SOUTHERN NEW HAMPSHIRE UNIVERSITY
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OPEN UNIVERSITY OF TANZANIA

MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT
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"A PROJECT ON ENHANCEMENT OF COMMUNITY PARTICIPATION IN COMMUNITY HEALTH INSURANCE A CASE OF MWANANYAMALA WARD. SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT IN THE SOUTHERN NEW HAMPSHIRE UNIVERSITY AT THE OPEN UNIVERSITY OF TANZANIA"2007.

Lyatuu Patricia Mwesiga

CERTIFICATION

The undersigned certify that he has read and here by recommends for acceptance by the Southern New Hampshire University at the Open University of Tanzania a project paper entitled "**Enhancement of community participation in community health insurance" a case of Mwananyamala ward**, In fulfillment of the requirements for the degree of Masters of Science in Community Economic Development of the Southern New Hampshire University at the Open University of Tanzania

Zera

Mr Zera Baseki

(Supervisor)

Date 30th August 2007

STATEMENT OF COPYRIGHT

DECLARATION

I Patricia Mwesiga Lyatuu {Mrs.} declare that this report is my own work produced in the course of working with Umoja wa Matibabu Secta Isiyo rasmi Dar es salaam (UMASIDA) as a community economic development technical adviser, as part of fulfillment of the requirements for the degree of Masters of Science in Community Economic Development of the Southern New Hampshire University at the Open University of Tanzania

DEDICATION

To God almighty who through His Holy Spirit strengthened me throughout the project work and in producing this report.

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ACRONYMS

CBHF	Community Based Health Fund
CBHI	Community Based Health Insurance
MHO	Mutual Health Organizations
PHR	Partners for Health Reforms
STI	Sexually Transmitted Infections
TNCHF	Tanzania Network of Community Health Fund
UMASIDA	Umoja wa Matibabu Secta Isiyorasmi Dar es salaam
VCT	Voluntary Counseling and Testing

ABSTRACT

Tanzania faces serious challenges to improve the health and wellbeing of its people. Action is urgently needed to create fundamental change in the health status of Tanzanians living in poverty. In order for the goals of the poverty reduction strategy and health sector to be realized, particular commitments must be made to those who are impoverished, marginalized and other wise vulnerable (Hutton (2003)) The Ministry of health and its partners in government, the donor community and civil society have responded with concerted action, in many cases achieving significant gains. In efforts to stem the deterioration of the health system and address systemic financing, service delivery and management concerns, a Health Sector Reform (HSR) program was initiated in 1995/96 including the necessity of complimentary partnership between communities and the government in cost sharing to finance health care services.

As a response community health funds (CHF) were established. UMASIDA-Umoja wa Matibabu Sector Isiyo Rasmi Dar es salaam is a mutual health scheme for the urban informal sector. These are poor people with marginal and seasonal income. The main objective of UMASIDA is to organize them so that on a mutual basis they can access comprehensive health care. Currently the scheme has enrolled 25% of the total target group and response to premium payment is very poor. This is because of poverty.

This project was intended to increase accessibility for informal economy operators in Mwananyamala for health services through enhancement of the capacity of their community based organization and community's disposable income by widening their business opportunities.

EXECUTIVE SUMMARY

This paper shares the result of the project research conducted by a community economic development technical adviser in collaboration with the community based organization UMASIDA regarding community participation in community based health insurance fund in Mwananyamala ward.

Despite of the efforts of the Ministry of Health to announce its reform that requires each citizen to share costs of health services, there have been a large number of people who seek free health care service in government hospitals (Mwananyamala Municipal Hospital, Out Patient Daily Register Book 2005).

According to UMASIDA; the group above is formed by informal economy operators. These are people with Marginal and seasonal income and due to their income rates and schedules it is difficult for them to pay for their social services in mutual basis. (Brief on UMASIDA 2004)

1.1 Statement of the project assignment.

Problem statement Mwananyamala informal economy operators are living under poverty line. This is expressed by the following features; inability to pay for health services and other basic services. Income poverty is manifested in different ways including failure to enroll and pay premiums to their pre-paid health scheme, sell of properties, use of herbs, borrowing, seek free health services from government hospitals or just wait to die. Despite of the fact that the scheme facilities offer some of services free, many poor target people can not afford transport costs and as sick persons they can not walk the distance to health

facilities. This is affecting target group members in that they are highly exposed to poverty and death as a result of diseases including HIV/AIDS and other infections. It is also threatening the sustainability of their scheme by causing insufficient premium payments from the members and fewer membership enrollments than intended.

This project aims at facilitating some community economic development knowledge and skills through provision of technical support to the members of the community and the community based organization which is working with the community (UMASIDA) through enhancement and improvement of business skills and community participation in the scheme. Community participation here refers to both ownership and accountability.

The project was planed following community needs assessment and organizational internal scanning. The two processes revealed the following gaps within the community and the community based organization which the project intended to fill:

Low household disposable income: this is because community members depend on single seasonal business which also provide marginal returns

Insufficient organizational capacity: The social staff of the scheme lack enough and proper knowledge on guidelines, tools and methods of enhancing community participation to there own developmental projects.

Insufficient community involvement in Management of the scheme: According to Tanzania Community Health Fund Act each ward should have

Ward Health committee which is responsible with the management of Health providers and finances of the scheme. Despite of the presence of Ward Health committee the mandate of the committee was not set open to the board members for this reason it has remained inactive. Therefore this project had the following objectives:

1. To increase house hold disposable income by 95% to target group by December 2006.
2. To increase the capacity of organizational staff and on Community participation approach from 30% to 95% by April 2006.
3. To Increase the capacity of Ward Health Board on management of community health fund from 35% to 90% by March 2006

In order to achieve the three objectives the following strategies were employed:

a. **Organizational staff development by:**
b. Preparing and Conducting a workshop with 3 social staffs of the organization on preparation of a guide manual on participatory approach in designing and implementing a community economic development project.
c. **Raising individual income through enhancement of entrepreneurial altitudes and tendencies among community members: particularly provision of** seminar on entrepreneurship to 30 community members by March 2006.
d. **Enhancing accountability and good governance to Ward health Board** through provision of seminar on Health Reform Policy analysis and advocacy in April 2006.

All these strategies were successfully implemented as planned and the terminal evaluation report which was conducted in December 2006 showed that there were remarkable positive changes in the three addressed gaps which was revealed by an increase of community participation from 18% to 50%, increased commitment of Ward Health committee in management of the scheme and individual average disposable income increased from 20,000 to 35,000.

CHAPTER 1

1.0 Community Needs Assessment

This chapter provides research methods, findings and conclusions through which the real needs of the community were identified and prioritized.

1.1 Community Health Fund

Community-based Health Insurance/Financing Scheme is any scheme managed and operated by an organization, other than government or a private for-profit company, that provides risk pooling to cover the costs (or part thereof) of health care services. The scheme is voluntary in nature but could be owned by a variety of organizations and covers a variety of benefit packages.

1.2. History of UMASIDA

UMASIDA was registered in Tanzania on 12th March 1997 with registration number So. No.8907. Its vision is to become a centre of excellence in provision of comprehensive, equitable, effective and affordable health care services to the poor and marginalized groups and serve vulnerable groups including street children and orphans. The mission of UMASIDA is to provide comprehensive, quality and affordable health care services to the marginalized groups and meet their expectation in accessing health care services. The main objective is to organize informal economy operators so that on a mutual basis they can access to comprehensive health care services. Five informal sector groups formed this scheme in 1994. The institute of Development studies (IDS) of the university of Dares salaam at Muhimbili was requested to provide technical support. With initial financial support from the International labor Organization (ILO)

the IDS worked closely with the informal sector groups to facilitate growth and functioning of UMASIDA.

1.2.1 What does UMASIDA provide?

The scheme provides a comprehensive package of health care benefits. These include all required outpatient care, maternal and child health services, laboratory tests, family planning, limited observation, free voluntary counseling, and testing, free sexually transmitted infections (STI)diagnosis and treatment (management) free condoms , free HIV/AIDS information on awareness and prevention, malaria management- prevention and cure.

In this project the roles of UMASIDA were: To link the CED advisor with the target groups, to participate in all steps of the project cycle and to provide trainees on community participation approach who will intern bring changes to the approach of the organization in addressing community development.

The role of the community economic development technical adviser was to facilitate community economic development through provision of technical support to the members of the community and community based organization working with the community

The role of the community was to participate in project planning. Attend seminar on entrepreneurship and to provide relevant information (unit of enquiry for researches).

1.2.2 Vision and Mission of UMASIDA

1.2.3 Vision of UMASIDA

The vision of UMASIDA is to become a centre of comprehensive, equitable, effective and affordable Health Care Services t the poor and marginalized groups and serve vulnerable groups including street children and orphans.

1.2.4 Mission of UMASIDA

UMASIDA'S mission is to provide Comprehensive, quality and affordable Health Care Services to the marginalized Groups and meet their Expectation in accessing Health Care Services

1.2.5 .Core values of UMASIDA

Quality Comprehensive Services, Equity, Participation and excellence.

1.2.6 Challenges faced by the scheme

Since its inception, it has succeeded to enroll 18% of the intended population. Moreover the members do not pay premiums as scheduled.

1.3 Community Needs Assessment

The technique used to assess the needs of community was structured discussion and research. The problem was discussed by the stakeholders together with the CED adviser and possible solutions were also proposed. More detailed information about the problems, about the community, and about the resources available were collected through research.

1.3.1. RESEARCH METHODOLOY

This section presents research methodology which was used to collect accurate and reliable data. There are many data collection methods that can be used in any research. Each has its advantages and disadvantages and must be chosen in light of particular questions, timeframe, and the resources that characterize the research task While some researchers have strong preferences for qualitative or quantitative techniques, today the prevailing wisdom is that no one approach is always best, and a carefully selected mixture is likely to provide the most useful information (Russell K.S. 2004). For the purpose of this survey, questions to be asked were not complex, the available time and other resources were also limited. It is in this context that the combination of cross-sectional survey, documentary review and observation methods were employed as the best mixture to provide the most useful information.

1.3.2 Needs of the Survey:

The information need was on the following three topics; level of community awareness, factors affecting community participation and possible solutions for solving the problem. Therefore the specific objectives of this survey were:

a. To assess the level of community awareness about the scheme
b. To identify the factors affecting the rate of community participation in the scheme
c. To identify possible ways for enhancing community participation

1.3.3 Research questions:

a. What is the level of community awareness about the scheme?
b. What are the factors affecting community participation in the scheme?

c. What are the possible ways which can enhance community participation in the scheme and other community development projects in the area?

1.3.4 Specific objectives of the survey:

Basically the objectives of the survey were;

a. To determine the percentage of community members who are participating in the scheme.

b. To identify areas in the scheme (project cycle) that the community would like to be improved.

c. To assess the level of community awareness about the scheme

d. To identify the factors affecting the rate of community participation in the scheme

e. To identify possible ways for enhancing community participation

1.4 Characteristics of the survey:

1.4.1. Area of the Study

The fields work of this study was conducted in Kinondoni Municipal at Mwananyamala Ward.

1.4.2 Unit of enquiry:

UMASIDA is now operating in five regions of Tanzania. These regions include Arusha, Dar es Salaam, Kilimanjaro, Mbeya and Mwanza. The survey was conducted at Mwananyamala ward to collect information for analysis. Mwananyamala ward which is located at Kinondoni district, in Dar es Salaam region was selected as a unit of enquiry for study of poor people involvement in health cost sharing and UMASIDA was selected as community based organization in supporting the poor.

Kinondoni district was selected because of vicinity to Dar es Salaam, where this course is offered and because of the convenience in terms of communication and accessibility. Informal economy operators residing Mwananyamala were involved and four units of enquiry were determined at ward level as follows: Scheme members – 30 (100% of the scheme members), 10 scheme staffs, 2 ward leaders, and 30 – none scheme members. At regional level the units of enquiry were 3 UMASIDA leaders, 2 Tanzania commission for Aids officials, and 2 staffs from Tanzania network of community health fund.

1.4.3 Research Design

Cross- sectional survey design was adopted which comprised the observation and interviewing of the target group at a single point in time

The Unit of inquiries included scheme members, non members, board members and staff of the organization.

1.4.4. Benefits and concerns of the designs

1.4.4.1 Benefits:

The distinguishing character of a cross - sectional survey designs is that, with them data are collected at a single point in time. Cross-sectional survey designs have the following benefits:

a. They describe things as they are, so that people can plan.
b. They are relatively easy to conduct

1.4.4.2 Concerns:

The main concern of cross – sectional design is that it provide a portrait of things as they are at single point in time, hence they are limited in that if things change rapidly the survey information will possibly become outdated

1.4.5 Type of survey instruments:

The survey instruments used were structured questionnaire with a mixture of both open and closed ended questions.

1.4.5 Psychometrics characteristics:

1.4.5.1 Scales;

The responses to close ended questions can take the form of yes-no answers, checklists and rating scales. Rating scale may be graphic but often they ask respondents to make comparisons in the form of ranks (1=top, 10 = bottom) or continuums (1=definitely agree, 2= agree, 3 = disagree, 4 = definitely disagree.) The numerical values assigned to rating scale can be classified as nominal, ordinal, interval or ratio. Each has characteristic that must be considered when you analyze the results of your survey. (Fink, A. and Kosecoff, J. *How to conduct surveys*). For the purpose of this survey questions took the form of yes and no answers and checklists scales.

1.4.5.2 Reliability;

Reliability is a statistical measure of the reproducibility or stability of the data gathered by the survey instrument. In survey research, error comprises two components: random error and measurement error.

a. Random error is unpredictable error that occurs in all Research.

b. Measurement error refers to how well or poorly a particular instrument performs in a given population (Michel A. and Mutasa F. assessing and interpreting survey psychometrics.)

1.4.5.3 How established (stability, equivalence, homogeneity)

Stability reliability;

Stability is usually computed by administering a survey to the same group on two different occasions and then correlating the scores from one time to the next. A survey is considered reliable if the correlation between results is high; that is people who have good or poor attitudes on the first occasion also have good or poor attitude on the second occasion. The higher the correlation the better. (Fink A. and Kosecoff J. *How to conduct surveys*}. In this survey stability reliability was computed by using a test-retest method where by respondents where interviewed when at their homes and when they were at there working places. In both occasions the responses remained the same.

Equivalence; Two forms of the same survey were given to the same group of people on the same day. The mean scores and standard deviation of each form of survey were compared also; the scores in each form of the survey were correlated with the scores of the other. The two forms had almost the same means and standard deviations and they were highly correlated. Therefore the surveys had equivalence reliability.

Homogeneity; this survey did not need to consider homogeneity. This is because there was no need of using several items to measure one characteristic.

1.4.5.4 Adequacy of reliability for surveys uses

The survey was tried out to see if it will provide the needed information. Two questions that were found misleading were restructured. The rest showed that they could be administered and bring the accurate data.

1.4.5.5 Adequacy of description and methods for establishing reliability

a. Pilot test of survey was done and necessary corrections to the questions were done.
b. The length and clarity of questions were reviewed by an expert in research methods from the University of Dar es salaam.
c. The methods used were a combination of open and closed ended to ensure provision of both qualitative and quantitative data hence providing a good mixture for obtaining the most useful information.
d. The terms were clearly defined and all biased words were avoided
e. The sample was carefully formed to form the true representative of population. Stratified random sampling method was used in selecting respondents where by 8 UMASIDA staff, 60 community members were selected forming a sample size of 68. This sample was adequate for generalization because participants have common bonds and needs and therefore perfectly homogeneous.

1.4.5.6 Validity;

Adjibodou and Mutasa in *Assessing and Interpreting Survey Psychometrics* make us to understand that an item that is designed to measure a certain variable example hunger should indeed measure hunger and not some related variable such as anxiety. And in addition to determining reliability one must assess the validity of items, scales and

whole survey instruments – that is how well they measure what they are intended to measure. Once a surveyor has documented that a scale is reliable over time and alternate forms, he or she must then make sure that it is reliably measuring the truth. Researchers typically measure several types of validity when assessing the performance of a survey instrument: Face, content, criterion, and construct (Michel A. and Mutasa F. (2006) *Assessing and interpreting survey psychometrics*)

1.4.5.7 How established:

Face validity: can be established by casual review of how good an item or group of items appears. Normally it is assessed by individuals with no training in the subject under study. In this research the questionnaires were reviewed by two CED students. Suggested corrections on the font size, line spacing and arrangement of words on the form were made to give an appearance which encourages the respondent to read and fill easily.

Content validity: Deciding on a surveys content means setting surveys boundaries so that you can write the correct questions; a survey can be validated by proving that its items accurately represent the characteristics or attitudes that are intended to be measured. Content validity is always established by asking experts whether the items are representative samples of the attitudes and traits in question. In this Survey an expert in establishment of community health fund, Sister Ritter the Director of Tanzania network of community health fund reviewed the items. The items which proved not to be representative sample of the attitudes and views to be surveyed were removed from the form and replacements were structured.

Also to help bolster content validity the following topics were included; the level of community awareness, factors affecting the rate of community participation and ways to enhance the involvement of the community to the scheme. This helped to ensure that the survey could bring the needed information, also to see that all topics were included and that sufficient variety in the response was available.

Criterion: concurrent

It measures how well the item or scale correlates with gold standard measures of the same variable. To establish it the identification of an established, generally accepted gold standard is required for comparison. To establish the concurrent validity of a new survey of community participation in UMASIDA, I could administer the new survey and the already established validated survey to the same group and compare the scores from both instruments. A high correlation between the new survey and the criterion measure means concurrent validity. This was not possible due to the lack of the already established, validated survey on the same topic.

Criterion (predictive): Measures how well the item or scale predicts expected future. One can validate a survey by providing that it predict an individual's ability to perform a given task or behave in a certain way. The design of this survey is a cross sectional; Its main concern is to provide a portrait of things as they are at single point in time that is to determine the causes of poor community participation in the project and not to predict how they will be able to participate in future Therefore predictive validity of the instrument is not relevant.

Construct validity: Is a theoretical measure of haw meaningful a survey instrument is, usually established after years of experience by numerous investigators. It is established experimentally by trying a survey on people whom the experts say do and do not exhibit the behavior associated with the construct. if the people whom the experts judge to have high degree of construct also obtain high scores on surveys designed to measure the same then the surveys are considered to have construct validity. For the purpose of this survey time and nature of information needed could not allow determination of construct validity of the survey instrument.

1.4.5.8 Respondent rate;

The following techniques were used to improve the rate of response:

a. Over sampling; Instead of selecting 40 people that were really intended to be used, 50 people were selected. The extra ten people will serve as replacement of dropouts.

b. Face to face interview technique was used to enhance high response rate.

1.4.5.9 Relevant literature and other surveys on the same topic:

Studying of documents was the key instrument for collection of secondary data. These include:

a. Constitution of UMASIDA
b. Financial reports for the past 3 years
c. Community health fund policies
d. Tanzania Community health fund Act and rules
e. Audit report for the past 3 years

f. Report of different studies conducted available at the offices of Tanzania network of community health fund.

g. National health policy

h. International health policy including millennium development goals

The literature review examined the level of community involvement in the scheme and key finding on the different communities in Tanzania in response to a health sector reform programme (HRS- which was initiated in Tanzania 1995/96) .These reforms underlined the necessity for complimentary partnership between communities and government in cost sharing to finance health care services. The main focus was on key barriers to access among the very poor due to cost sharing and how other communities in Tanzania are addressing such barriers specifically in designing and implementing relevant community health funds. The impact of the schemes to the communities was also among the major concern.

1.5 SURVEY METHODS:

1.5.1 Design;

The term design in this contest refers to the surveyor's way of arranging the environment in which a survey takes place. The environment consists of the individuals or groups of people, places, activities or objects that are to be surveyed (SNHU, (2006) Research methodology template) The design of this research was cross – sectional where the data were collected only once to the target group. Simple random cluster sampling was used to get an equal representation of intended groups which are; respondents from community and from UMASIDA staff.

Method used to collect data include review of organization project records, interviews and face to face administered questionnaire The Unit of inquiries includes scheme members, board members and staff of the organization. Basic instruments for data collection include; structured questionnaires, observation and study of secondary data.

1.5.2 Experimental or descriptive

It was a descriptive aimed at describing the status of community involvement in the project, impact and or relevance of the scheme to the community and suggesting possible ways to enhance the same.

1.5.3 Limits of internal and external validity;

Limitations experienced in the study include;

a. Lack of enough literature and records covering the regulations of Tanzania government (and International) on how to conduct community health fund to the poor.
b. Funds were another limitation that hindered throughout coverage of the whole population. Out of 300 scheme members only 20were interviewed.
c. Lack of enough time was another constraint. The survey was to be conducted within the academic semester which was of five months long. This did not allow enough time for testing content, construct, and criterion validity.

1.5.4 Sample; a "sample" is the number of the people in the survey. To decide on surveying everyone or just a sample depends on how quickly data are needed, available resources, type of survey being conducted, need for credibility and researchers familiarity with survey sampling methods. Two basic sampling methods are probability

and non probability. A probability sample is one in which each person in the population has an equal chance of being selected. The resulting sample is said to be representative. Non probability sample include those acquired by accident such as the first forty people to register in the scheme. Also included are purposive samples for which people are chosen because they know the most or are most typical.

Statistical methods are available to help researchers sample representatively in order to make wise decision on how large should the sample be that is the sample and population should only differ by some specified amount.

Response rate should be as high as possible. If random sampling methods are used, losing peoples responses introduces bias, if it is not, then loss of credibility is resulted. Response rate can be improved by planning ahead to replace people who drop out.

1.5.5. Population or sample:

Due to limitation of funds and time, type of survey being cross-sectional and good knowledge in survey sampling, only a sample of 68 people out of 300 was surveyed.

1.5.6 How sample was selected:

Probability method was used in choosing the sample so as to obtain the accurate view of the whole group, and to have a sample that is representative of the general population.

1.5.7 How sample size was chosen;

Stratified random sampling was used so as to get an equal representation of intended groups which were; respondents from community and respondents from organization

staff. These two groups of respondents were easily obtained through the chosen method as follows;

The population was Sub divided into subgroups; community members and organization staff and the required numbers from each stratum was selected randomly. The required numbers of respondents from the strata were; 60 and 8 respectively. How ever ten extras respondents proportion wise from each group were selected in order to serve as replacements in case of any dropouts.

Reasons for choosing stratified random sampling method;

a. Probability method was chosen so as to obtain the accurate view of the whole group, and to have a sample that is representative of the general population.
b. Stratified random sampling helped to get an equal representation of intended groups which are; respondents from community (scheme members and non members), respondents from UMASIDA staff and respondents from UMASIDA board members. These four groups of respondents were easily obtained through the chosen method as follows;

The population was subdivided into groups of scheme members, non scheme members, UMASIDA staff and board members then 10, 10, 12, and 8 respondents from each stratum was selected respectively

1.6 RESEARCH FINDINGS AND ANALYSIS

1.6.1 Data analysis

All the collected data were presented into tabular information showing the relationship among categories of information. Data material belonging to each category were put in

one place and analyzed by using a computer program- Statistical Program for Social Science (SPSS) see annex 9 for statistical output. In analyzing the collected data, main important area was to find out how UMASIDA has managed to enhance the ability of the community in Mwananyamala to respond to the health services reforms that requires sharing of health cost between government and communities. The analysis assessed the aspect of community participation in scheme and the factors affecting their participation

1.6.2 Findings:

All sixty eight administered questionnaires were well answered see appendix 1 for respondent rate analysis. The analysis of these data revealed the following status in respect to research objectives.

Demographic data: Gender: Out of 60 respondents from the community 31 were female as indicated in table 1

Table 1

Gender of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	29	48.3	48.3	48.3
	Female	31	51.7	51.7	100.0
	Total	60	100.0	100.0	

Income per month: In average the majority of individual income per month fall in the following rates: below 20,000/= and between 20,000/= and 40,000/= see table 2 for percentages.

Table2

Income per month of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Below 20	22	36.7	37.3	37.3
	20 -40	25	41.7	42.4	79.7
	Above 40	12	20.0	20.3	100.0
	Total	59	98.3	100.0	
Missing	System	1	1.7		
Total		60	100.0		

This agrees with PRSP (2000) which states that:

"Although poverty is less acute in the urban area, it is still a serious problem, especially in urban areas other than Dar es Salaam. According to the 1991/1992 HBS, the basic needs poverty incidence for Dar es Salaam was 5.6 percent, and for the other urban areas, 41 percent. These results are supported by the 1993/1994 HRDS, with corresponding figures of 4.2 percent and 30.8 percent, respectively. Results from updated estimates for year 2000 suggest that the incidence of poverty may have increased further. **The urban poor are concentrated in the informal sector."**

The results also show that 8 percent of the respondents depend on single business while 20 percent of them are unemployed. This suggests that the cause of income poverty among the community is unemployment and underemployment.

Table 3:

Types of business of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Food vending	17	28.3	28.3	28.3
	Market retailer	31	51.7	51.7	80.0
	none	12	20.0	20.0	100.0
	Total	60	100.0	100.0	

Number of dependants: The majority of respondents have the burden of 4 and more dependants besides their own children (Table 4). Comparing the average income of respondents and the number of dependants, it shows that this people cannot afford even basic food needs.

Table 4

Number of Dependants of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-2	4	6.7	6.7	6.7
	3-4	32	53.3	53.3	60.0
	more than 4	24	40.0	40.0	100.0
	Total	60	100.0	100.0	

Regarding community awareness status the results show that about 87% of the respondents were well aware about the existence of the scheme (table 5)

Table 5

Awareness status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	52	86.7	86.7	86.7
	No	8	13.3	13.3	100.0
	Total	60	100.0	100.0	

With regard to obstacles to community enrollment to the scheme 87% of the respondents reported being unable to afford the premiums see table 6.

Table 6:

Reasons for not joining the scheme

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I don't like	1	1.7	2.7	2.7
	I cannot afford premium	32	53.3	86.5	89.2
	Others	4	6.7	10.8	100.0
	Total	37	61.7	100.0	
Missing	System	23	38.3		
Total		60	100.0		

This situation is also faced by other schemes and it is being mitigated by other schemes through the following ways:

- Overcoming poverty by promoting income generating activities in rural areas as the source of revenue to pay premium.
- Encouraging solidarity groups for various activities of generating income.
- Reviewing premiums so that matches with fluctuating cost of services.

{Tanzania Network of Community Health Fund annual report (2005)pg 23).

4.3 The results provide the following answers to the survey questions;

The major factors contributing to low rate of premium payments and enrollment are lack of enough money to pay for enrollment fee and premiums

With regard to possible ways for enhancing community participation in the scheme: fire questions were directed to all sixty eight respondents and the responses are summarized in table 7. The suggested strategies include community involvement in ownership and decision making as well as continuous community education and

sensitization. Also 21 percent of respondents suggested feedback system to be put in place.

Table 7:

Ways to enhance community participation to the scheme

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Involve them in decision making	36	60.0	61.0	61.0
	Hold sensitization meetings	10	16.7	16.9	78.0
	Others	13	21.7	22.0	100.0
	Total	59	98.3	100.0	
Missing	System	1	1.7		
Total		60	100.0		

This agrees with empirical findings in that" all flourishing community health funds which have also benefited the community and seen to have improved health services in their community are those which allow 100% community participation in regards to determining health care priorities, deciding where fund should be allocated and monitoring expenditure.

1.6.3 Relevance of the scheme to the community:

The results also show that 72 percent of the respondents seek health services more than four times per year and they always do not have money to pay. For this reason they opt to use unreliable herbs, try to borrow or just wait to die. 28 percent of the respondents who are scheme members reported that the always afford to pay for their health services each year. More over 98 percent of the respondents recommended the idea of having community health fund which involve the community in decision making. They

also requested community development practitioners to prioritize community economic enhancement in the course of addressing community developmental. This is inline with the experience of other organizations implementing community health funds. For example: findings from the assessment of Hanang , which was one of the nine roll-out districts in the initial phase of expansion of the community health fund scheme, reveal that for all community health fund members the benefits of the scheme outweighed the cost (Chee et al,2002 in Poor peoples experiences of Health Services in Tanzania, 2003). Most members and non-members alike believed that it had led to improved services at community health fund participating facilities. Community health fund resources had been used to improve the quality and range of services throughout the district by purchasing drugs and equipment and refurbishing health facilities.(Poor peoples experiences of Health Services in Tanzania, a literature Review 2003).

For many members, one of the greatest benefits of the Community Health Scheme in Hanang was that it ensured unlimited access to health care for the whole family (Chee et al.2002).Others considered it a positive form of savings for unpredictable illnesses in the future. However, in spite of these positive findings the average membership rate for the seven community health fund participating facilities visited during the assessment was estimated to be fairly low at around an average of 5percent of all households in the catchment's area in 2001.In ability to pay a lump sum of Tshs 10,000 was the most common reason given for not joining or renewing community health fund membership, implying that the very poor were essentially excluded from the scheme. Few were aware that the membership fee could be paid in installments. It was easier for people to

pay user fees that were introduced around the same time as community health fund: Tshs 1,000 per person for a single visit to the health facility. For the same reason, the preferred mode of payment for the majority (70 percent) in Lushoto was fee for service; only a minority who report relatively high household income favored community health insurance (Agyemang-Gyau & Mori 1999).

Another very important strategy which has made other community based health insurance scheme to prosper is enhancement of economic status of the target members : For example taking a case of community based health insurance in Rwanda: Greater accesses of the poor to community based health scheme benefits are being promoted through two main strategies.

First building on partnerships between the schemes, grassroots associations and micro-finance schemes (banques populaires), existing and newly formed grassroots associations are motivated to enroll as a group in the schemes under a financing scheme were the micro-finance schemes provides small loans to the associations members to pay for their yearly contributions to the community based health schemes. Such a financing scheme has busted enrollment of the poor in the community based health insurance schemes. In addition, it has opened opportunities for poor community based health insurance scheme members for greater access to larger micro- finance loans to finance income generating activities. Such financial arrangements developed as a consequence of the institutional arrangements between schemes, micro-financing schemes and health centers, and innovations introduced by local actors. Second, non-government organizations and administrative districts are building on the institution

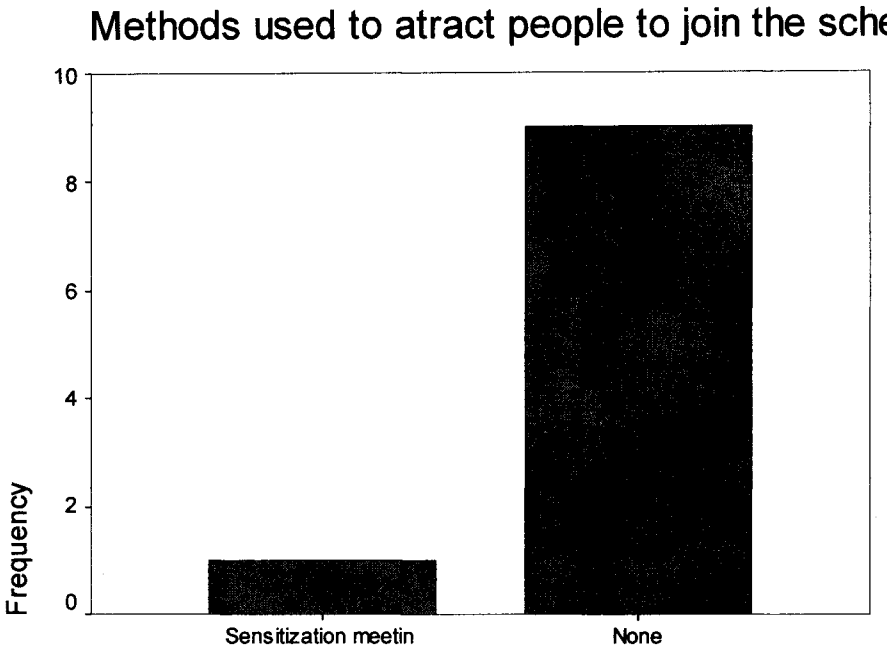
bridges between the communities, the community based health insurance schemes and health care providers to finance the enrollment of the poorest indigents and vulnerable groups (orphans, widows, people living with HIV/AIDS}. Under this demand- based subsidy schemes, community leaders play administrative functions in the identification of the poorest and indigents and vulnerable groups, the community based health insurance schemes manage the consumption of health care for these groups, while the subsidized are financed by non-government organizations and administrative districts who save as intermediaries for primary sources of finance (state, external aid)

1.6.4 Theory analysis

According to World health Organization "Policy-makers in all parts of the world are continually reviewing the way their health systems are financed. Both in the way the funds are collected, how they are pooled to spread risks, what services are provided or purchase and how providers should be paid.

Common concerns are the need to generate sufficient funds for the health, improving efficiency or reducing cost, reducing the financial risks involved in obtaining care and ensuring that the cost of care does not prevent people from receiving needed services (WHO, 2005). This put it clear that the concern of cost sharing policy is to design a health financing system were every community member who can contribute is allowed to do so and those who are very poor are identified and served under waivers and exemption.

On the side of the scheme staff the results show that they have very low knowledge on importance and methods of community participation in developmental projects see one of the bar chart showing their activities



Methods used to atract people to join the scheme

1.6.5 How finding compare with those of other surveys

The findings reveal that lack of enough money is the major factor contributing to low rate of membership enrollment and renewal of membership to the community based health insurance scheme, this is supported by; findings from the assessment of Hanang district, which showed that the average membership rate for the seven community health funds participating facilities visited during the assessment was estimated to be fairly low at around an average of 5 percent of all households in the catchment's area in 2001.In ability to pay a lump sum of Tshs 10,000 was the most common reason given

for not joining or renewing community health fund membership, **implying that the very poor were essentially excluded from the scheme**. It was easier for people to pay user fees that were introduced around the same time as community health fund: Tshs 1,000 per person for a single visit to the health facility. For the same reason, the preferred mode of payment for the majority (70 percent) in Lushoto was fee for service; only a minority who report relatively high household income favored community health insurance (Agyemang-Gyau & Mori 1999).

The result also shows that the community based health insurance scheme (UMASIDA) plays a good role in bettering the health services to its members. This is in line with findings from the assessment of Hanang , which reveal that for all community health fund members the benefits of the scheme outweighed the cost (Chee et al,2002 in Poor people's experiences of health services in Tanzania, 2003). Most members and nonmembers alike believed that it had led to improved services at community health fund participating facilities.

One of the greatest benefits of the community health fund scheme in Hanang was that it ensured unlimited access to health care for the whole family (Chee et al.2002).Others considered it as a positive form of savings for unpredictable illnesses in the future.. Community health fund resources had been used to improve the quality and range of services throughout the district by purchasing drugs and equipment and refurbishing health facilities. This finding is also in line with the case of Rwanda where by:

As a consequence of the removal of financial barriers to access to health care by community based health insurance schemes members of the schemes are four times

more likely to seek modern health care when sick than non- members (Dip, 2000). The households survey results of the pilot phase have been replicated, based on routine data from health centers during the pilot phase and resent results from health centers in the same pilot district and results from health centers in the districts which have implemented community based health insurance schemes between 2001 and 2003 (Butter, 2004).Community based health schemes coverage has also increased the use of reproductive health services, including prenatal care and delivery care, they have no effect, however, on the use of family planning services.

As a result of their insurance function, community based health insurance schemes protect the income of their members against financial risk associated with illness through two mechanisms. First, when sick, members of the schemes seek care earlier resulting in efficiency gains in the consumption of the health care services. Second, sick members pay small out of pockets co payments at the health centers. Consequently, out of pocket payments are reduced significantly among scheme members.

1.7 IMPLICATIONS AND RECOMMENDATIONS

1.7.1 Implications

The survey results make us to understand that the concept of health insurance as the means of improving the health services to Tanzanians is good but only applicable to a minority of Tanzanians who have relatively high household income and to make it successful community involvement and social-economic empowerment is an important ingredient. That is people need to be involved in deciding on the membership

conditions; example the amount and installments of premiums, and other responsibilities such as:

Decision making, prioritization of expenditure, project monitoring and evaluation. They also need to be educated on the importance of the scheme and the reasons for health cost sharing (all about Health Sector Reforms). More over pooled efforts to empower the poor communities social-economically should be employed simultaneously with the establishment of the community based health insurance schemes just as the lesson from Rwanda experience.

1.7.2 Recommendations;

a. UMASIDA social staff should be trained on the importance and procedures for community involvement in development project
b. Mwananyamala health board needs to be educated on management of CHF
c. Target community should be empowered social economically through education particularly on their role in CHF and on entrepreneurship. This will enable them to participate in the scheme both financially and in governance and accountability.

Chapter 2

2.0 PROBLEM Identification

During community needs assessment, existing community needs were prioritized in a participatory manor. The prioritized community needs were then identified as problems. This chapter explains the existing problem, causes and how this project planned to address it.

2.1 Problem statement: Mwananyamala informal economy operators are living under income poverty line. This is explained by the results of the survey which was conducted during Community Needs Assessment where by; 36% of the respondents earn below Tshs 20,000/= and 41% earn 20,000 - 40,000 per month; this is about 0.5 USD per day. This agrees with (NSGRP 2005) stating that urban poverty is evident in households with low and unreliable income, the unemployed urban vulnerable groups and those in the informal sector. It is there fore of no doubt that income poverty is one of the main factors contributing to the existing problem in Mwananyamla ward which is insufficient community participation and contribution in their pre paid health scheme. The assessment also showed that lack of knowledge on management of CHI by the ward health committee and UMASIDA staff is a limiting factor to community involvement in the scheme. This problem is affecting target group members in that they don't have assurance on mutual access to health services. It is also threatening financial sustainability of their scheme by causing insufficient premium payments and fewer membership enrollments than intended.

Current community condition: The target community does not access health services in mutual basis from the scheme as it was intended. The main causes of this situation include: community living under marginal and seasonal incomes, not being involved in designing the scheme and lack of knowledge on CHF management:

Desired aspiration: It is the desire of this project that the target community will engage themselves in viable and sustainable economic activities, the ward health committee will gain knowledge on the management of the scheme and be involved in planning, prioritization of funds and making decisions on scheme matters, and hence community involvement n the scheme will be enhanced.

Community participation constitute to financial, institutional and social sustainability of the project. Basically the community is supposed not only to benefit from health services but also to participate fully in planning, prioritization of funds, making decision on who is to provide health services to scheme members and other managerial aspects of the scheme. Nevertheless it has remained only a beneficiary of health services leaving all managerial responsibilities to UMASIDA staffs.

2.2 Project goal in CED terms: To have all informal Economy Operators Involved and participating in planning and implementing their own health schemes, in corporation with UMASIDA Staff

2.3 Project objectives

To increase by 80% the capacity of UMASIDA staff on Participatory Project Design by March 2006

To Increase by 80% the capacity of Mwananyamala ward health board and UMASIDA management on proper management of community health funds by April 2006.

To increase by 80% entrepreneurial attitudes, knowledge and skills to 30 informal economy operators residing Mwananyamala by May 2006

2.4 Target community: the project targets informal sector operators residing in Mwananyamala ward (the market retailers and food venders). Mwananyamala ward is situated in Kinondoni district Dar es Salaam city. This community is characterized by:

Low level household disposable income: More than half of the people are below the poverty line; they depend on small and local businesses which do not conform to competitive business standards. As such they face poverty as manifested in different forms including lack of income to ensure sustainable livelihoods, inability to accesses health and other basic services.

2.5 Stakeholders

The groups of people who had a stake in this project, their roles and impact has been summarized in table 9.

2.6 Project implementation

In order to achieve the intended objectives the following activities were implemented:

a. A 5 workshop on participatory project design was conducted to 3 UMASIDA staffs.

b. 8 ward health board members were educated on management of CHF.

c. A 5 days seminar on entrepreneurship was conducted to 30 target community.

Table 9: Stakeholders analysis:

Stakeholder	Participation	Evaluation	Impact of participation	rate	Plan
Target community	Ownership, premium payments and service beneficiaries	Low	Institutional, social and financial sustainability	-	Provide social economic empowerment
UMASIDA staffs	Provide technical support	High	Institutional sustainability	+	Educate on community involvement
Donors	Financial support	High	Financial sustainability	+	Encourage them to extend support
TGVT	Offer tax exemptions policies	Moderate	Institutional sustainability	+	Encourage participation

2.6.1 Prerequisites for the project implementation

a. In order to fulfill these objectives the project had the following needs:
b. Two entrepreneurship facilitators
c. One facilitator on participatory project design
d. A technical advisor on "guidelines to community Health Board Action".
e. Money: Tshs. 9,411,000 to pay for stationeries, facilitation fee, training venue, transport, transport allowance, meals and emergency.

2.6.2 Methods used to obtain the project needs:

A trainer on entrepreneurship was obtained from Vocational Training center Dares Salaam.

The project coordinator facilitated the workshop on community participation approach including preparation of a community participation guide manual.

The required money was raised as follows; CED advisor volunteered to facilitate a workshop on participatory project design worth Tshs 500,000 and 8,911,000 was contributed by the host organization the UMASIDA.

2.7 Organizational aspects and structure

The UMASIDA dispensaries are now integrated centers where HIV/AIDS services (VCT, STI, and IEC), malaria treatment and prevention are provided at one stop under one roof and by the same team. Comprehensive care is a third component.

The scheme is community based, financed and managed. It has a council consisting of informal sectors group leaders. This is the highest policy making level. The next level is a board which consists of representatives from the Ministry of Health and social welfare, the private sector and the World Health Organization. It also has four coordinators for: Advocacy and social mobilization, Health care services, administration and finances. See organizational chart in annex 6

CHAPTER 3

3.0 LITERATURE REVIEW

This chapter intends to show Community Health Fund in literature, this include theoretical, empirical and policies addressing it. Under theoretical literature there is meaning, types, history, objectives and situation of CHF in Tanzania. Empirical literature shows case studies on CHF in Tanzania and some other countries in Africa. Regarding the policies addressing CHF this chapter has discussed some national and international policies.

3.1 Theoretical literature review

3.1.1 What is community Based Health financing Scheme?

Community-Based Health Financing Scheme is any health scheme managed and operated by an organization, other than government or a private for-profit company, that provides risk pooling to cover the costs (or part thereof) of health care services. The scheme is voluntary in nature but could be owned by a variety of organizations and covers a variety of benefit packages.

3.1.2 Special examples/Types of CBHI/F schemes are:

Mutual Health Organizations (MHOs) or "Mutuelles de Santé"- autonomous, non-profit community or enterprise-based health financing schemes based on the up-front contributions of many people for the health care costs of a few. Contributions are rated on a community basis as opposed to an individual basis. MHOs attempt to maintain

democratic accountability to their members and promote solidarity and mutual aid between members. MHOs can increase access to health care by reducing financial barriers, enable access to quality health care for marginalized sections of the population, help stabilize the incomes of poor people, contribute to resource mobilization for the health sector, and help make public providers more efficient and responsive to consumer needs. MHO is a term specific to Ghana. "Mutuelles de Santé" are found in francophone West Africa and Community Health Fund (CHF) - a voluntary community-based financing scheme whereby households pay contributions to finance *part* of their basic health care services to *complement* the government health care financing efforts. The CHF term is specific to Tanzania. In 1998, CHF expanded to 10 districts. The CHF Act passed in April 2001 aims at expanding CHF to all rural districts by the end of 2003.

3.1.3 History of Community Health Fund in Tanzania

In the early 1990s health sector reforms in Tanzania took place. It underlined the necessity of complimentary partnership between communities and the government in cost sharing to finance health care services. As a response to this, rural areas community health funds were established Households voluntarily pay a premium that gives them membership in the fund for a defined period. The community health fund package of health services enables members and their families to use no charge Primary health care services from the local public dispensaries and health centers.

The Community Health Fund began as a pilot program in December of 1995 as a component of the larger Tanzanian health financing strategy (which includes cost

sharing with hospitals and a national health insurance scheme). According to the Tanzanian CHF Act of 2001, "CHF" is a voluntary community-based financing scheme whereby households pay contributions to finance part of their basic health care services to complement the Government health care financing efforts." It is further complemented by a social health insurance fund for formal sector workers. In practice, the CHF concept in Tanzania is understood by communities and health staff to encompass both user fees and the pre-payment program.

In 2003, community health funds were operating in twenty three districts of Tanzania with the goal of implementation in all districts by the end of year 2003. Districts are free to set their premiums at any level they wish, given their socio-economic environment. The Ministry of health makes a matching grant for the premiums collected it also coordinates all operations of the community health funds (Evaluation Report Hanang community health fund (2002)).

3.1.4 The objectives of the CHF in Tanzania are:

a. To mobilize community financial resources
b. To provide quality and affordable health care services through a sustainable funding mechanism and
c. To improve health care services management through community empowerment,

3.1.5 Situation of Community Health Funding in Tanzania

Tanzania is struggling mightily in implementing the Alma Alta vision of providing "health care for all" Also it is wisely moving in an incremental manner towards the vision of achieving

universal financial risk protection for all its citizens. In this context there has been a paradigm shift in its approach to health financing.

5.1.5.1 Existing health financing options

Private individual / arrangement: Here health Organizations operate as private insurance companies and provide services to salaried workers on individual basis or as employees of a registered employer. Members join voluntarily and it is common in urban areas.

Micro insurance or mutual health insurance schemes

It covers the informal sector or groups of common interests, Benefit package and contributions are set and agreed by members. Currently the number of mutual health insurance scheme is on increase from churches and charitable organizations

User fees"

It started in hospitals and gradually scaled down to lower levels. It covers all those who are not in prepayment plans (still subsidized by the government by 50%). It is aimed at preparing the public for pre-payments plans

Community Health Fund as per CHF Act no 2 2001:

Aim at providing alternative to paying user fees. People pre-pay on voluntary basis when they can afford to –not when they experience illness or injury. Generated fund is used to increase access to regular supplies of health services, drugs and medical supplies. I strengthen community participation, ownership and empowerment. By contributing directly to public health services households recognize services have a value and that they have a right to express their demands. It provides complimentary resources at the local level making it possible to respond to community defined needs improve moral and job satisfaction of local health workers. Their successes depend on establishment of health boards and health committees.

Compulsory programs:

Under this category there is National Social Security Fund (form June 2005) National Health Insurance Fund.-NHIF (from JULY 2001). It covers workers from the formal sector is financed by employer and employees contributions. Population coverage is 248,343 principal members by the end of 31st March 2005 of which 56%are male and 44% female. Total beneficiaries are 1,142,378which are 3% of the entire population. He size of the family includes principal member, spouse, and up to four children or dependants

Public Health Programs:

These include MCH services at all levels, under five years old and pregnant mothers services, Vaccination and Immunization, Improved infrastructure and services.

3.1.6 Lessons learned and conclusions from assessment of a selected CHF in Tanzania:

Membership levels in CHF programs are lower than anticipated (around only 2.8 percent of target population in Hanang District) CHF membership levels and revenues from premiums are both decreasing Most people have heard of CHF but level of detailed knowledge varies The opinions of most target populations were generally favorable High cost of premiums was cited as a barrier to entry into the CHF There is a need to clarify within Tanzania the CHF objectives and what it can accomplish Although most people think of CHF as insurance, the main risk pooling still occurs through government budgeting revenues. CHF (including user fees) has had a positive impact on funding availability at the local level. Capacity building is still needed in areas of financial management, operations procedures, data analysis, and marketing/promotion of CHF (Hanang (2002) District CHFs Evaluation Report)

3.1.7 Mechanisms that can be implemented to help CBHI/F schemes better serve the poor?

a. CBHI/Fs should advocate for government subsidies for the poor

b. Reinforce solidarity among communities

c. CBHI/Fs can search for other sources of contributions for the poor

d. Could link CBHI/F to micro-credit organizations

e. Benefits package could be redesigned to address needs of poor

f. Improved quality of care for poor

g. Improved health worker attitudes towards the poor

h. Covering cost of transport for poor

i. In some cases, CBHI/F might not be the best means of addressing the needs of the poor exploring

3.1.8 What needs to be added to make CHF more responsive to needs of poor?

a. Incorporation of a facilitator to ask community or CBHI/F structure to identify poverty

b. Indices for themselves (i.e., who qualifies as poor?)

c. Creation of mechanisms for raising additional revenue for the poor (e.g., income-adjusted premiums)

d. Incorporation of mechanisms for evaluating impact on poor within CBHI/F structure

e. Concentration on improving quality of care

3.2 Empirical literature

This section of literature review provides a case study from Ghana (a developing country like Tanzania) and 3 case studies from Manyara, Mwanza and Kagera regions in Tanzania. The main focus is on how the schemes operates, challenges faced and achievements obtained by the schemes.

3.2.1 CBHI/F Schemes in Ghana a case presented by Patric Apoya in a work shop of Partners for Health Reforms (PHRplus)

Since 1985, Ghana has sought to finance health care delivery through several different methods. These include different kinds of geographically based mutual health organizations (MHOs), social health insurance for the formal sector, and private health insurance. Within these three categories, the Ghanaian government estimates that private health insurance and social health insurance cover only an estimated 15 percent of the population. MHOs cover the remaining 85 percent of the population..

The objectives of health care financing in Ghana include:

a. Cost recovery
b. Increased community participation in management and financing of health care
c. Increased quality of care

Recent achievements of schemes in Ghana include:

a. Increased awareness of the MHO concept following advocacy programs which where conducted in June 2001 under the support of Partners for Health Reforms.
b. An increase in actual number of MHOs (from four in 1999 to 47+ in 2001)
c. Development of local management capacity of MHOs

d. A shift towards participatory models of MHOs and away from provider-owned schemes **(A.B. Silvers (January 2002))**

3.2.2 Case studies in Tanzania:

More than twenty three districts in Tanzania have formed community health funds following the reforms of health care services in the Ministry of health. Different donors are committed in supporting the establishment and sustainability of the funds. For example German government via its organ the GTZ is funding the non- governmental organization - Tanzania network of community health fund which is organizing networking of the community based health funds in the country. Many of this community health funds have proved to be essential tools to ensure accessibility of health services to the communities in question (TNCHF (2005) annual report,). Below are some of this community health funds:

3.2.2.1 Hanang Community based health fund-Manyara region.

The CHF scheme was initiated in Hanang district in 1998. Members were about 24% of district population. The annual premium for a household is Tshs 10,000 payable in one or two installments Those who do not join the community health fund have to pay user fees patient visits, (Tsh 1,000 at dispensaries and 1,500 at health centers for out patients and Tshs 3,000 per in patient at hospital), at the time of receiving health care from any of the government health facilities. Facilities are allowed to exempt the indigent from these fees (Hanang, CHF 2002.)

3.2.2.2 Mkula Community Health Fund Magu district-Mwanza region:

It was established in July 2001 with the purpose of providing affordable health care services in Mkula division. The number of people covered by the scheme is 1008 in total belonging to 53 households. The catchment's area of the scheme is 150,000 people. The premium is paid in advance once a year and is collected throughout the year and it differs from group to group: (i) Children less than five years pay 3,600/= per year (ii) Adults pay 7,000/= per year (iii) Households pay 20,000/= per year (iv) Cost sharing of T.shs 200/= when a member comes for treatment to avoid misconduct of the member. The ceiling is 60,000 for the individual members. The community owns the scheme and therefore has elected chairperson, secretary, and an accountant. Health care provider is Mkula Hospital. The community can also select other providers.

Impact of the scheme to the community.

The scheme is not sustainable yet. A maximum of 10,000 members would make this scheme sustainable but it has succeeded to enroll only 2,000 members. Right now there are only limited funds for marketing.

3.2.2.3 ELCT/NWD – community Based Health Fund Kagera region.

It was established in 2001. Purpose of establishment is to enable communities in service areas of ELCT/ NWD to access health care and as means of generating income to sustain ELCT Health facilities financially. Initiator is ELCT/NWD, while ownership is of community with own board and diocesan community based health fund office and staff. The scheme has its own bank account. All cash received are recorded and banked.

Mobilization planned since 2001, and this helped in raising the number of members as shown in the table 9and Marketing which are continuous activities were implemented well as

Table 9 Trend of membership enrollment

Year	2001	2002	2003	2004	2005
Members	1536	2391	3183	3580	4580

Source project record book

Achievements/ impact of the projects: The scheme has helped to sustain the health units because membership has reduced debts and absconding.

Problems faced:

a. Community based health fund is a new concept, not easily understood by the rural community.
b. The high level of poverty due to poor coffee prices in the rural community is a drawback.
c. Confusion in the community due to introduction of national health insurance fund that started at the same time the scheme was taking off. The rural community could not differentiate between the two schemes.
d. HIV/AIDS is a threat to scheme: Members who are infected are likely to increase the number of patients when they fall sick and hence consume more income. It has an impact on sustainability, increasing demand and expenditures.

Way forward:

a. To overcome poverty by promoting income generating activities in rural areas as the source of revenue to pay premium.

b. To encourage solidarity groups for various activities of generating income.

c. To review premiums so that matches with fluctuating cost of services.

d. {Tanzania Network of Community Health Fund annual report (2005).

3.3 Policies related to community health fund:

Policy-makers in all parts of the world are continually reviewing the way their health systems are financed Both in the way the funds are collected, how they are pooled to spread risks, what services are provided or purchased and how providers should be paid.

Common concerns are the need to generate sufficient funds for the health, improving efficiency or reducing cost, reducing the financial risks involved in obtaining care and ensuring that the cost of care does not prevent people from receiving needed services (WHO, 2005).

There are a number of national and international conventions, goals, Acts, policies and other instruments that define the frame work for action for reaching the poor with health. Some examples are listed below:

3.3.1 Tanzania health policy and health policy reforms;

The policy shows clearly the need for every Tanzanian to contribute to health costs in order to ensure sustainability and satisfaction of health services. The overall objective of the health policy in Tanzania is to improve the health and well being of all Tanzanians, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. This can not be achieved without funds and the government need partners in funding the health services.

The specific objectives of the health policy are to:

a. Reduce infant and maternal morbidity and mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions;
b. Ensure that health services are available and accessible to all in urban and rural areas.
c. Move towards self sufficiency in manpower by training all the cadres required at all levels from village to national levels.
d. Sensitize the community on common preventable health problems and improve the capabilities at all levels of society to assess, analyze problems and to design appropriate action through genuine community involvement.
e. Promote awareness in Government and the community at large that health problems can only be adequately solved through molt-sectors which are education, agriculture, water and sanitation, community development, women's organizations, political parties and non-governmental organizations with the ministry of health taking the lead;
f. Create awareness through family health promotion that the responsibility for ones' health rests squarely with the able-bodied individual as an integral part of the family.

These objectives must be achieved through Primary Health Care (PHC) which is the central element of health promotion aiming at coordinated action by all concerned:

health and health related sectors, local authorities, industry, non-governmental and voluntary agencies, the media and the community at large.

The emphasis on equitable universal availability of effective essential health care at a cost the country and the community can afford predicates continued stress on public health spending on preventive and promotive health services and the involvement of new partners in health. The poor, disadvantaged and vulnerable groups will be given special attention.

The following are areas in the national health policy (1990) that needs to be amended:

a. The National Health Policy (1990) states that health care will be provided "FREE". The country has already introduced user-charges and is considering alternative financing methods.
b. The policy places a pre-dominance of the government in the provision of health care. This situation has to change as public/private mix is developed.
c. Private health care providers (both for profit and not-for-profit) are now partners rather than opponents or competitors for the demise of the other (Ministry of health (1994) Proposals for Health sector Reforms)

3.3.2 The Tanzania Community Health Fund Act. No 2 of 2001

According to Tanzania community health fund Act; the objectives of community health fund are:

a. To mobilize financial resources from the community for provision of health care services to its members.

b. To provide quality and affordable health care services through a sustainable financing mechanism and to improve health care services management in the communities through decentralization by empowering the communities to make decisions affecting their health. This act governs the establishment of the community health fund in any district (Hanang CHF 2002).

c. Voluntarism – Households decide whether to join the community health fund or to pay fee for service.

d. Strengthening community participation UMASIDA is working inline with the Tanzania health services reforms and the community health fund Act. However it needs to enhance the aspect of "strengthening community participation."

3.3.3 Poverty reduction policy in Tanzania makes us to understand that:

We live in a divided, polarized world. Half of the five billion people living in the developing world live on less than $ 2 a day. Massive poverty signifies too many deep failures in the prevailing market oriented system of global governance, the global economy and policy reform efforts. Economic growth is too slow, income distribution too unequal, and poverty distribution too constrained to generate a sense of progress and hope. The rules of the game and the rights of human being (humanity) seem skewed to favor the have over the have not. This project recommends community health fund to be among the ways to enhance accessibility to health services by the poor and hence a way out of negative skewness of the accessibility to health services as one of the rights of human being.

3.3.4 International policies and goals:

Policy-makers in all parts of the world, not only in low –income countries, are continually reviewing the way their health systems are financed – either in the way the funds are collected, how they are pooled to spread risks, what services are provided or purchased, and how providers should be paid. The objectives vary, but common concerns are the need to generate sufficient funds for health, improving efficiency or reducing costs, reducing the financial risks involved into obtaining care, and ensuring that the cost of care does not prevent people from receiving needed services. The following strategies have been recommended by World Health Organization: Social health insurance; Sustainable health financing, universal coverage and community health insurance.

3.3.4.1 Universal coverage is defined as access to key promotive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with world health organizations 'concepts of health for all and primary health care" Realization of universal coverage is dependent on organizational mechanisms that make it possible to collect financial contributions for the health system efficiently from different sources; to pool these contributions so that the risk of having to pay for health services is shared by all and not borne by each person who is sick; and to use these contributions to provide or

purchase effective health interventions. The ways in which countries combine these functions determines the efficiency and equity of their health-financing systems (WHO, (2005)).

3.3.4.2 Millennium Development Goals:

The following are Millennium Development Goals which are related to this project include:

a. To reduce child mortality with the target of reducing by two-thirds between 1990 and 2015 the under - five mortality rate.
b. To improve maternal health with the target of reducing by three-quarters, between 1990 and 2015, the maternal mortality ratio.
c. To combat HIV/AIDS Malaria and other diseases with the target of having halted by 1015, and begun to reverse the spread of HIV/AIDS.

{Millennium development goals and corresponding Indicators (undated)}

Looking at other developing countries (example a case of Rwanda) were the community health insurance schemes are flourishing we also have the following lesson to learn:

As a consequence of the removal of financial barriers to access to health care by community based health insurance schemes. Members of the schemes are four times more likely to seek modern health care when sick than non- members (Diop, 2000). The households survey results of the pilot phase have been replicated, based on routine data from health centers during the pilot phase and resent results from health centers in the same pilot district and results from health centers in the districts which have

implemented community based health insurance schemes between 2001 and 2003 (Butera, 2004).Community based health schemes coverage has also increased the use of reproductive health services, including prenatal care and delivery care, they have no effect, however, on the use of family planning services.

As a result of their insurance function, community based health insurance schemes protect the income of their members against financial risk associated with illness through two mechanisms. First, when sick, members of the schemes seek care earlier resulting in efficiency gains in the consumption of the health care services. Second, sick members pay small out of pockets co payments at the health centers. Consequently, out of pocket out payments are reduced significantly among scheme members.

Greater accesses of the poor to community based health scheme benefits are being promoted through two main strategies.

First building on partnerships between the schemes, grassroots associations and micro-finance schemes, existing and newly formed grassroots associations are motivated to enroll as a group in the schemes under a financing scheme were the micro-finance schemes provides small loans to the associations members to pay for their yearly contributions to the community based health schemes. Such a financing scheme has busted enrollment of the poor in the community based health insurance schemes. In addition, it has opened opportunities for poor community based health insurance scheme members for greater access to larger micro- finance loans to finance income generating activities. Such financial arrangements developed as a consequence of the

institutional arrangements between schemes, micro-financing schemes and health centers, and innovations introduced by local actors.

Second, non-government organizations and administrative districts are building on the institution bridges between the communities, the community based health insurance schemes and health care providers to finance the enrollment of the poorest indigents and vulnerable groups (orphans, widows, people living with HIV/AIDS}. Under this demand- based subsidy schemes, community leaders play administrative functions in the identification of the poorest and indigents and vulnerable groups, the community based health insurance schemes manage the consumption of health care for these groups, while the subsidized are financed by non-government organizations and administrative districts who save as intermediaries for primary sources of finance (state, external aid)

This experience open us to the importance of pulled efforts of multilateral stakeholders in building and sustaining community based health funds including community based health insurance schemes.

CHAPTER 4

4.0 IMPLEMENTATION PLAN

Implementation is the specific steps taken when attempting to reach a specific goal. The implementation of any project and the achievement of intended development goals require a substantially increased effort, both by the community themselves and by other stakeholders, based on the recognition that each stakeholder has primary responsibility for its own development and for the support of the community based insurance

Based on the findings of this study, it was proposed a set of general and specific recommendation to UMASIDA. The general recommendation is that UMASIDA should work in a spirit of partnership with the community of Mwananyamala to implement the community health insurance project, and try to solve problems which face the community. This is mainly because it is the people in and within the community who know their problems better and therefore are capable of making fundamental contributions towards formulation and implementation of a comprehensive, focused intervention strategy.

More over UMASIDA needed capacity enhancement in community participation strategies while Mwananyamala community needed entrepreneurship skills. This chapter provides the project implementation plan and shows its actual implementation.

4.1 Project goal: to contribute in improving livelihood of mwananyamala informal economy operators by reducing social economic barriers to their access to health services

4.1.1 Project objective

To increase by 50% community participation in community health fund through social economic empowerment by December 2006.

4.1.2 Specific objectives

a. To increase by 80% the capacity of UMASIDA staff on Participatory Project Design by March 2006
b. To Increase by 80% the capacity of Mwananyamala ward health board and UMASIDA staff on proper management of community health funds
c. Increase by 80% entrepreneurial attitudes, knowledge and skills to 30 informal economy operators residing Mwananyamala by May 2006

4.2 Project outputs:

By the end of June 2006 the project was expected to accomplish the following

a. Three UMASIDA staffs trained on methods for community involvement in developmental projects
b. 8 Mwananyamala health board members trained on Community Health Fund Management as per Tanzania Community Health Fund Act number 2 of 2001
c. 30 Mwananyamala informal economy operators trained on entrepreneurship

4.3 Project Implementation plan

4.3.2 Timing: The project planned to accomplish all the specific objectives by June 2006. The activities needed to accomplish each objective including people responsible, time frames and resources required have been summarized in table 10.

4.3.3 Project inputs

The project was expected to utilize human resource, money and other non human resources as follows:

a. Staffing pattern: Human resource needed include; experts on Tanzania health reforms, entrepreneurship and expert on project design logistic manager and a project manager.
b. Money needed is Tshs.9, 411,000/=
c. Time ; a total of 143 days were needed for intensive engagement in the project activities to be spent as follows: 63 days for preparation of workshop and practical, 91 days for project monitoring and 21 days for evaluating the effect and impact of the project.

Table 10 Project implementation plan

Objective 1: To increase by 80% the capacity of UMASIDA staff on participatory project design through workshop by March 2006

Activity	Project month												Resources needed	Person Responsible
	1	2	3	4	5	6	7	8	9	10	11	12		
1. Prepare and conduct a 5 days Staff workshop on participatory project design			x										Cost of facilitation fee, fare, meals and stationeries 773,000/=	CED advisor, 3 social UMASIDA worker
Objective 2: To increase knowledge of Mwananyamala Ward Health Board members on management of CHF through provision of seminar by April 2006.														
Prepare and conduct a 4 days seminar for 8 board members and three UMASIDA social staffs				x									Cost of facilitation fee, fare, meals, venue and stationary 1,170,000	CED advisor, Expert on Health reforms, 8 Ward health board members and 3 UMASIDA social staffs
Objective 3: To increase by 80% entrepreneurial attitudes, knowledge and skills to 30 target people through provision of seminar by May 20006														
Prepare and conduct a 5 days seminar on entrepreneurship to 30 target people					x								Cost of Facilitation fee, meals, stationeries and venue 2,008,000/=	CED advisor, an expert in entrepreneurship, 30 target people.
Objective 4 To monitor and evaluate project by December 2006														
Conduct project monitoring and produce monitoring report	x	x	x	x	x	x	x	x	x	x	x		Monitoring team money Tshs 1,155,000	CED advisor, 2 ward health board members, 2 UMASIDA staff and 3 scheme members
Evaluate the effect and impact of the project													Evaluation team Money Tshs 4,305,00	External evaluator

Source Project plan January 2006

4.4. Project activities

4.4.1 Workshop on the Management of CHF and participatory project design

The workshop needs were planed to be conducted in the first week of April 2006 in order to identify the knowledge and skills needed by the board members. The third week of April was to be used to prepare materials and other workshop requirements and the actual workshop was to be conducted in the last week of April 2006.

4.4.2. Seminar on Entrepreneurship

The actual needs assessment of the seminar was planned to be conducted in the second week of May 2006, preparation of seminar materials and practical in the third week and the actual seminar during the fourth week of the same month.

4.4.3. Participatory monitoring of the project

Monitoring exercise was intended to be participatory where by 2 Ward Health Board members, 3 scheme members, 1 UMASIDA staff and CED advisor were to comprise monitoring team. The main purpose was to ensure that the project objectives are in track during the project life time and are leading to achievement of project objectives. It was planned that the track of information of each activity will be kept by recording information on daily basis. This was to be done by responsible people for each activity as shown in the implementation plan. The information monitored were planned to be analyzed at the end of each activity.

The monitoring team agreed to monitor the following:

a. Timing of activities to as per implementation plan

b. Type of materials used in workshop and seminars.

c. Attendance of participants and facilitators in the workshop and seminars

d. Availability of resources

e. Trend of membership enrollments and premium payments

f. Entrepreneurial behavior change

g. Individual average income per month

4.5. Project implementation

The project implementation was planned to involve training needs assessments for UMASIDA staff, target community and ward health board members, preparation of a workshop on participatory project design, a seminar on Management of CHF, and another seminar on entrepreneurship. The workshop was to be conducted to three UMASIDA social staffs and the two seminars to eight ward health board members and thirty community members respectively. All the activities were intended to be monitored by recording required information daily and reporting the results at the end of each activity as shown in the implementation plan. Summative and formative evaluations were scheduled in December 2006 with the aim of evaluating effect and impact of the project to the community and achievement of project goal and objective. Evaluation results showed a remarkable increase of community participation in the scheme (by 50%)

It is an on going project starting in January up to December 2006. Main implementers are Target community, UMASIDA staffs, Mwananyamala Ward health board members and CED advisor.

4.6 Staffing

Project staffs comprised of 3 UMASIDA social staffs and 8 Mwananyamala Ward health board members under the supervision of CED technical advisor.

Job descriptions are as follows

4.6.1 Functions of UMASIDA senior social staff

To deal with all project logistics including; mobilization of resources, taking care of all project costs.

4.6.2 Functions of UMASIDA social staffs

a. To participate in conducting training needs assessment for community members and ward health board members
b. To identify and invite seminar participants and facilitators
c. To prepare seminar requirements
d. Take attendance
e. Support seminar facilitators in distributing materials
f. Do any other assignment given to them by senior social worker

4.6.3 Functions of CED advisor:

Supervision of all project activities

Provision of guidance to ensure the project focuses on community economic development

Table 11: Project implementation summary

Objectively Activity	Duration	Resources required	Responsible person	Planned delivery time
Conducting workshop to UMASIDA staff on participatory project design -Conduct needs assessments and identify workshop participants -Prepare requirements and Conduct the workshop for 5 days	1-30/3/2006	Facilitator Venue Tshs 773,000/=	CED advisor UMASIDA management and staff	31/3/ 2006
Provision of seminar on Management of CHF -Assess the actual seminar needs, -Prepare seminar requirements and Conduct seminar for 4 days	1-30/4/ 2006	Facilitator, venue and Money Tshs 1,170,000	UMASIDA Local Government officers, Ward board members and CED advisor	31/4/ 2006
Providing entrepreneurship seminar to target community: Assess the seminar, Prepare seminar requirements and Conduct a 5 days seminar	1-30/5/2006	Facilitator Venue Money Tshs 2,008,000/=	Facilitator CED advisor UMASIDA staffs Local Get officers Target community	31/3/ 2006
Monitoring and evaluation Monitor project activities Evaluate effects and impact to community and achievement of project goal and objectives	1/3-31/11 2006 1st - 31st Dec 2006	Monitoring team, Tshs 1,155,000/= Evaluation team Money Tshs 4,305,000/=	Monitoring team Evaluation team External consultant	30/11/2006 31/12/2006

4.7 Budget

The total amount of money required was Tshs. 9,411,000/=. This entire amount was collected as follows; UMASIDA contributed Tshs 8,911,000 and the remaining potion of 500,000 was contributed by CED advisor by volunteering to facilitate Community participation workshop. The estimated project budget is summarized in table 12

Table 12 Estimated project budget

Income budget	Expenditure budget	
Category	Budget items	Amount
CBO contribution Tshs 8,911,000	Cost of workshop and 2 seminars	3,951,000
CED advisor contribution 500,000	Cost of monitoring and evaluation	5,460,000
Total Tshs 9,411,000	**Total**	**9,411,000**

4.8 Actual implementation of the project

The actual implementation of the project was as follows:

4.8.1 Activity 1: Workshop on participatory project design

Training needs were identified in the first week of March 2006. Workshop design was developed and used to conduct workshop with 3 three UMASIDA social staff on participatory project designing. It was a five days workshop in the fourth week of April 2006. During the workshop a guide manual on participatory project design was produced. This activity has been achieved by 85%. At the end of the workshop the participants were able to identify areas, methods and stages to involve community in the scheme.

4.8.2 Activity 2: Seminar on Management of CHF as per Tanzania CHF Act No.2 of 2007

The needs of the seminar were identified in the first week of April 2006. In the second week the design of the seminar was prepared and used to conduct the seminar. The seminar involved 8 Mwananyamala ward board members and three UMASIDA staffs. At the end of the seminar the participants were able to identify their roles and limitations in managing the Community health Fund. Hence the activity succeeded by 95%

4.8.3 Activity 3: Seminar on entrepreneurship to 30 target community members

The needs of the seminar were identified in the first week of May 2006. Seminar design was developed and used in conducting seminar of 30 Mwananyamala informal economy operators. The entire process covered the first three weeks of May 2006.The entrepreneurial motivated the participants, and they promised to change their perspectives and attitudes towards life. The participants promised to design more business ventures. This activity was achieved by 50%.

4.9 Lesson learnt

Participatory identification of workshop and seminar needs lead the organization to conduct actual need focused seminars and workshop. This enhanced positive community attitudes towards the scheme. Also the average individual monthly income was increasing gradually. These changes contributed to the increased number of enrollments and premium payments to the scheme.

CHAPTER 5

5.0 Monitoring, evaluation and sustainability:

This chapter intends to discuss on how monitoring and evaluation were conducted (based on a logical framework as it is seen appendix; 3 which enabled the scheme to know if the intended objectives has been met or not, to explain how the project will continue to function in case of changes of external funding or phase out of the project as the project was for two years 2005-2007. (Project sustainability)

In order to understand whether the project perform and show the changes Participatory monitoring and evaluation plan was developed and used.

5.1 Monitoring: Monitoring is the process of routinely gathering information on all aspects of the project. It is a continuous process which provides information needed to: Analyse current situation, identify problem and find solution, discover needs and patterns, keep project activities on schedule, maintain progress towards objectives and formulate/ revise future goals and objectives, make decision about human, financial and material resources.(CEDPA Training Manual Series Volume II)

Monitoring was part and parcel of the project implementation, which helped the scheme to assess day-to-day activities performance. It was done based on the objectives of the project. Therefore a monitoring plan was developed which included monitoring of project operation, Activity monitoring plan and result or objective monitoring

5.1.1. Monitoring purpose

The purpose of monitoring was to provide information during the life cycle of the project such as progress and effectiveness of the project activities, usefulness of the resources,

improvements being needed and challenges being faced towards the achievement of the objectives.

5.1.2. Monitoring questions.

Monitoring questions were developed and used to collect the following information:

a. If resources used were enough and helped to accomplish the planned activities

b. If a seminar for 30 target community were organized and conducted.

c. Whether the targeted seminar participants were available at the reasonable time as planned.

d. Whether the workshop on community participation was conducted and the Community participation guide manual was prepared

e. If the Community Health board was provided with a seminar on management of CHF as per Tanzania CHF Act no2 of 2001.

f. If the Organizational staff is working in line with the guidelines of the government on the Implementation of Community Health fund (Checking organizational adherence to community participation strategies). Including the use of community participation guide manual.

g. Type of workshop and seminar materials which were developed

5.1.3 Monitoring Indicators.

Indicators are quantitative or qualitative criteria for success that enable one to measure or assess the achievement of project objectives. Normally good indicators do answer monitoring questions. There are three types of indicators:

a. **Input indicators**- describe what goes into the project example the number of hours of training

b. **Output indicators** – describe project activities such as the number of community members trained.

c. **Input indicators** - measure actual change in conditions such as increased number of scheme enrollments.

The following indicators were used to assess whether the activities were achieved or not. These indicators include:

a. Number of workshop needs identified.

b. Types of materials collected

c. Number of sources where the materials were collected.

d. Type of workshop materials prepared

e. Number of seminars conducted

f. Number of members participated in seminars.

g. Types and number of seminars conducted.

h. Content of Community participation guide manual.

i. Availability of community participation guide manual to the organization

j. Status of Community Health Board; is it active?

k. Monthly individual average income of the trained community members

l. Rate of new member scheme enrollment

m. Rate of premium payments

n. Status of community involvement in scheme activities

5.1.4 Expected output for monitoring

Monitoring team was expected to provide a report which show an ongoing picture that will allow the stakeholders to determine Weather the activities are progressing as planned and are leading to objectives (contributing to increasing rate of membership enrollment and premium payment) so that early adjustments can be made

Table 13 summary of project activities monitoring plan

Activities	Duration	Methods	Current progress	Solution
Workshop on community Involvement to 3 UMASIDA staffs	1 – 31/2006	Review of workshop material and attendance register Observation of workshop sessions	-Workshop materials relevant to the needs of focus group -All focused attendee attending the workshop -Workshop facilitator delivering properly OR Irrelevant materials, poor attendance and or improper facilitation	-Encourage the use of the materials -Encourage them to continue with good attendance -Encourage him to facilitate as required Correct the materials to suit the needs, insist smooth attendance and proper facilitation
Conduct seminar to 8 health board members	1-30/4 2005	Review seminar materials and attendance register Observe facilitation skills	Materials are relevant to seminar needs Attendance is good Facilitator is capable OR Materials are not relevant, poor attendance and improper facilitation	Encourage consistence of use of same materials, good attendance and proper facilitation Adjust the materials to suit needs, insist smooth attendance and proper facilitation

5.1.5. Monitoring tools

Tools used to collect information on progress of project activities its impact to the community include: baseline report, observation, seminars and workshop attendance registers and UMASIDA records such as members register, premiums collection forms, and financial accounts.

5.1.6 Timing of monitoring activities:

Records of project activities were kept daily, analyzed at the end of every month and reported to the responsible stakeholders monthly also presented in half of year stakeholders meetings.

.5.1.7. Participants for monitoring

Monitoring of this project was a participatory activity between the organization staffs, Project coordinator and the community therefore it involved; the project advisor, 2 scheme leaders, 2staff and scheme members and 2 community health board. All were involved in order to ensure project sustainability by allowing all who are concerned to make close follow-up so as to make sure that the intended objectives are achieved.

5.1.8 Monitoring methodology:

Method used to monitor activities includes observation, review of educational materials and records including attendance records, membership records and premium payment records. Observation of education sessions and review of educational materials were intended to assess if the activities were on track while review of membership and

premium records were aimed to check if the project activities are heading in the right direction that is contributing to increased community participation to the scheme.

5.1.9. Data analyses and presentation.

Data collected were analyzed manually by monitoring committee under the supervision of project advisor and presented through numerical, percentage, tables and narrative way that enabled different stakeholders to understand and interpret easily. The flow of information was through reports presented as follows to:

a. Leaders, who discusses the reports every month in their meetings.

b. Ward health board members discussed the report in monthly, quarterly, half yearly and annually bases during their planned meetings.

c. Scheme members during their annual meetings conducted in December 2005 and 2006.whereby 18 members attended out of 30 in 2005 while 40 members attended in December 2006. There was membership increase in 2006 due to added efforts of community health board action

These enabled members to acknowledge that the planned activities were on track and were leading to project objectives. Final monitoring report showed that:

a. The planned workshop on community participation strategies was conducted to social staff whereby all targeted 3 staffs attended. During the workshop community participation guide manual was prepared; the manual is composed of meaning, importance, of community participation, also stapes and strategies to involve community in the scheme activities

b. Sources were used in collecting relevant materials, which helped in improving and in developing realistic community participation strategy. The sources include Ministry of Health and Social welfare, Tanzania Network of Community Health Funds, Policy Forum and the CEDPA Training Manual Series.

c. Seminar needs related to entrepreneurship skills were identified by 28 members out of 30 expected members. Skills identified include how to identify viable economic activities, costing and pricing, bargaining and negotiation skills, record keeping, and diversification of seasonal businesses.

d. Seminar materials to be used in business development training were developed according to the identified needs and trainings were developed and conducted.

e. One seminar on entrepreneurship was conducted for five consecutive days from 15th to 19th May 2006 where by 28 out of 30 targeted participants attended. Field visits in business premises noted 10 community members who attended the training to have increased the number of business from one to two of which are of different seasons.

f. Regarding the impact of seminar to the participants and the relationship between average monthly income and enrollment and or premium payment, monitoring results show the following summary

g. Seminar on guidelines to community health board action was conducted and all 8 board members attended. The responsibilities and mandate of the board were put inlight to board members as they are stipulated in Tanzania Community Health

Fund act. During the seminar the following responsibilities of the board were identified:

a. To liaise between the community and the organization

b. To participate in planning meetings

c. Supervising activities of the scheme including service delivery at the facility

d. Monitoring and evaluating scheme.

e. To mobilize enrollment of members and premium payments.

f. The board has the mandate to make managerial decisions under the guidance of technical staff of the organization. The decisions include hiring and firing of staff, appointing health service providers, planning and prioritization of funds. After the seminar the Ward Health Board organized and conducted two meetings in Mwananyamala ward on the importance of community health fund and convinced the community to join the UMASIDA health scheme. Community attended the meetings were about 70 people.

The figures in table 14 show progressive increase of average monthly individual income which is proportional to the increase in number of business and also correspond to the increase in membership enrollment and premium payments. This means that the project activities were leading to the objectives of increasing individual average monthly income, increasing membership enrollment, and premium payment rate

Table 14: Impact of seminar to community

Month	Number of respondents	Number of business	Average monthly income in Tshs 000	Membership status	Premium payment status
June	28	1	20 -30	10	5
July	29	1	20 -30	10	5
August	30	2	25 -35	13	10
September	30	2	30 – 45	15	15
October	35	2	40 – 60	28	28
November	38	2	40 – 60	35	35
December	40	2	40 - 60	40	40

Source: Project Progress Report December 2006

Together with the above-mentioned achievements, the project managed to show the following outcomes:

a. The scheme has increased the rate of premium payments from the average of 2 members per month to 20 members per month.

b. Project design approach has improved. The responsibilities of the community and that of the organization staff was put clear. This increased community ownership and accountability so did participation. The scheme has separated the accounts. Before the project interventions it was not easy to know how much is from premium and membership enrollment and from other sources because all money received was recorded in one book. After the interventions, it is easy to identify money from different sources and their respective expenditure. Availability of

clear records encouraged members to increase rate of paying their premiums and non members were encouraged to join the scheme.

c. Ward health board members are very committed to make sure that the project interventions are achieved. Most of the time they are making follow-up of premium payments to members, which reached to 2, 740. 000/= Tanzania shillings by December 2006 and 30 new members joined the scheme.

5.1.10 Lessons learnt

Problem encountered during the implementation

Although the activities were implemented, there were problems, which to some extent affected the implementation. These problems include:

a. Inadequate funds to support project implementation. Some of activities had to be done in voluntary basis for example the CED advisor was forced to volunteer to facilitate workshop on participatory project design a service which was planned to cost Tshs 500,000/=

b. Low level of education to target community. Among 30 seminar participants on entrepreneurship only 8 only 18 were well literate, this caused very slow leaning and even adoption of skills imparted by the project. This problem was minimizes by visiting the participants in their business premises regularly and offering entrepreneurial advises. That is why the improvements were taking place gradually. Also the illiterate group was advised to attend literacy classes under adult education program

Good experience:

Involvement of ward health board in project cycle, transparency of organizational staffs and social-economic empowerment of the target community lead to increased community participation, ownership and accountability to the scheme. This enhanced membership enrollment and rate of premium payments

5.2 Evaluation:

Participatory evaluation was done by developing evaluation plan as it is shown in project plan and the actual evaluation was conducted in December 2006.

5.2.1 The objective of the evaluation.

The overall objective of the project evaluation was to asses the effectiveness and efficiency of the project in achieving its intended goal and objectives

5.2.2 Specific objective of evaluation:

a. To determine the extent to which the project objectives have been achieved in reference to indicators of acceptable performance as indicated in the project plan

b. To assess the impact of the project interventions / activities on the targeted community and focused group in particular

5.2.3 Evaluation guiding questions:

The evaluation coverage was to be guided in groups as follows:

5.2.3.1 Achievement of project objective

What are the objectives of the interventions? Do they fit the expectations of the community in regard to UMASIDA

To what extent are the interventions objectives complimentary to the development needs of the country?

To what extent have the project objectives been achieved?

5.2.3.2 Project results:

What impacts were expected from each project activity at this stage?

Have the expected benefits and impacts been realized?

In what ways have beneficiaries been affected positively and negatively during and since the implementation of the project? What were the most important factors contributing to the project observable impact or lack of impact?

To what extent has the project empowered UMASIDA staff and focused group?

5.2.4 Evaluation team.

The scheme staffs, community, and ward health board members under the supervision of project advisor managed to select the team of 5 people based on the required skills for undertaking comprehensive participatory evaluation. Members were from scheme members, UMASIDA staffs, Mwananyamala health board members and Project advisor.

External consultant from the organization known as Tanzania Network of Community Health Funds facilitated evaluation.

5.2.4. Performance indicators.

The indicators used to provide information needed for evaluation were from the logical framework these indicators were categorized under each project objective as follows:

Objective 1:

a. Workshop on participatory project design conducted as planned by March 2006.

b. Community participation guide manual available in UMASIDA office and in ward office.

c. The roles of scheme members ward health board and UMASIDA staffs in the scheme well understood and adhered.

d. Increased members in the scheme from 18%(September 2005) to 50% by December 2006.

e. Increased rate of paying premium by 50%

Objective 2:

a. Seminar on management of CHF conducted

b. Ward health board playing its role in the scheme.

Objective 3:

a. Increased number of community members with business development skills from 0(September 2005) to 30 members by (December 2006.)

b. Number of members engaging into profitable economic activities increased from 0 (September 2005) to 30 members by (December 2006.)

c. Average individual income increased from Tshs 20,000 (September 2005) to 40,000 and above by (December 2006)

d. Rate of premium payment increased from 2 members per month (September 2005) to 30 members by December 2006).

e. Number of membership enrollment increased from 18% (September 20050 to 50% and above by December 2006

5.2.5 Evaluation methods

In order to facilitate critical evaluation process a broad range of methods was utilized. The proposed methods and tools to be used are show in the evaluation plan as summarized in table 5.

5.2.6 Source of information.

During the evaluation activity, data were collected from different sources, which include:

a. Project documents, which include project proposal, need assessment report, baseline, monthly, quarterly, and yearly reports.

b. Members of the scheme.

c. Members of the community.

5.2.7 Tools for evaluation.

a. Checklists were used to guide focused group discussion whereby members were given chance to express and show their feelings towards the project. Information collected by using this tool supplement the information collected by using questionnaire whereby a person were supposed to feel what was required in the questionnaire.

b. Questionnaires were used to collect information which required direct answers

c. Field visits / observations guides were used to provide a full picture of what is happening in the area. The application of knowledge and skills acquired from workshop and seminars by the participants were viewed physically. Example community members who are applying entrepreneurial skills such as innovations.

d. Interview was also used to collect data from on individual average monthly income

e. Observation method was used by evaluators to verify some of information given by those who were interviewed.

Table 15 Evaluation plan

Evaluation objective	Indicators	Methods	Tools
Extent of the achievement Of project objective	Accomplished planned activities	Documentary Review Field visits Observations	Project documents Implementation reports Visits and observation guides
Assessment of project results	Behavioral changes due to project activities Changes in the individual monthly average income Number of people received education in workshop and seminars. Changes in rates of membership enrolments and premium payments.	Documentary review Household interviews Field visits and observations Focus group discussion	Project documents Baseline survey Questionnaires Discussion guides Observation checklist.
Data collection on implementation process	Baseline data Accomplished planned activities Monitoring and evaluation systems	Documentary review Field visits Observations Focused group discussion	Project documents Baseline survey Field visits Observation Interview guide Focused group[discussion guides
Sustainability assessment	Project sustainability strategy Level of community participation Level of staff, ward health board and community capacity to run the scheme smoothly and effectively	Documentary review Focused group discussion	Project documents Project reports Discussion guide

Source: Project implementation plan

5.2.8 Data collection, analysis and presentation.

Data collected during the evaluation were analyzed by both software (SPSS)and manually and presented in narrative, numeric and tables, the report was presented to members during the annual meeting 31st December 2006.

5.2.9 Evaluation findings.

After the implementation of this project the scheme managed to achieve the following:

a. Increase community participation (ownership and accountability) by 80% through application of community participation strategy in redesigning of the project

b. The seminar on Management of CHF enabled ward health board members to gain knowledge and more confidence in mobilizing premiums within their members and encourage more people to join the scheme.

c. Premiums paid were increased from Tanzania shillings 2000 per month (September 2005) to Tanzania shillings 30,000 by December 2006.This amount enabled the scheme to increase its capacity to provide health services of high quality to its clients. There fore more members were attracted to join the scheme.

d. There is an improvement in entrepreneurial attitudes and skills within members, which enable them to diversify their seasonal businesses by having businesses of varied seasons from one season business (September 2005) to two business of different seasons by December 2006.

e. Individual average income increased from 20,000 per month in September 2006 to 40,000 in December 2006.

f. Field visits observed about 15 members owning more than one business of different seasons. This enhanced stabilization of their income throughout the year.

In short the project enabled the scheme to achieve its target. From the data collected, it is noted that the project was viable and it addressed a real need of the scheme because before project intercessions the scheme was facing the following problems:

a. Low community participation

b. Target community was too poor economic wise to afford premiums.

c. The number of scheme members was decreasing as the days went on.

d. These problems have been minimized by the mentioned project outcomes.

5.2.10 Timing of evaluation

The whole evaluation was completed within a period of 21 days. This included design of the tools, field work, data analysis and submission of evaluation report

5.2.11 Lesson learnt.

Participatory evaluation identified the following as major challenges and difficulties faced so far by the project:

a. It was difficult to gather the seminar participants at the same time and days because they have different responsibilities. This challenge was solved by paying the participants to compensate their extra work hours.

b. The concept of CHF is still new so it was difficult to mobilize people to join something they do not know. This problem was overcome by conducting continuous community sensitization on the subject.

c. Increased financial burden to the scheme. This is because the population entitled exemption (children under five and people living with HIV/AIDs) is bigger and is the one seeking health services frequently than the number of people who are supposed to pay. This is due to the increase of prevalence and new HIV infection. This financial gap is filled by resources/ funds which are obtained from other sources including donors.

5.3 Project Sustainability.

Project sustainability or project continuity refers to the capacity of the project to continue functioning supported by its own resources (human, material and financial), even when external source of funding have ended. Project sustainability is an important aspect of the evaluation process. Sustainability need to encompass the following:

5.3.1. Financial viability: Ability of the project to continue to function regardless of changes in external funding and phasing out. Questions to be answered include:

Are the project activities facilitating community self-help and self reliance?

Are the activities building capacities of community in a sustainable manner?

Are the approaches facilitating community to plan, implement and manage activities?

5.3.2. Social viability was assessed by using the following checklist

To what extent the project based on community felt need?

What was the process of community entry and participation in community felt needs identification?

5.3.3 Institutional /Organizational viability was assessed through the following question

To what extent is the community prepared to self –organization?

Is there a well organized structure of the project?

5.4 Observations of evaluation on project sustainability

5.4.1. Financial sustainability

The following ensure community self reliance in future

a. Members will use entrepreneurial skills to strengthen and improve their economic activities, which will increase earnings from income generated from their profitable economic activities. Furthermore skills equipped will enable members to diversify into other economic activities, which in one way will contribute in increasing average monthly income within members. This group of people will be role modal for other community members to learn on entrepreneurship

b. UMASIDA staff will continue to approach other donors – National and international to fill the gap of exemptions..

5.4.2 Political sustainability:

Tanzania government is implementing health reforms whereby every body is required to share the cost of health. CHF is one of the strategies of the ministry of health to make people who can share health cost with government do so. Therefore the project is inline with the national goals hence no doubt it will get support from government.

UMASIDA is publicizing and distributing brochures on the project activities

A strategy to hold continuous advocacy meeting for the scheme is in place.

5.4.3. Institutional sustainability:

The following established situations will favour the sustainability of scheme institutionally:

a. Ward leadership will continue to provide favorable environment to the project so that it will be easy for the project leaders to mobilize premium payments. This is due to the fact that one of the tasks of the ward leaders is to encourage community to participate in government reforms including Tanzania health service reforms.

b. UMASIDA staff will continue to make use of community participation knowledge and guide manual which was obtained from the workshop. Trainings and workshop on the same will be provided to new staff to ensure that community is fully involved in all stages of the project. The staff members who participated in the workshop will be the resource people to train other on community participation strategy

c. Knowledge about management of CHF by ward health board members will help to ensure community ownership and accountability to the scheme

d. The project has developed good relation with Tanzania network of Community Health Fund (TNCHF) together with the ward health board, which will enable the project to continue with its functions. Therefore TNCHF will continue to build capacity of scheme staffs and members in the following area:

a. Community involvement

b. Good governance and accountability.

c. Strategies to overcome project obstacles/ problems

d. Review of constitution and policies.

e. Link the scheme to other CHF to get more exposure and learning in relation to membership enrollment mobilization and community involvement aspects.

CHAPTER 6

6.0 CONCLUSIONS AND RECOMMENDATIONS

This section explains the conclusion drawn from this project and provides recommendations for further actions.

6.1 CONCLUSIONS:

The experience obtained from this project make us to understand that the concept of health insurance as the means of improving the health services to Tanzanians is good but only applicable to a minority of Tanzanians who have relatively high household income and to make it successful community involvement and social-economic empowerment is an important ingredient. That is people need to be involved in deciding on the membership conditions; example the amount and installments of premiums, and other responsibilities such as deciding on prioritizations, monitoring and evaluation of the fund. They also need to be educated on the importance of the scheme and the reasons for health cost sharing (all about Health Sector Reforms). More over pooled efforts to empower the poor communities social-economically should be employed simultaneously with the establishment of the community based health insurance schemes in order to empower the people with marginal income economically so as to enable them to afford the premiums and membership fees. This is a lesson from this project and other projects of the same mission as indicated in the empirical literature review in chapter 3 of this report.

6.2 RECOMMENDATIONS

1. UMASIDA social staff should continuously receive trainings on the importance and procedures for community involvement in development projects.
2. Another study on specific needs of Mwananyamala community with regard to income busting is recommended
3. The situation of health services to the poor reveals that there is a need for a health care system that requires not only massive investments of funds but also a renewed commitment and vision among all actors – government, policy-makers, donors, non-governmental organizations, faith based organizations, health workers themselves and others to generate fundamental change. This call for change is fundamental for Tanzanians living in poverty, for which treatment is becoming increasingly unavailable, and for whom expensive private care is simply not an option.

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