Journal of Advanced Research in Humanities and Social Sciences
Volume 11, Issue 1 - 2024, Pg. No. 23-32
Peer Reviewed Journal

Research Article

Sustaining Practices of Community Health Fund and HIV/AIDS Services in Dodoma Central Tanzania

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How to cite this article:
Babune GJ. Sustaining Practices of Community Health Fund and HIV/AIDS Services in Dodoma Central Tanzania. *J Adv Res Humani Social Sci 2024*; 11(1): 23-32.

Date of Submission: 2024-02-10
Date of Acceptance: 2024-03-16

A B S T R A C T

The persistence of diseases varies across countries due to differentials in investment by various health actors, among other factors. This paper investigated the practices in the provision of community health fund (CHF) and human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) services in Dodoma, central Tanzania. The paper explored the differences in experiences between urban and rural settings. A cross-sectional design and a mixed approach were employed for comparative and complementation purposes, respectively. A sample size of 400 was used to gather data by survey, documentary review, and key informant interviews. The analysis was done using descriptive statistical methods. It was found that the area received improved CHF services using 10,000 to 12,000 Tanzanian shillings (Tshs) as an annual fee per household. It accounted for the enrollment of 61195 households and 19000 households from 2008 to 2016 in the Kongwa District Council (KDC) and Dodoma Municipal Council (DMC), respectively. There had been groups formed due to HIV/AIDS adaptation, whereby 48 and a few in DMC and KDC, respectively, were served by financial mitigations. This amounted to 152, 498, 306 Tshs and 16, 000,000 Tshs for DMC and Kongwa, respectively, from 2010 to 2017. It concluded that there had been improvement in the practices of CHF and HIV/AIDS services in the area. These were purposeful practices by project actors and national programmes on HIV/AIDS services. However, these practices are not sustainably promoting the social well-being of communities. Recommended for adoption are community practices that build awareness and knowledge regarding the potentials of CHF services on their lives, as well as HIV/AIDS awareness mitigations that are community-centred.

Keywords: Community Health Fund, Practice, Health Facility Committee and Council Health

Introduction

Globally, health service provision varies according to the level of effectiveness of investment to address the challenges. This variation can be reflected in the evidence of progress in investment against the HIV epidemic, which tracks closely with the investments made in national HIV responses.[1] The investment has been realised to decrease in low- and middle-income countries in one year (2018), calling attention to investigating the compromised strategies over the epidemic. According to the health governance model by,[2] health governance has various sets of actors, including politicians, policymakers, and other government officials. Others are health service providers. The principal actors are the beneficiaries, service users, and the general public, making up community members. The model portrays that each category of actors has equal influence and power. But this is argued by.[3] the degree of power between actors in health governance is differentially distributed among the three health actors. While this is argued, the paper was interested in finding out how the government health actors collaboratively practice the delivery of health services to the public, particularly HIV, malaria, and community health fund (CHF) services.

According to,[4] the Declaration of Alma-Ata meant that community participation (CP) was crucial to the achievement of health for all. It articulated that primary health care needs and enhances maximum community and individual self-reliance and involvement, making the fullest use of local, national, and other available resources.[5] The Bamako Initiative claimed to make primary health care accessible for all through community funding and management.[6] However, questions remained as to whether or not, how and how much poor people in low-income countries have awareness or knowledge of these services, and how they should expect to contribute to health care.

Community health fund schemes across countries have been regarded as a strategy for the inclusion of pro-poor communities in health services. According to,[7] there are five options for the development of CHF presented as increasing the risk pools and developing a purchase-provider split, a move from passive to active enrolment, adoption of community-based enrolment, and moving towards insurance, i.e., separation of the district from CHF services and expanding risk sharing by establishing regional CHF offices.[8] argues that the effectiveness of management and user committees depends on the structure, composition, motivation, and capacity of their members. The CHF service providers, together with community structures for health governance such as CHSBs and HFGCs, did not appear to alter the existing power relations between lower-level principals and higher-level agents (technical district staff).[9] Tanzania possesses the policy and legal framework for CP in health matters.[10] According to the guidelines for CHSBs and HFGCs of 2013, the health boards and committees shall promote CP through sensitization for their health care initiatives. They shall promote sustainable health infrastructure and reliable logistics and supply systems .[11,12] They have the role of improving the quality of care, ensuring that exemptions are respected, and mobilising resources from the community.[13a] Experience shows low performance on CP. According to,[14] at the local level in Tanzania, it was evident that CP was low.

The provision of health services in Tanzania has been one of the priorities over social services, being among the three enemies of the state fought since independence, namely ignorance, poverty, and diseases. The Tanzanian local public health service operates under a decentralised framework where community members are owners of the primary healthcare facilities. The Constitution of the United Republic of Tanzania,[15] Chapter 8, Section 145 (1), provides the powers of the public to participate. According to the constitution, there will be local government structures in every region, district, town, and village in the United Republic. Section 146(1) of the chapter states that the purpose of the establishment of local governments is to decentralise powers to the citizens. It is further stated that the structures under the local government authorities will have the right and powers to enable the public to participate in the planning and implementation of development activities in their areas of jurisdiction and countrywide in general.

The health governance framework is composed of a central health ministry at the tertiary level and secondary health facilities at regional levels that oversee the decentralised local health governance of the primary health care facilities.[16] The local government authorities constitute the health departments, which are responsible for the provision of health services to the community members within the jurisdiction of the health facilities established for management by the health board and governing committees. According to[17a] the United Republic of Tanzania Guidelines for the Establishment of CHSBs and HFGCs (2013a), these structures are composed of community representatives selected from within the community members and who, upon their selection, join with the public health service providers, policymakers, and political actors in the planning, management, evaluation, and feedback communication over health services.

The CHF scheme became formal in 2001 after the establishment of the CHF Act of 2001. The scheme is important in that it addresses the health challenges of the general community members at the level of households at the lowest cost. The establishment of the scheme required knowledge of its extent to improve the provision and use of health services. In spite of having some achievements

in the health sector, the communities face a high burden of disease, particularly malaria, tuberculosis, and HIV/AIDS. Malaria is still the leading root cause of morbidity, accounting for 27 percent of all registered outpatient cases involving children under 5 and 22 percent of cases among children aged 5 and above in 2014.[18] The CP health structures in Tanzania, except Dar es Salaam, had a low capacity for promoting health services[19] and.[20] In the Dodoma Region, despite the high level of awareness and positive attitude towards health services by communities, a substantial proportion of communities do not use the services.[21] Health service provision in the Dodoma Region is still unfavourable.[22] According to,[23] poor management of health services results from a lack of CP in the Kondoa and Mpwapwa Districts of the Dodoma Region.[24] Also, Mpwapwa and Kondoa Districts indicate challenges for CP in governing health services. Therefore, this paper was designed to address the knowledge gap related to how government health actors practice the provision of CHF, and HIV services in the study area.

Methodology

The study was done in Dodoma Urban and Kongwa Districts of Central Tanzania. The area was chosen due to the varied practices of CHF services between urban and rural settings. A mixed approach was used due to the need to complement qualitative and quantitative results. The study employed a cross-sectional design due to the comparative need for variables in rural and urban areas. It involved various methods of sampling. Systematic random sampling was employed in recruiting community members using a three-stage interval. A sample of 400 community members was involved. The key informants were involved in purposive sampling procedures. Methods of data collection involved questionnaires, surveys, and interviews with key informants. The study permit was granted by the University of Dodoma on behalf of the central authority of the government and later by the regional and local government authorities of the Dodoma region, Dodoma Municipal Council and Kongwa District Council, respectively. Ethical issues such as validity and reliability, confidentiality, and consent, to mention but a few, were adhered to in the study process. The analysis was done using descriptive statistics and thematic analysis of the data. Data were presented through explanation building as well as using tables and figures.

Results and Discussion

Use of Community Health Fund Services

The study found that the CHSBs and HFGCs were using the legally established procedures for advocacy on CP in the CHF scheme. The activities included the contribution of community members to CHF services. The health facilities collect funds at the district level to account for drugs and other related needs. In turn, after services to community members, the health facilities receive matching funds for CHF membership use. The health facilities also collect user fees directly from members who come for services. Yet, the level of use of CHF health services by community members in DMC and KDC was found to be at a low level. It was also revealed that the CHF Services in one of the health facilities were being not provided as stated by one of the health service providers during the interview below:

The CHF services are not there; this is because of the few resources available at our hospital. The CHF contributions are low such that they can compromise our capacity to pay human resources and run the health services if we choose to provide such services" (Interview: Health Service Provider, DMC.

The study found that the scheme adopted a peculiarly different approach accorded by the CHF Act 2001 with increased cost from the normal Tanzanian Shillings 5,000/= to 10,000/= per a maximum of 6 members of household contributed annually. The project recognized the existence of the CHF structure from the council and division to village/street levels in the district. At the council level, there is the CHF Board that is responsible for overseeing the Council CHF services under the CHF Manager and the CHF Coordinator whereas in the Divisions; there are CHF Officers who are linked with wards and villages/streets (CHF Enrolment Officers) in their jurisdictions.

Yet, the results indicate that the revamped CHF scheme which was the pilot project in the Dodoma Region since 2012 was not effective. It was found that there were several challenges associated with the scheme such as poverty, low level of knowledge and awareness and the problem of shortage of drugs that limited members of the community from sustaining their membership.

Practices to Improve CHF Services

Community sensitization, enrolment of 6 community members for Tanzania Shs. 10,000/= to 12, 000,000/= annually. Use of CHF cards for healthcare access by CHF members. However, the use of CHF services despite the claimed less costly, is mainly limited by drugs that community members see and therefore judge in terms of poor services provided.

Membership in the Revamped CHF Scheme

Figure 1 presents results on improving membership in the CHF scheme in DMC and KDC. Community membership in the CHF scheme is one of the indicators of participation in health governance by community members. The study found that 83 (41.5%) had not been members, while 117 (58.5%) were members of the DMC. In KDC, it was indicated that 175 (87.5%) of the respondents were members of the scheme, while 25 (12.5%) were not.

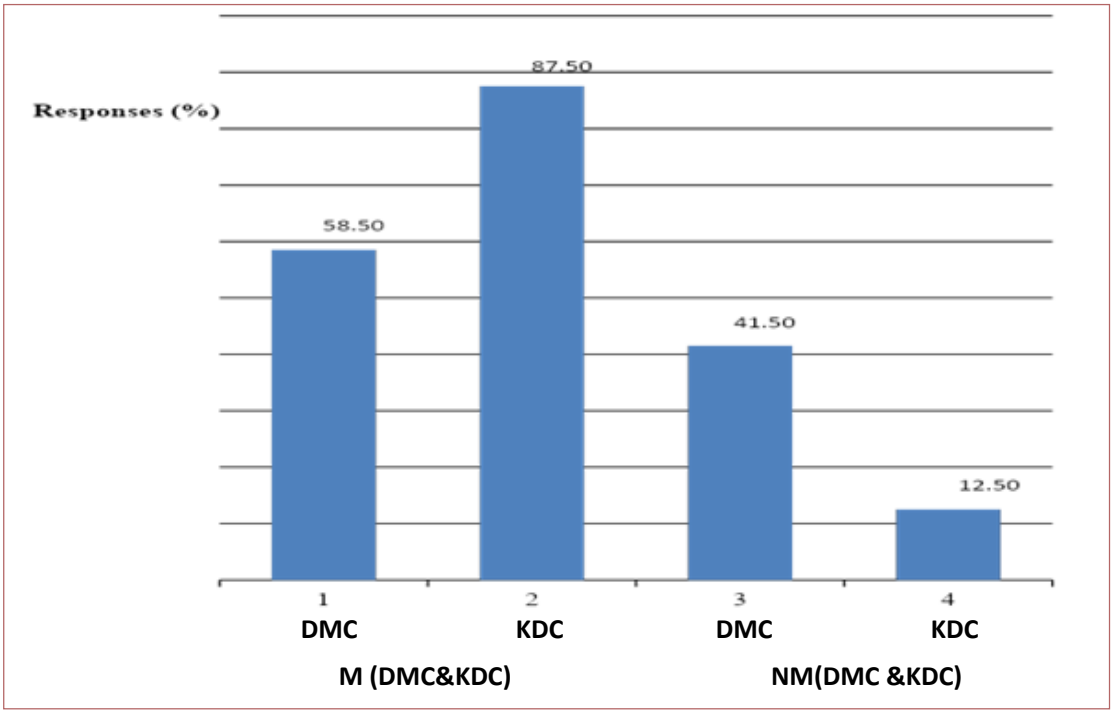
These results concur with[25] that lack of financial resources and insufficient knowledge of health insurance schemes were among the problems facing the development of a viable healthcare financing system in Eritrea. Also, the results of CHF enrolment status since 2012 indicated a comparatively lower membership in DMC than in KDC, as shown in Figure 1. Likewise, in measuring the perception of community members, it was found that the majority of them indicated a moderate level of improvement, as presented in Figure 1. The FGDs indicated that the health services provided to members of CHF were poorer compared to the community members who were contributing user fees for access to health care on the spot. According to the WHO Regional Office for Africa,[26] owing to constraints in human resources, medicines, and health products, not all health services function well. This implies that, despite evidence of the increasing number of CHF schemes as an indicator of improvement, this is not effective because of the observable CHF challenges that were not addressed effectively by actors. The results are consistent with,[27] who found that although HFGCs have the core role of mobilising the community to contribute to the CHF scheme and ensuring the availability of drugs and equipment, there is no shred of evidence for the implementation of this responsibility. This responsibility is carried out by CHF enrolment officers, CHF officers, village and street government leaders, and the CHF team at the council level.

The interview with the health administrator indicated the influence of CP, as per the response:

The cost of CHF to some people influences; those who are in the TASAF Programme got agreement to join CHF with the TASAF Programme guarantee, but those with low income and without the programmememe have difficulty joining CHF (Interview: Community Development Officer, DMC).

These results are consistent with the DMC and KDC data on improving CHF enrolment from 2008/2009 to 2016/2017, as shown in Figure 1, Figure 2, and Table 1. According to,[28] the use of village health workers and local government leaders in community mobilisation and service delivery has been a practice in Tanzania in interventions like immunisation programmes, health education, environmental conservation, health resource allocation, and resource mobilisation programmes.

These results are also consistent with the findings by, [4], which indicate the implications for community-based health insurance schemes in India and elsewhere. Only community awareness was explained to be low to enable full and effective participation in the scheme. The CHF scheme can protect poor households against the uncertain risks of medical expenses.[4] argues that schemes like the CHF can be implemented in areas where institutional capacity is too weak to organize nationwide risk-pooling. Such schemes can cover poor people, including people



Note: M stands for Members and NM for None members in Dodoma Municipal Council (DMC) and Kongwa District Council (KDC)

Figure 1.CHF Membership in DMC and KDC (n=200 per Council)

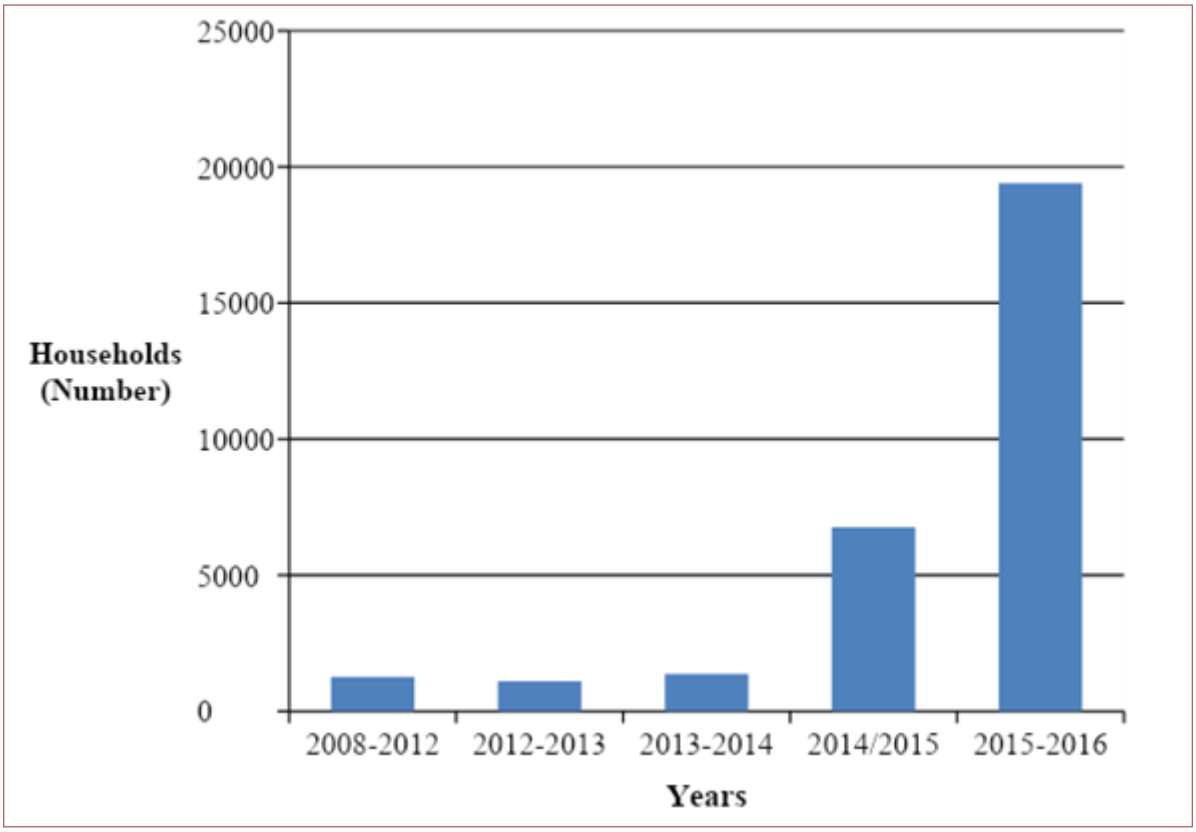


Figure 2.CHF Enrolment in DMC from 2008/2012-2015/2016

and households below the poverty line. The documentary review further indicated some shreds of evidence of the improvement of CHF services in DMC. In one of the CHSB meetings about the success of CHF, it was indicated that "the revamped CHF membership in the period starting from September 2012 to June 2013 has resulted in a total of 2083 households joining the revamped CHF scheme, whereby a total of Tanzanian Shillings 20,860,000.00 were collected "(DMC, 2013).

These statements were a result of health actors' roles in the health promotion and system strengthening project that operated from 2012/2013 to the 2015/2016 period. Therefore, it cannot be generalized to mean that CHF services have been improving efficiency. It can be said that there is a great link between the availability of drugs in health facilities and the rate of enrolment by community members in the CHF scheme, as has been shown here:

The Deputy Municipal Medical Officer said that the state of drugs in the health facilities has started to improve after the department bought and distributed sufficient drugs and medical facilities. This state of affairs has made members of the community feel good about joining the CHF scheme (DMC).

Apart from individual or family contributions, there were contributions from other facilitators such as the Tanzania Social Action Fund (TASAF) and the Saidia Wazee Tanzania (SAWATA-Dodoma) programme on vulnerable and poor communities. For instance, in KDC, TASAF contributions enabled the enrolment into the CHF scheme of 5400 households, equal to the Tanzanian shillings of 54,000,000/= in 2016 and 2800 households in the previous years. The total contribution equals 61195 households in Kongwa district from 2012 to 2016. This makes for an enrolment rate of 32% compared to the previous one of 3% in 2012, as presented in Table 1. The same was done in Dodoma Municipality by these contributors. Yet, a significant population remains without joining the CHF scheme, mainly because of the lack of communication about poor health services, particularly the availability of drugs.

These results indicate variation in the two councils and concerning other studies in Tanzania. According to,[29] the government of Tanzania targeted 85% of the population to be members of CHF, but enrolment remained as low as 9.2% by 2014. The most sticking problem is the variation in enrollment in different districts, such as Iramba (54%), Bariadi (40.9%), which had high enrollment, Liwale (8%), and Rungwe (6.5%), which had low enrollment.

Table 1.CHF Enrolment in KDC since the Year 2008-2016

Year	Households Enrolled	Percentage
2008	No available Data	0
2012-2016	61195	32 of all households

In DMC, communities were also reported to have been benefiting from the TASAF programme as well. It was reported that TASAF I enabled the enrolment of 1460 households into the CHF scheme in 2015, TASAF II enabled 1367 households in 2014, and TASAF III enabled 788 households in 2016. The total CHF enrolment of community members for DMC from 2008 to 2016 equals 19394 households, a 24% increase from 3% in 2012. According to,[30] DMC had 93,339 households enrolled in total. Therefore, it has a significantly lower number of CHF members.

It was revealed that most individuals have not been returning to renew their membership once it expires. It was explained that there had been a change in user fees to attract CHF membership. However, in practice, it had not been realized. This was because of the perceived poor quality of healthcare attributed to being a member of the CHF scheme. It was noted that there was no effective CP in CHF despite the change of bylaws for healthcare users' fees, which increased. This created a contradiction, which was prompted by a lack of knowledge and awareness of both community and government health actors on CP.[31] argues that effective participation is a similar term based on access to information, access to the decision-making process, and access to judicial redress if a dispute arises or the public wants to challenge a decision.

The interviews and documentary review indicated that CHF services had been popular since 2012. This was the period in which the Health Promotions and System Strengthening Project was launched in the Dodoma Region. These results do not relate to[32] that despite the high level of awareness and positive attitude towards health services by communities, a substantial proportion of the community does not use the health services in the Dodoma Region. These results relate to the Health Belief Model's (1950s) contention that an individual is likely to adopt preventive health behaviours if there are benefits associated with reducing the risks and that the benefits outweigh the barriers. Knowledge, awareness, and socio-economic barriers influence community members to participate in the CHF scheme. It is argued that there are challenges for CP in governing health services in the Dodoma Region. This is associated with the low level of awareness among community members and care given to the CHF compared to user fees. Government health actors are oriented toward pleasing their superiors rather than responding to citizens' needs.[3]

National HIV/AIDS Control Programme

According to,[33] HIV/AIDS is among the killer diseases that the Primary Health Service Development Programme (PHSDP) 2007–2017 put as a priority. The National AIDS Control Programme (NACP) was planned to expand and strengthen care, treatment, and support services in rural communities and make the services accessible to all in need by 2017. This section examined practices for CP in programme implementation.

Formation of HIV/AIDS Groups in the Community

The paper found that there was a use of group formation among HIV/AIDS people as an adaptive strategy. It was reported that community participation aided the creation of awareness and enabled community members to promote group formation as a strategy for sharing knowledge and sustaining socio-economic livelihoods for HIV/AIDS-infected and affected individuals. It was found that the majority of the respondents confirmed the existence of active HIV/AIDS groups in the community. This means that there were active practices of CP targeting intervention for HIV/AIDS groups in the community. However, it was found that there were few HIV/AIDS groups, indicating a moderate level of practice of CP informed by the low level of awareness by community members. The FGDs and interviews showed that Dodoma Municipality had 48 HIV/AIDS groups, whereas Kongwa District Council had 26 HIV/AIDS groups.

These results are consistent with the documentary review of KDC and DMC, which indicated the participation of HIV/AIDS people in the Prevention of Mother-to-Child Transmission (PMTCT) services as practiced in the years 2014, 2015, and 2016. The results indicate that women's HIV/AIDS and PMTCT services are delivered in all the public health facilities. The women community members had also been actively participating in the use of the services for testing and counselling purposes. Again, it was evident from the participation of couples in PMTCT services that some women have been involving their partners, as there were 9335,[34] 9976,[35] and 1039[36] couples in KDC. Unlikely, there were 3782, 5115, and 15970 couples,[37,38] and[39] as users of PMTCT services in DMC, respectively. According to,[40] in England, there are areas where there are government health actors' effective efforts to make people participate in HIV services, as extracted hereunder:

Health providers and commissioners gave significance to influencing community participation, particularly people with HIV, in various ways to make sure that the voices of various community groups could be heard in the right manner and be linked to the varying priorities of one community to the other. In one community, however, people with HIV were participating in the governance and oversight arrangements for HIV and sexual health services and in the development of HIV strategy as members of the respective programme boards and through its work streams (some of which were led by third-sector user-led ganizations). In the case of rural areas, with a small number of HIV-infected populations across a large area, there were no formal processes for people to participate in governance. In all areas, it was heard that people living with HIV were not all available or able to be involved, as effective treatment means that they can continue busy lives with little free time. Overall, it was found that a consistent recognition of the importance of the participation of people living with HIV translated into variable practice on the ground.[40]

These explanations imply that both the government health actors and the community members have been participating in the control of diseases by attending health facilities for healthcare services. However, there has been a low but varied level of participation between the two councils by couple members in the prevention of HIV/AIDS. This is because the annual number of couples attending health facilities for PMTCT services is still lower than the number of pregnant women in a year. This can be associated with others with low knowledge and awareness of CP by both government health actors and community members' socially perceived barriers. Also, the varied number between men and women couples is because HIV/AIDS and PMTCT services are mandatory for pregnant mothers in Tanzania as opposed to their couples, who were not necessarily required to do so.

Therefore, this contributes to lowering the number of male partners compared to females attending HIV testing. As a result, there had been perceived barriers by community members in the utilisation of health services as per the Health Belief Model's (1950s) contentions.[40] A study on knowledge of health information communication in Tanzania indicates that the major constraints in adopting health education messages include poverty, inappropriate health education, ignorance, and local beliefs.

Financial Mitigation for HIV/AIDS Impacts

The government health actors have the responsibility to facilitate the provision of health services, as presented in Table 2. One of the health practices is mitigating the impact of the HIV/AIDS disaster by providing care and support for the community. One of the spaces where community members get invited to health services is the availability of financial resources from the council's government actors. These called for the establishment of affected and infected groups among community members. The study indicates that the Ward Development Committees and the HIV/AIDS Committees facilitate the participation of individuals in the groups.

The study also found that government health actors had been promoting educational and resource provision measures as strategies to mitigate the impacts of HIV/AIDS in DMC and KDC. There have been practices undertaken to reduce the impact of the pandemic in terms of financial resources, which motivates transparent and open-minded groups to fight against the HIV/AIDS impacts. It indicated that DMC had 48 active HIV/AIDS groups. These had been facilitated with financial resources amounting to Tanzanian Shillings 152,498,306/= from 2010 to 2017, as presented in Table 2. Table 2: Funds Distributed to HIV/AIDS Groups 2010-2017

Table 2.Funds Distributed to HIV/AIDS Groups 2010-2017

Dodoma Municipal Council		Kongwa District Council Households Enrolled		-
Year	Groups	Tanzanian Shillings	Groups	Tanzanian Shillings
2016/2017	14	14,000,000	26	16,000,000
2015/2016	10	10,000,000	26	
2014/2015	14	14,000,000	26	
2013/2014	37	37,000,000	26	
2012/2013	37	37,000,000	26	
2011/2012	30	30,000,000	26	
2010/2011	37	10,000,000	26	
Total	48	152,498,306	26	16,000,000

According to an interview held with the administrator, it was found that in KDC, Tanzanian Shillings Sixteen Million (16,000,000/=) were provided to the existing 26 groups of HIV/AIDS-infected people in the council. Table 2 presents the mitigating and preventive practices of DMC and KDC on HIV/AIDS in the community, respectively. These results indicate that government health actors have been playing their roles in HIV/AIDS management. Hence, there had been improved CP on the aspect of HIV/AIDS relating to the observed services in health facilities. The PHSDP on HIV/AIDS has been practical despite the stigma associated with HIV/AIDS, which has been seen as one of the remaining challenges.

These findings differ from[39] in England, where in some areas, examples of impact and any changes made in response to people's views or suggestions were harder to come by. It is further argued by[39] that almost all the examples that are heard are about how individual services are operated rather than how the various services are combined to shape people's overall experience of living with HIV. This variation is due to differences in socio-cultural background between England and Tanzania and the Dodoma Region in particular, where CP has the advantage of being adopted more readily in terms of group or community-based perspectives in HIV/AIDS governance than in the western cultural context.

Conclusion

The paper concludes that there is improvement in the practices of CHF and HIV/AIDS services in Dodoma, central Tanzania. HIV/AIDS services are accessible to holistic members of the community, including women and men. These involved monetary, reproductive, and medical services. There were also CHF services that served all community members' health service access voluntarily. This indicated an increased membership that was triggered by the Health Promotion and System Strengthening Project in the Dodoma region. However, these practices were gauged as not sustainably effective. This is because of the evidence from a purposeful project that supported CHF services in the area. As well, there were vertical and national programmes on HIV/AIDS services that promoted the status core of services. These, due to their nature as externally oriented, impinge on sustainability effectiveness.

Recommendations

It was recommended that sustainable adoptive and empowerment measures be taken to effect the use of CHF services by the majority of the public. This should involve the commitment of all health governance actors at the national and local level in areas where CHF services are available. It is recommended that HIV/AIDS services be made the primary responsibility of institutions from their sources of funds to reduce dependence on external sources, which will sustain strategies on board. Last but not least, CHF enhancement measures and HIV/AIDS mitigations should go hand in hand with sustaining strategies in areas of health education and awareness creation among the public in groups such as schoolchildren, parents, youths, the elderly, and women and men.

Acknowledgments

This study was done and submitted for the fulfilment of the requirements for the award of Doctor of Philosophy from the University of Dodoma in 2018. I would like to acknowledge my supervisors, namely Dr. Victor M. George and Prof. Albino AJ Tenge, for their support in making this work successful. Others are Dr. V.V. Krishnan, Dodoma Region officials, as well as DMC and KDC participants and the general public.

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