was almost equal proportion of males (52%) and females (48%) who participated in the study. most of respondents were married (48.1%) and those who were not yet married (39.4%). Few respondents constituted females who were widow and divorced. The average household size identified by the survey was 5 members whereby majority households

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had 4 to 6 members (55.2%). Such average number of people per household justifies a need to enroll households to iCHF in order to save cash payment which cannot be available especially to poor people when a household member demand healthcare. Based on education levels, most of survey participants had primary education (64%). Other respondents completed secondary school (19%) and few participants attended tertiary education (2%). Therefore, majority of respondents were literate except 15% who had never attended formal education. The type of occupation which employ many people is agriculture (53.2%) followed by small business (38.3%). Some respondents had no employment because they are either very old or housewives engaging in domestic works.

Table 2: Distribution of respondents basing on demographic characteristics

Demographic characteristics		**Frequency**	**Percent**
Sex :	Male	54	52
	Female	50	48
	Total	**104**	**100**
Marital status:	Married	50	48.1
	Single	41	39.4
	Divorce	6	5.8
	Widow	7	6.7
	Total	**104**	**100**
Household size:	1-3	25	26
	4-6	53	55.2
	7-10	18	18.8
	Total	**97**	**100**
Education:	Never attended school	14	15
	Primary education	60	64
	Secondary education	18	19
	Tertiary education	2	2
	Total	**94**	**100**

According to their age groups, many respondents (39.6%) were belonging in the age group of 40-49 years (Figure 1). The mean age was 46.6 years with a standard deviation of 10.63. In overall, most of respondents were belonging to the age below 60 years and above 20 years and hence, such community members are obliged to pay the cost of health services through iCHF or other mode of payment in government hospitals, health centres and dispensaries or private health facilities. Only 14.6% of respondents comprised of elderly people who are automatically offered cost exemptions from government health services including dispensaries, health centres and hospitals. In spite of large proportion of community members who can enroll to iCHF based on their age groups, only 23.1% of respondents are iCHF members in Masereka village. These iCHF households belong to poor households which are supported by Tanzania Social Action Fund (TASAF) phase III. The households supported by TASAF III were sufficiently informed, highly sensitized and very much encouraged to enroll to iCHF as program strategy of enhancing social safety net to beneficiaries. Therefore, more effort is required to promote the enrollment of community members who are not TASAF beneficiaries to iCHF scheme in Masereka village.

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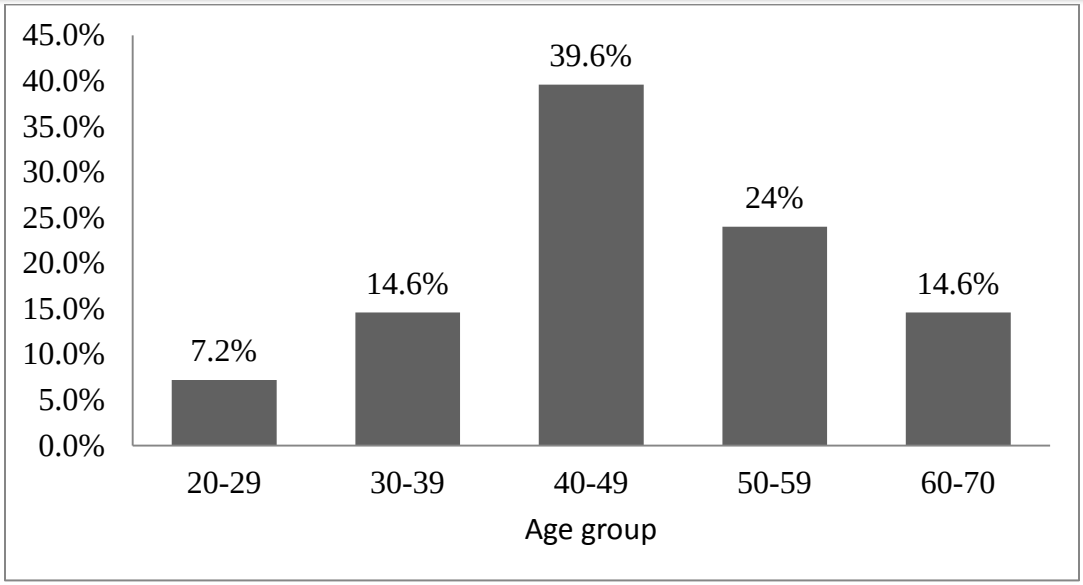

Figure 1: Age group distribution of respondents (n=104)

5.2 Awareness of community on improved community health fund

The community awareness regarding the criteria of enrolment to iCHF was assessed in order to understand if clients in Masereka village are familiar with iCHF scheme. The findings regarding community awareness on iCHF services are presented in Table 3.

Table 3: Community awareness of improved community health fund

Item of measurement of community awareness	Yes	No
For a household to enroll to iCHF, it should comprise a maximum of 6 members.	(47)50.5%	(57)49.5%
The premium of iCHF for a household of 6 maximum members is Tanzania shilling 30,000 per year.	(71)75.5%	(33)24.5%
Hospitals, health centres and dispensaries owned by government within administrative region are iCHF accredited health facilities.	(42)44.7%	(62)55.3%
Overall awareness of the community on iCHF	(53)56.9%	(51)43.1%

Note: Numbers in brackets are frequencies

The study found that a half of people (50.5%) are aware about the criteria of 6 people as maximum number of members for each household which can be enrolled to iCHF (Table 3). More findings revealed that most of the respondents (75.5%) are aware enough about the premium of 30,000 Tanzania shillings required for a household of maximum of 6 household members to be enrolled to iCHF. Many people ask about the cost for household to enroll to iCHF when they attend to the village dispensary and visit to village office. However, few residents (44.7%) were aware of health facilities which are accredited to iCHF scheme. In fact, health facilities where iCHF members can obtain health services are hospitals, health centres and dispensaries owned by the government within a particular administrative region. Many other respondents were not familiar with health facilities which are accredited to iCHF. In this case, members of iCHF have direct access to healthcare services from government dispensaries. They can move to health centre, district hospital and regional hospital when given referral from a particular lower health facility. Lack of awareness among community members about the coverage of iCHF can be a reason of low iCHF enrolment in Masereka village. The overall community awareness based on average response (56.9%) revealed that residents are somewhat familiar with improved community health fund (iCHF) in Masereka village. Therefore, lack of awareness among the residents is one of the reasons which contributed to low enrollment of households to iCHF in Masereka village.

6.3 Perceived reliability of service quality provided by improved community health fund scheme

The study assessed perceived reliability of service quality provided by government health facilities accredited to iCHF scheme in Masereka village. The study revealed the findings regarding the reliability of

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dispensaries, health centres and hospitals to perform the promised services to clients dependably and accurately. The perceived reliability of quality services in health facilities accredited to iCHF scheme was assessed by measurement items which include timeliness and accuracy of health examination and treatment services; whether the patient's examination schedule is performed appropriately; if the health service procedure is not complicated; and whether clients find easier to contact the medical staff. The items of measurement of perceived reliability of service quality were measured by using a 5-point likert scale comprised of the following indicators; 1=strongly disagree, 2=disagree, 3=neither agree nor disagree, 4=agree, and strongly agree.

Table 4: Residents' perception on reliability of improved community health fund (iCHF)

Reliability item of measurement	Number of respondent	Mean score	SD
A member of iCHF has access to fast treatment services when attend health care facility.	104	3.5	1.165
A member of iCHF has access to appropriate medications when attend health care facility.	103	3.3	1.211
A member of iCHF has access to accurate medical examination services.	104	3.4	1.327
A member of iCHF has access to accurate treatment.	101	3.1	1.336
A member of iCHF has access to easier contact with health worker or assigned medical officer in accredited health facilities.	104	3.6	1.148
Overall community perceived access to iCHF services		3.4	1.237

Note: SD=standard deviation

Before rating, the minimum and maximum rating score was 1 for strongly disagree and 5 for strongly agree. The mean score of the rating scale was supposed to be 2.5 to represent the choice of neither agree nor disagree. The findings are presented in Table 4. Majority of respondents perceived that members of iCHF are treated in time when attend accredited healthcare facilities (Mean score=3.5, SD=1,066). The findings demonstrated that community members satisfy with reliability of service quality from accredited health facilities as they provide treatment. In regard to access to accurate medication provided to iCHF members, most of respondents perceived that iCHF members are provided medicines which are appropriate to their sickness (Mean score=3.3, SD=1.211). They are provided appropriate medications when attend healthcare facilities including their village dispensary and neighbouring dispensaries located in adjacent villages.

More findings revealed that majority of respondents perceived agreed that iCHF member has access to accurate health examination services (Mean score=3.4, SD=1.327) and promised treatment services (Mean=3.1, SD=1.336). According to findings, the community agreed with iCHF services since members have access to health examination services provided by health workers in accredited health facilities where they attend for healthcare services. Also, respondents perceive that iCHF members have access to treatment which they deserve from accredited health facilities.

Table 6: Residents' perception on relative advantage of improved community health fund (iCHF)

Relative advantage item of measurement	Number of respondents	Mean score	SD
When you are a member of iCHF you minimize the cost of health services in comparison to when you rely on cash payment.	104	3.5	1.066
Membership premium for iCHF is fair in with regard to the healthcare services provided to clients.	101	3.8	1.104
Members of iCHF are cared by medical staff like non-iCHF members.	104	3.2	1.209
Overall community perceived relative advantage of iCHF services		3.5	1.126

Note: SD=standard deviation

In spite the respondents have agreed that reliability of service quality offered in iCHF accredited health facilities, still there are many households which have not yet enrolled to iCHF scheme in Masereka village. The study found that relying on traditional medicine was the main reason for most residents not to enroll to iCHF. The findings indicated that about a half of non-iCHF members (59.2%) who participated in the survey had not enrolled to iCHF because they believe traditional medicine (Figure 2). The more rely on

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traditional medicine including medicinal plants for prevention and treatment of diseases roots than conventional medicine. This attitude of relying on alternative medicines such as extracts of medicinal plants which are not well researched, tested and lack proper dosage creates health risks to the community members.

The other reason given by some respondents (26.3%) for not being members of iCHF was high cost of premium which makes them not able to afford paying the amount of Tanzania shilling 30,000 per household of maximum 6 members per year (Figure 2). The community perceived the premium to be high due to the fact that they do not afford getting money to pay for premium offered by iCHF because they have low income. They depend on smallholder agriculture and petty business which cannot generate sufficient income for the households. Therefore, poverty of households constrains access to quality health services and makes community more susceptible to health related risks.

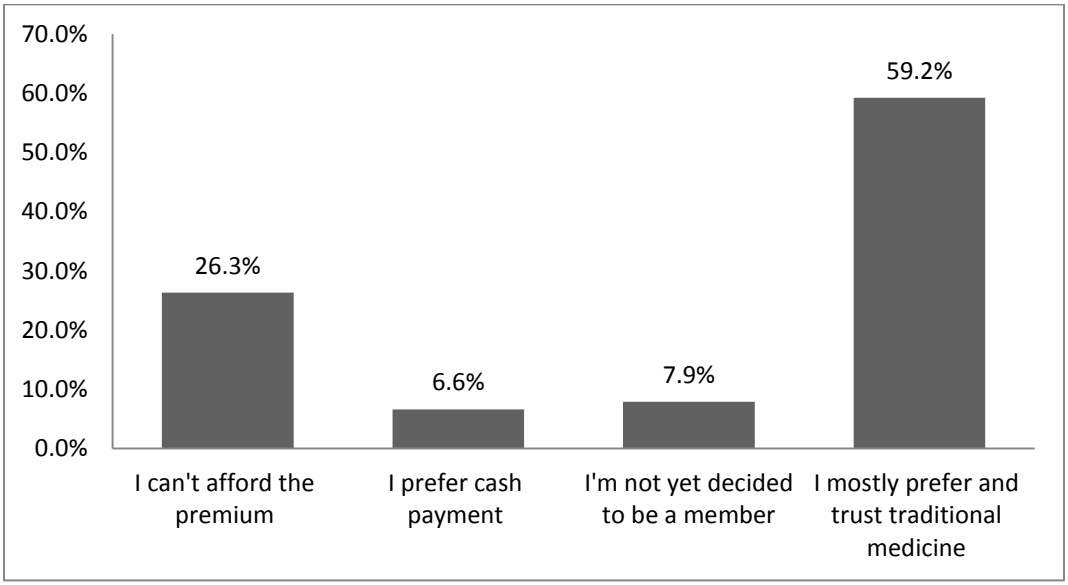

Figure 2: Responses regarding the reasons of not enrolled to iCHF (n=80)

Other findings revealed that some few respondents (6.6%) prefer cash payment in health services when they attend to health facilities while 7.9% of survey participants said that they have not yet decided to be iCHF members (Figure 2). Hence, community members who are not ready to make decision of enrollment to iCHF and those depending on cash payment might be lacking clear information regarding iCHF operation and advantages of packages offered.

7. SUGGESTIONS

The study provides the following suggestions to iCHF management and health sector stakeholders:

i. The iCHF management, Lushoto district council and partner organizations should implement interventions which can create more awareness of iCHF operations, its service coverage and relative advantage of the fund so as to motivate clients to enroll to iCHF in Masereka village.
ii. The governmental of Tanzania through iCHF management and health sector stakeholders including Tanzania Social Action Fund (TASAF) and non-governmental organizations should increase their support of paying for iCHF premium to households which are extremely poor. Supporting the poor to pay for iCHF premium will escape them from risk of health related problems including communicable and non-communicable diseases.
iii. Community members particularly in Masereka village should be provided with health education so that they can understand about the importance of using conventional medicine as the most preference healthcare in Tanzania so that they can be motivated to enroll to iCHF scheme.

8. CONCLUSION

The government of Tanzania has recently made a reform to the Community Health Fund (CHF) scheme by addressing operational and financial management challenges which existed. Now, the Improved Community Health Fund (iCHF) scheme is implemented especially in rural areas. The CHF has existed since 2002 while providing access to health services to community members particularly those who are working in informal sectors especially in rural areas

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including farmers and market vendors**.** In Lushoto District, Improved Community Health Fund began its operation in 2019 while providing healthcare services to all 134 villages including the Masereka village. However since it was started, still there is low enrollment of households to iCHF scheme despite the effort which have been done by the government through iCHF management and coordination team.

The fact is that many residents in the village are not aware of the criteria required for enrolment of new members to iCHF. Also, they are not familiar with health facilities accredited to provide healthcare services. Through iCHF scheme, members of improved community health fund of not more than six have access to government health facilities including dispensaries, health centres, district hospitals and regional hospitals within their regions. The referral from primary health facility is given to iCHF member to get access to healthcare services in higher level health facilities. However, most of residents of Masereka village are familiar with a premium of thirty thousand per year for a household of maximum six members. The health facilities providing healthcare services through iCHF were perceived by residents of Masereka village as being offering reliable quality of services. They provide fast and accurate examination and treatment services, perform appropriate health examinations as promised, their service procedures are less complicated and easy to contact the medical staff. However, residents who are not members of iCHF scheme prefer using traditional medicine from plant and animal extracts in steady of using conventional medicine. Some residents are not able to afford the premium of iCHF because of being extremely poor. Therefore, more strategies are required in raising community awareness while keeping on improving the managerial and operational performance of iCHF scheme in Lushoto District particularly for Masereka village so as to enhance enrolment members.

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