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RESEARCH ARTICLE

Implementation of the redesigned Community Health Fund in the Dodoma region of Tanzania: A qualitative study of views from rural communities

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Summary

The need to understand how an intervention is received by the beneficiary community is well recognised and particularly neglected in the micro–health insurance (MHI) domain. This study explored the views and reactions of the beneficiary community of the redesigned Community Health Fund (CHF) implemented in the Dodoma region of Tanzania.

We collected data from focus group discussions with 24 groups of villagers (CHF members and nonmembers) and in-depth interviews with 12 key informants (enrolment officers and health care workers). The transcribed material was analysed thematically. We found that participants highly appreciate the scheme, but to be resolved are the challenges posed by the implementation strategies adopted. The responses of the community were nested within a complex pathway relating to their interaction with the implementation strategies and their ongoing reflections regarding the benefits of the scheme. Community reactions ranged from accepting to rejecting the scheme, demanding the right to receive benefit packages once enrolled, and dropping out of the scheme when it failed to meet their expectations. Reported drivers of the responses included intensity of CHF communication activities, management of enrolment procedures, delivery of benefit packages, critical features of the scheme, and contextual factors (health system and socio-political context). This study highlights that scheme design and implementation strategies that address people's needs, voices, and values can improve uptake of MHI interventions. The study adds to the knowledge base on implementing MHI initiatives and could promote interests in assessing the response to interventions within the MHI domain and beyond.

KEYWORDS

Community Health Fund, implementation processes, micro–health insurance, people-centredness, response to interventions

1 | INTRODUCTION

In recent years, micro–health insurance (MHI) initiatives have been widely implemented across low- and middle-income countries as a means of extending social health protection to people working in the informal sector.[1–3] The concept of MHI refers to a form of voluntary health insurance that targets low-income people who are normally not included in existing health protection systems.[2,4] Available evidence indicates that MHI schemes can improve access to care and reduce out-of-pocket expenditure among their members.[5–8] The literature, however, has also consistently reported that these schemes suffer from low uptake among target populations, a feature that jeopardises their effectiveness and sustainability.[3,9]

In an attempt to understand low uptake of MHI among target communities, attention has mostly been paid to assessing determinants of enrolment. Specifically, researchers have explored how both a household sociodemographic and economic profile and the features of a scheme (design, benefit package, and management structures) influence the decision of whether or not to join an MHI scheme.[2,10] However, very little research has looked at perceptions and reactions to scheme implementation processes among target communities. Similarly, there is limited literature that explains how these perceptions and reactions ultimately relate to the uptake of MHI products. Prior research points to the importance of intervention design, implementation approaches, and the level of community participation in enhancing the beneficiary community's acceptance of the interventions.[11–15] Furthermore, interventions with critical features and implementation strategies that directly respond to community needs and values may receive a positive response from the beneficiaries.[16] With specific reference to the implementation of MHI schemes, one could hypothesise that low penetration rates among target communities do not necessarily indicate that MHI schemes are not needed, but rather that their features and their implementation processes are not people-centred; ie, they do not directly respond to community needs and values and as such are unable to attract and retain members.

Literature also reports that the presence or absence of participatory implementation approaches that build on community needs, structures, and resources and promote community participation may explain the success or failure of public health interventions.[14,17,18] For example, a study in Nepal[12] describes the implementation framework that gives voice to local priorities and enhances community participation in the implementation of MHI schemes. Apart from programme (design) factors, specific contextual issues across contexts, such as organisational weaknesses, socio-economic, and political factors, may influence programme implementation and community response to the intervention processes.[13,19]

The case of the Community Health Fund (CHF) in Tanzania is of particular interest as it is an example of an MHI scheme with low enrolment and poor retention rates among target populations.[20,21] In 2001, the CHF Act mandated CHF implementation in all districts of mainland Tanzania.[22] The CHF is a district-based MHI scheme whereby members of the community prepay for health services and the scheme receives a "matching grant" from the central government, which is equivalent to the premiums paid by the enrolled households. In 2011, to address the challenges faced by the standard (old) CHF, an innovative programme, "CHF-Iliyoboreshwa" translated and hereafter referred to as the "Redesigned CHF," was launched in the 7 districts of the Dodoma region. The intervention builds on the results of a situational analysis of the old (standard) CHF programme, which revealed structural problems.[21] The Redesigned CHF has instituted several administrative, governance and health service provision reforms to the standard CHF to make it a viable health insurance scheme. Table 1 details the components of the CHF-Iliyoboreshwa.

This paper is part of a larger process evaluation effort of the Redesigned CHF[23] and aims to fill the knowledge gap pertaining to community response to the scheme's implementation processes by answering 3 specific research

TABLE 1 Differences between the standard CHF and the Redesigned CHF

Standard (old) CHF	Redesigned CHF
No separation between purchaser and provider of health services, that is, the Council Health Service Board represents both the interests of CHF members and health care providers (health facilities)	Reorganised structure that displays the different roles of purchaser (CHF) and health care provider (health facilities)
Weak data management system	Reform of data management system by installation and use of an insurance management system with a central server with online and offline modes
Passive enrolment strategy based on health facilities	Active close-to-client strategy with village-level enrolment officers
Restricted benefit package with card applicable at the enrolled facility and rarely involving hospital services	Expanded range of services to include hospitalisation and portability of CHF cards within the region
Passive to no community sensitisation campaigns	Active mobilisation campaigns with social marketing strategies that involve both community-based campaigns and mass media campaigns
Identity card given to head of the household (only one card for the household)	Each member of the household is given individual membership cards

Abbreviation: CHF, Community Health Fund.

questions: (i) what are the community's views on the implementation of the Redesigned CHF scheme; (ii) what are their reactions to the scheme implementation strategies; and (iii) what are the factors influencing the community's views and reactions to the implementation process of the Redesigned CHF?

2 | METHODS AND MATERIALS

2.1 | Study design and settings

Data collection for this study took place between October and November 2014. In this study, a predominantly descriptive qualitative approach was used to capture the views of the beneficiaries, with an explanatory component being added to understand factors influencing their responses to the scheme implementation process. This study was conducted in 3 districts of the Dodoma region, namely, Chemba, Kongwa, and Chamwino. The 3 districts are mainly rural and have a combined population of 876 227, equivalent to 42% of the population in the Dodoma region.

2.2 | Study population and sampling

We interviewed community members, enrolment officers (EOs), and health care providers. Purposive multistage sampling (districts, wards, villages, and individuals) was applied to identify study respondents.

First, we selected 3 out of 7 districts in the region based on the speed of change in enrolment rates following the implementation of the Redesigned CHF scheme. Chemba, Kongwa, and Chamwino were selected as the districts with the highest, average, and lowest growth in enrolment rates. To ensure geographical distribution, we purposely selected 4 wards within each district according to their enrolment rates in CHF, one with the highest enrolment rate and one with the lowest enrolment rate. Within each ward, we purposively selected 2 villages, one village with a health facility and one without, to include views of people living closer and further from service provision. A total of 8 villages were selected from each of the districts.

2.3 | Data collection

We gathered data from community members through a total of 24 focus group discussions (FGDs), that is, 8 FGDs per district. In each village, we conducted one FGD, while we collected data from village EOs and health care workers through a total of 12 in-depth individual interviews (IDIs). Both FGDs and IDIs relied on using a semistructured interview guide that reflected the main themes addressed by the study questions, ie, views, reactions, and their influencing factors. Each FGD had 8 to 12 participants and constituted a homogenous group, with men and women and the young and the elderly being interviewed separately. Establishing homogeneous groups was intended to remove potential barriers to a free and open exchange as a result of existing social roles or cultural norms.[24]

The discussion during FGDs focused on community experiences, perceptions of the CHF scheme, motivation to enrol or not to enrol, positive and negative reactions to the implementation of the Redesigned CHF, and opinions on how to change or sustain the current state of the scheme. In line with prior research,[25] we preferred FGDs to IDIs when interviewing community members because we judged the former to be an appropriate method to elicit discussions and allow a given community to generate relevant findings through their shared knowledge. In-depth individual interviews with EOs and health care providers were used to ensure triangulation of sources to increase credibility of the overall findings.

Thus, our IDI guide largely reflected the one used to facilitate the FGDs but taking different perspectives. In the IDI guide, we focused on the individual experiences and the perceptions of how and why the community members responded to the interventions.

Trained research assistants were in charge of data collection, supported directly by the first author. All tools were pretested and then adjusted to accommodate the knowledge acquired during the pretest.

Participants in both FGDs and IDIs were asked for consent and assured of anonymity and confidentiality. All FGDs and IDIs were voice recorded, verbatim transcribed, and translated into English by professional translators. The first author checked all transcribed translations.

2.4 | Data analysis

Analysis of the transcribed material was carried out by 2 independent researchers, the first and second authors. Analysis relied on the framework method[26] and was assisted by the N-Vivo software (QRS International). This method was chosen for its flexibility, its transparent step-by-step interconnected stages that guide the analytical process, and the possibility to use a mixed (inductive-deductive) coding approach.[26,27] The selected approach to data analysis was aligned to our study design given the predominantly descriptive approach.[27]

Analysis followed the 6 stages proposed by the framework approach: familiarising with the data, coding, developing an analytical framework, applying an analytical framework, charting the data into the framework matrix, and interpreting the data.[26] Coding followed a case and theme-based approach, whereby conceptual themes were developed, a case-theme matrix was created, and data from each individual case (FGDs or IDIs) were transferred into the conceptual cells to ensure that the individual case stories contributed towards defining a single comprehensive whole. Coding of the transcribed material started by applying a deductive approach, which relied on codes based on preexisting theoretical constructs. As we proceeded through the analysis, codes that emerged directly from the transcribed text were added. As the analysis continued, we reflected and modified our initial codes. Codes were grouped into categories before generating the main themes evolving from the data. The emerging themes were discussed by at least 2 of the co-authors who also agreed on the final quotes to substantiate results.

3 | RESULTS

The first and second parts of the results are mainly descriptive as they outline community views and reactions to the implementation processes, whereas the third part is more explanatory as it reports on the factors shaping these views and reactions. Verbatim quotes are used to illustrate the findings.

3.1 | Community views on the Redesigned CHF and its implementation

3.1.1 | Differences between the standard (old) CHF and the Redesigned CHF

Across the districts, FGD participants indicated their awareness of the CHF-Iliyoboreshwa. They could explain that CHF-Iliyoboreshwa differs from the standard CHF by (1) the presence of the EOs, (2) CHF membership card provided to single members of the household, (3) photographs for CHF card taken by EOs using mobile phones, and (4) access to health services at any primary health facility in the entire region using a CHF card.

Further analysis of the FGDs indicated that the presence of EOs at the community level simplified enrolment in comparison with the traditional system, whereby health facilities are in charge of this activity. Focus group discussion participants applauded the arrangement of free-of-charge photographs for identity cards, as well as the provision of individual cards, rather than household ones, as a means of simplifying access to health care services. The inclusion of hospital care and the portability of cards across health facilities were identified as unique advantages of the CHF-Iliyoboreshwa.

> *In the standard-CHF, only a single member of the family is the one who was known but in the CHF-Iliyoboreshwa every member of the family can get his/her own card and uses it every time he/she wants even when travelled to other places. (FGD 16, male, >40 y)*

Focus group discussion respondents did not have a comprehensive knowledge of all the scheme's features, but they could clearly recall differences between the standard CHF and the CHF-Iliyoboreshwa. Across the districts, men had better knowledge of CHF-Iliyoboreshwa operations in comparison with women.

> *I do not know all the two schemes, but I suppose that the CHF-Iliyoboreshwa has been improved enough to accommodate our needs. (FGD 22, female, >40 y)*

3.1.2 | Encounters with the implementation processes

Focus group discussion participants reported interacting with the CHF-Iliyoboreshwa in 3 ways: during the information and dissemination campaign, through the actual enrolment process, and when accessing care as CHF members.

Experiences with the information and dissemination campaign differed across the districts and villages, with respondents in some FGDs reporting more intense activities than in others. In general, however, most FGD participants reported receiving information on the CHF-Iliyoboreshwa through routine village meetings, mass campaigns in the villages, mass media communication, and CHF-Iliyoboreshwa brochures and posters.

> *We get information from newspapers, radio and meetings and what follows is to find how we can get money, then we go to the enrolment officer. (FGD 17, male, >40 y)*

Respondents also reported variations in the way EOs managed enrolment procedures across districts. The variations were a result of the type of the major activity of the EOs, as they performed enrolment on a part-time basis. For example, in the Kongwa district, where most of the EOs were community health workers (CHWs), enrolment procedures took place either in health facilities or as part of maternal and child health outreach services. When CHWs had other tasks to perform in the village, they combined enrolment tasks with other tasks. In the Chemba district, enrolment procedures took place either at school or at home as most of the EOs were teachers. Still, the vast majority of respondents reported being satisfied with the entire enrolment process. Some EOs, especially teachers and CHWs, were sometimes too busy or frequently absent and failed to keep their enrolment appointments.

> *…when you go for enrolment, they [EOs] first provide you with explanations about the operations and benefits of the scheme, then take a picture of you, you pay premium and they give you a receipt. The most important part is education on insurance before they enrol you…this is what convinces people to join the CHF-Iliyoboreshwa. (FGD 17, male, >40 y)*

EOs should keep their appointments, and they should be available at the place of appointment without the need for us to remind them by phone calls. (FGD 16, male, >40 y)

The overall quality of services provided by the scheme once enrolled was rated low by the majority of FGD participants. More specifically, the delivery of the benefit package received criticism from CHF members and was described as unsatisfactory.

I should say that the way health care services are provided needs a lot of improvement just like the way you say CHF-Iliyoboreshwa [improved CHF], should be "huduma zilizoboreshwa" [improved services]. It would be very good that I contribute 10,000 Tshs and I get good services, but it is not always the case. (FGD 02, female, >40 y)

Some FGD participants pointed out the lack of village-level structures that could address issues related to CHF, as the EOs or health workers cannot address some problems that are largely their responsibility, such as frequent absenteeism and poor customer care. Some respondents from the FGDs suggested establishing a specific committee or task force to reinforce accountability of the EOs, health workers, and the village leadership.

…any development in the village is monitored by the Village executive officer. But we have not seen any clear commitment of our village leaders to push the CHF-Iliyoboreshwa forward. If we could have another committee that follows up these things that could have been better. (FGD 17, male, >40 y)

Although both men and women embraced the scheme rationale while finding it problematic in implementation, their encounters with the scheme were different. While men were more concerned with the management of enrolment processes and the premiums, women were more concerned with the quality of health services provided to CHF members. There were no clear differences across age groups, although young men appeared to be more critical of accountability issues.

3.2 | Community participation and voice in the scheme

Across districts, FGD participants indicated that most community members had been enrolled at least once, either in the standard CHF or in the CHF-Iliyoboreshwa. Enrolment was motivated by the perception that as a prepaid scheme, the CHF represents a cheaper alternative than paying for care once ill.

CHF is a health insurance that helps us (poor people) because after paying the premium you just go to health facilities and access services. So we see that this scheme has more benefits for us. (FGD 04, female, <40 y)

Similarly, both IDI and FGD participants indicated that participation of community members in the implementation of the CHF-Iliyoboreshwa was limited to enrolling in the scheme and receiving health services thereafter. They were unaware of any actions that required them to participate in planning, experience sharing, or managing the scheme's processes. Some FGD participants suggested wider involvement of CHF members in scheme implementation and said:

I suggest that, groups of people who have enrolled in the scheme should go to other villages and mobilize others to join in the scheme. I believe that if villagers hear from fellow villagers, many will join the scheme. (FGD 11, male, >40 y)

There was a variation of opinions with regard to who owns the CHF scheme and to what extent the community should have a voice and power in the scheme, whereby some community members indicated that the scheme is owned by the community itself, while others indicated that the scheme is owned by the government. Furthermore, the majority of respondents were not aware of the grant provided by the government to match the revenues raised through direct premium collection.

I think, we (the community) are the owners of the scheme, but we do not know how to engage, we are therefore only looking on how the (upper) authority decides for us. (FGD 20, male, <40 y)

Nonparticipation in the CHF was motivated by experience with poor-quality health service provision, low household income, and scepticism about the scheme.

We know that health care is very expensive, some find it difficult to understand why the premium is so low in CHF. They also take our pictures, are they sending our pictures to freemasons [a secret society believed to belong to a satanic cult by people in some parts of Tanzania[28]]? (FGD 14, female, <40 y)

Similarly, discrepancies between the expectations and the reality of the scheme motivated people to drop out.

If you meet a person in this village and talk about CHF-Iliyoboreshwa, you will not be understood…because; people have lost trust on the scheme. At the beginning many people joined the scheme with higher expectations, but now, not wanted by many because you don't get what was promised. (FGD 17, male, >40 y)

Alongside people not enrolling because of affordability concerns, several respondents indicated their willingness to pay even higher premiums should the quality of health service provision really improve.

The reality now is that, I pay 10,000 Tshs for CHF and I get poor health services, I would be willing to pay even 50,000 Tshs when I am sure that I will get quality services. (FGD 02, female, >40 y)

3.3 | Community perceptions and response to the implementation strategies

The implementation strategies adopted to facilitate implementation of the CHF-Iliyoboreshwa triggered a series of reactions from community members (see Table 2).

3.3.1 | Institutionalisation of CHF in village structures

Both the FGD and IDI participants reported a CHF-Iliyoboreshwa implementation strategy that was aimed at institutionalising the scheme in village-level structures. This strategy required village leaders to make CHF a permanent agenda in meetings of village government structures, such as the village assembly and the village council. The strategy resulted in different courses of actions. While some village leaders accommodated in-depth discussions about the scheme and its implementation, others only made short announcements about the scheme.

People are not able to discuss it because it comes as an announcement and not an agenda; the announcement would come out saying… "Mnakumbushwa kujiunga na CHF-Iliyoboreshwa." [You are reminded to enrol in CHF-Iliyoboreshwa]…Some people join without knowing what exactly CHF is. (FGD 02, female, >40 y)

3.3.2 | Reorientation of health financing towards prepayments by setting higher user fees

Respondents also reported that the district health financing strategy was being reoriented towards supporting the CHF-Iliyoboreshwa by setting higher user fees in health facilities. In-depth individual interview participants confirmed this observation by community members to be true and explained that the strategy aims to encourage enrolment in the scheme by discouraging reliance on out-of-pocket payments.

There is a letter distributed all over the district that whoever is not a member of CHF should pay 10,000 shillings in a health centre while in a dispensaries it is 7,000 shillings. (IDI 05, health worker)

TABLE 2 Reactions of the community members to the implementation strategies

Implementation strategy	Specific process	Responses (actions, reactions, and implications)
Changes in existing policies (by-laws) on CHF implementation	From a voluntary to mandatory scheme	Enrol in the scheme (coercion) Question where to claim for rights to get benefit package Reject enrolment (live with worry)
Institutionalisation of CHF to village structures	CHF as a permanent agenda in all village meetings	Discuss CHF as an agenda Announce that people should enrol in the scheme Do not say anything about CHF
Reorientation of health financing towards CHF	Set higher user fee charges	Enrol in the scheme (coercion) Question where to claim for rights to get benefit package More catastrophic expenditures for the poor
Access to health care for members and nonmembers	Setting aside medicines for CHF members CHF members given first priority in health facility Priority given to those who pay out of pocket	Segregation in access to medicines Coercion to join CHF Interfere with the right to health for nonmembers Unnecessary referrals for nonmembers How and where to claim for rights of being provided the promised benefit package
Informal payments (cash payments)	Fast-track services after informal cash payment	Do not enrol in CHF Enrol in CHF but also carry cash when going to health facilities in case informal payments will be asked for Rely on user fees and pay informal payments when requested Report to village authority (rarely) How and where to claim for rights of being provided the promised benefit package
Informal payments (in-kind payments)	Fast-track services after informal noncash payment	Do not enrol in CHF Enrol in CHF but also keep in mind that they are ready to pay if they are asked for informal payments Rely on user fees and pay in-kind informal payments when requested Report to village authority (rarely) How and where to claim for rights of being provided with the promised benefit package

Abbreviation: CHF, Community Health Fund.

Community reactions to the increase in user fees included enrolling in the scheme (cheaper alternative) or seeking care from private practitioners where the quality of health care is perceived to be better and prices comparable with the new fee level. Those who were already enrolled in the scheme demanded for the right to get better services through continuous feedback (meetings and direct reporting to village or district leaders) regarding the scheme's services and quality of health care in health facilities.

3.3.3 | Restructuring health service provision

Focus group discussion participants reported that in some health facilities, CHF clients are attended to first. Conversely, in other FGDs, participants reported that CHF members are attended to last and cannot obtain some "expensive" medicines.

> *If you go the health facility with cash, you are given a priority and you leave those with a card to stay for a long time. (FGD 24, male, <40 y)*

Delays in attending CHF clients reported by IDI participants were related to the long administrative procedures that needed to be completed while providing health care to be able to claim payment from the CHF-Iliyoboreshwa afterwards.

The major challenge…it takes a very long time to treat them… You will first have to scan the customer, then after treating all the patient's details have to be filled in forms both hardcopies and softcopies, and later you have to send that information through cell phone… Taking into account network failures, it is very difficult. (IDI 08, health worker)

The FGDs reported of a strategy of setting aside medicines for CHF enrolees. Although IDIs indicated the practice to attract enrolments, several FGDs linked the practice to informal payments. Focus group discussion participants reported that in some health facilities, CHF cards are not readily accepted unless accompanied by an additional informal payment. Similarly, respondents explained that even services that should be offered free of charge for all, such as maternal and child health care services, were often only offered free of charge to CHF members, thus sometimes denying such services to non-CHF members.

The situation is worse, it is like this, with your CHF card it becomes extremely hard to get medicine; for example we went to Chamwino and Dodoma to get medicine but it was not as straight as for those with cash. (FGD 01, female, >40 y)

…In this village, it is when your wife is pregnant that you find that it is important to join CHF, because without a CHF card, she will not be accepted for antenatal clinic and delivery services. (FGD 23, male, >40 y)

In both cases, community members reacted by enrolling in the scheme when favourable, dropping out of the scheme in favour of informal payments, visiting private facilities, or reporting mistreatment of both clients and nonclients to the village authority.

3.3.4 | Voluntary versus mandatory approaches to enrol in the scheme

Many FGD respondents reported on the district implementation strategy that makes enrolment in the Redesigned CHF mandatory. They mentioned witnessing different (sometimes coercive) reinforcement mechanisms to make them enrol in the scheme.

Now, it is becoming like something that is mandatory. If you do not have a CHF card, sometimes you are denied health services…but also, in this village, if you do not pay for CHF, you get arrested by "Mgambo" [village-level police]. (FGD 04, female, <40 y)

Actions taken by community members varied across districts, with a handful of community members enrolling in the scheme. Some of the community members were concerned that mandatory approaches might be violating their right to choose where to seek care, given their experiences with poor quality of health services in public health facilities and the availability of private health practitioners, including traditional healers.

3.4 | Factors influencing community response to implementation of the Redesigned CHF

Factors reported by both community members and key informants as the ones influencing stakeholder responses to the interventions are depth of information about the scheme, facilitation strategies to implement the scheme, individual factors relating to the implementers, health system factors, and wider socio-economic and political context factors.

Across districts, the depth of information on the CHF-Iliyoboreshwa varied in our data, and there was a loss of continuity regarding information dissemination activities. As they have observed, the depth of information on CHF as an insurance scheme was rare, but the social marketing efforts focused on marketing the CHF-Iliyoboreshwa brand. Community respondents also reported intense social marketing efforts at the onset of the interventions, with loss of continuity over time. As has been believed, the uneven distribution of the depth of information and lack of continuity

of information dissemination was a result of a lack of relevant structures to sustain information dissemination at the village level.

> *…CHF-Iliyoboreshwa in this village does not have even a special campaign. We could have done this better like the way we did in national census, we could count all households and know who is who and not joining in CHF-Iliyoboreshwa. (FGD 21, female, <40 y)*

Both FGDs and IDIs highlighted that the implementation strategies adopted by the districts were responsible for triggering a response from community members regarding the interventions. Participatory strategies that ensure engagement of the community members, the frontline implementers and service providers, the leaders, and the wider stakeholders, such as civil society organisations and community resource personnel, were reported to have produced a positive response, whereas the lack of such strategies produced opposite reactions:

> *…village leaders have been motivating people to join CHF in public meetings. Also, there are meetings in our hamlets [Vitongoji] about CHF. (FGD 17, male, >40 y)*

> *CHF-Iliyoboreshwa, has been improved with mobile phone technology and is quite different with the first one. It is easier to communicate to the administration and it is not the same like previous scheme. (IDI 01, enrolment officer)*

The actions (behaviour) of EOs and the health workers also emerged as important drivers of the community responses to the scheme implementation. The customer care practices, motivation to deliver the scheme, their attitudes, and the general communication practices with the community members could influence community members' participation or view about the scheme.

> *Our health workers are in two categories, some care about work (their main duties) some look at faces (they selectively provide services to people depending on whether they know them or if they know their powers). (FGD 12, female, >40 y)*

Across the districts, FGDs and IDIs indicated that scarcity of health workers, frequent medicine stock-outs, and absence of health facilities in some villages contributed to shaping their responses to the Redesigned CHF.

> *Lack of medicines in the health facility, discourage people to join CHF. If you go to the district hospital, the situation is even worse. (FGD 23, male, >40 y)*

Furthermore, in villages with no health facilities, some community members preferred to continue to pay out of pocket to enjoy the freedom of seeking care from nearby facilities of their own choosing, private health facilities, or alternative (traditional) healers. Lastly, the wider context, such as local politics and level of poverty, was also mentioned to influence community members' responses to the scheme.

4 | DISCUSSION

This study explored the views of the community members regarding the scheme and its implementation, their reactions to implementation strategies, and the factors triggering such responses. Our study is the first attempt in exploring the beneficiary community's response to interventions in the MHI domain, specifically in the CHF of Tanzania. Results show that the participants in our study appreciated the scheme and also that there are significant limitations pertaining to the delivery of the scheme's services. Response to interventions from members of the community ranged from enrolling in the scheme, pushing for their rights to the benefit packages once enrolled, and demanding village-level structures of accountability. Furthermore, some people reported dropping out of the scheme when expectations were not met and looking for alternative strategies, such as accessing health care in private health

facilities or relying on informal payments. Many of the concerns raised in this study indicate deficiencies relating to the people-centredness of the scheme design and implementation strategies. To make our findings relevant to guiding policy directions in the MHI domain, we discuss the study findings in relation to the people-centredness perspectives in health system interventions.[29,30] We use the aspects of people-centredness proposed by Sheikh et al[30]: putting people's voices and needs first, ensuring that people are at the centre of the services, making the system social, and attaching people-centred values.

4.1 | Putting people's needs and voices first

Features of the scheme that bring enrolment services close to the community and services close to individual members in the presence of EOs and the individualisation of the CHF cards respectively were appreciated by the study participants. They applauded the approach as a means to remove barriers to enrolment and create more flexibility in health service access, which hence adequately addressed their needs. The contribution of close-to-community providers in promoting access to and use of health services and reducing the workload among the health system actors is well documented.[31] The findings may also mean that the enrolment strategy adopted by the standard CHF that relied on health care workers could have missed the advantages of using community resource personnel and hence not addressing the needs of the people adequately, but rather adding to the burden on health care workers. Despite the close-to-community approach displayed by the scheme, communities still perceived their role as passive in relation to the implementation of the CHF-Iliyoboreshwa and felt that they should be further engaged in it. As Rifkin[14] asserts, community participation not only enhances the acceptability of the intervention but also sustains it in the long term. Active engagement of the community members in the Redesigned CHF implementation in terms of participating in planning, governing the scheme, and sharing experience in forums could help to harness the required implementation results as it would enhance responsiveness and create common interests between beneficiaries and implementers.[12] To maximise benefits for the people and enhance their voices, choices should be made and changes approached that recognise the bottom-up and top-down strengths and weaknesses in policy implementation.[32] Furthermore, the report of the absence of a village-level structure to enhance accountability of the EOs and health workers indicates gaps in the ability of village leaders to supervise implementation of the scheme. This claim is supported by the suggestions from community members for establishing viable bodies or committees at the village level to spearhead how the CHF-Iliyoboreshwa functions. Creating accountability mechanisms may help to reduce information asymmetry, enhance the voice of the beneficiaries, and increase gains from the scheme.[29,33]

4.2 | Ensuring that people are at the centre of services

The scheme's services after enrolment demonstrate flexibility in terms of allowing portability of CHF cards across the region. This indicates that the approach may provide better welfare for scheme members as opposed to when the CHF card is fixed to only 1 health facility given the inadequacy of health system inputs (broadly defined), such as the workforce and medical supplies.

The results indicating dissatisfaction with delivery of the health services to CHF enrolees echo the repeated findings of previous research in relation to the implementation of the standard CHF.[20,34,35] Furthermore, the report on informal payment practices of some health workers in public health facilities that appear to limit access to health care by CHF members is also reported by prior research.[36,37]

4.3 | Making the system social

The results of our study show a lack of mutual trust between the community members, the EOs, and the health care workers. This may be a result of the conflicts that arise in the client-provider interactions in response to this new intervention. The poor customer care to CHF enrolees and use of informal payments in service provision reported

in this study might be an area that needs attention in an attempt to make the intervention social and appealing to the beneficiaries.

The strategy that makes EOs' work on a part-time basis may also have contributed to unfavourable interactions between the community members and EOs, as they were not found at the time of need by the community members, hence producing negative reactions. The health care workers complaining about the long procedures when attending to one CHF client may also have contributed to the poor relationship observed with CHF enrolees. Our findings are similar to other studies in Tanzania that show lack of trust towards the CHF and health services.[20,34,38] Literature attests to the importance of building health systems as social institutions by setting up chains of relationships between actors in the health system.[30]

At the community level, the deeply rooted sociocultural factors appear to shape participation in the scheme. For example, community members' scepticism about the CHF-Iliyoboreshwa by associating it to some *Masonic* operations requires a solution that integrates sociocultural knowledge into the implementation of the scheme. It ought to be noted that this Masonic belief is not new in Tanzania[28,39,40] and represents an aspect that needs further enquiry and could be related to acceptance or rejection of other interventions of a similar nature. In this regard, formative ethnographic studies might be valuable for programme implementation. Furthermore, the presence of traditional (alternative) healing in the community complicates the chain of relationships between community members, the scheme, and the health facilities and this might require dialogue in the course of implementing the interventions. Similar findings exist in Tanzania regarding the complexity and synergisms brought in by traditional healing in the health system.[40–42]

4.4 | Attaching people-centred values

There is a major concern about the right to health care services in public health facilities for both CHF members and nonmembers. The community members point out the dangers to the rights of nonmembers regarding setting aside medicines or offering priority to CHF members, especially if the processes of implementing this approach are not well monitored. Moreover, setting higher user fees to make people revert to the CHF may lead to denying access to the poor segment of the population, especially given the presence of informal payments. Some community members were concerned that some districts had attempted to make CHF a mandatory scheme, since they felt that such an approach would interfere with their right to choose, given the fact that in principle, CHF is a voluntary scheme just like other MHI schemes elsewhere.

Another study[43] on the standard CHF reports that some community members would prefer that CHF is made mandatory, but the study said nothing about infringement on people's rights to choose given the problems in receiving the benefits from the scheme once one is enrolled in it. Therefore, it was evident that the aspect that concerns justice, equality, respect, and rights seems to dominate reactions to the scheme design and its implementation.

4.5 | Strengths and limitations of the study

In this study, we used both FGD and IDI guides to triangulate the information and therefore provide comprehensive study results. We addressed the problem of social desirability bias[44,45] by ensuring anonymity and confidentiality in the interview process, and also by using local research assistants familiar with the study context, yet outsiders in the specific sampled community. Although we ensured quality translation of the collected data as well as using appropriate sampling techniques, these procedures could have biased some of the findings. Given the exclusive qualitative work, we cannot claim generalisability of the study findings. Still, we trust the reader to be able to identify transferability of some findings beyond the study area, on the basis of similarities in context.

5 | CONCLUSION

This study indicates that the community responses to the implementation of CHF-Iliyoboreshwa were shaped by various factors manifesting as scheme design characteristics, implementation strategies, and contextual factors. The factors that facilitated acceptance and created positive responses towards the scheme are the close-to-community enrolment strategy, individualisation of CHF cards, and portability of cards across the region. The limiting factors included lack of village-level structures to reinforce accountability, use of part-time employed EOs, and lack of engagement of the wider stakeholders at the community level in the implementation of the scheme. In addition, community response to the interventions was largely influenced by sociocultural factors and health system challenges. Therefore, the study provides the necessary evidence base for adopting people-centred scheme designs and implementation strategies.

ETHICAL APPROVAL AND FUNDING

The study received ethical clearance from the Ethical Committee of the Medical Faculty of the University of Heidelberg in Germany and the National Institute for Medical Research (NIMR) in Tanzania. We obtained consent from relevant authorities and individuals and ensured their anonymity and confidentiality. This work was supported by the HPSS project operational research component and a Katholischer Akademischer Ausländer-Dienst (KAAD) scholarship to the first author.

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