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Factors affecting adoption, implementation fidelity and sustainability of the Redesigned Community Health Fund in Tanzania: A mixed methods study in the Dodoma region

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While it is assumed that micro health insurance schemes can be useful in enhancing universal health coverage for low income groups in resource poor countries, specifically so in Sub-Saharan Africa, enrolment rates among the target group remain low. Efforts to address the problem of low enrolment are numerous, but their results remain ineffective. The success or failure of the interventions aiming to improve enrolment outcomes may not only be a result of the characteristics (design) of the intervention but is also largely shaped by the way the intervention is implemented. Evaluation efforts that look at the implementation processes of the MHI initiatives can provide evidence to differentiate between implementation failure and design failure. Process evaluations are, however, rare in the MHI domain. The current study aimed at filling this knowledge gap by conducting a process evaluation of the Redesigned community Health Fund program in the seven district of the Dodoma region of Tanzania. Specifically the study assessed the factors affecting adoption, implementation fidelity and sustainability of the Redesigned CHF program

This study employed a convergent-parallel mixed methods design and it was carried out approximately three years after the launch of the Redesigned CHF program. The study is grounded in a conceptual framework which rests on the diffusion of innovation theory and the fidelity of implementation (FOI) framework and aligns itself to the people-centeredness perspectives in designing and implementing health system interventions. The study utilized multiple data collection tools (questionnaires, focus group discussions, in-depth interviews and document review checklists) for primary and secondary sources and aligned the evaluation questions to the Theory of Intervention (TOI) generated during the study. The primary data were generated from a cross-sectional survey of 308 village level implementers (enrolment officers and village executive officers) and 68 district level implementers (e.g.,CHF managers and officers), in-depth interviews with 51 participants (purposively selected key informants from village district and regional) and 24 focus group discussions.

Secondary data sources included program plans and reports, meeting minutes and the IMIS database. Descriptive and inferential analyses (correlations and regression) were employed for quantitative data. The outcome variables were the implementation process outcomes (adoption, FOI and sustainability) whereas the explanatory variables were the moderators of implementation such as contextual factors, sociodemographic variables and stakeholder responsiveness. Qualitative data analysis followed the framework method approach based on case-theme coding and development of the framework matrix before interpretation of findings.

The most important findings and conclusions from this study are as follows:

1) Adoption of the scheme procedures was affected by knowledge of the stakeholders (the community and related actors) and motivation to implement the scheme, whereas adoption of the CHF structures by the districts was shaped by the relative advantage of the scheme and the facilitation strategies.

2) FOI of the scheme procedures was shaped by satisfaction about the implementation climate and education level of the implementers, whereas at ecological level, FOI was shaped by the responsiveness of the stakeholders and social viability of the scheme. 3) Sustainability of the scheme processes was shaped by knowledge about the scheme processes at individual level and stakeholder responsiveness at the ecological level. 4)Stakeholder responses (reactions) to the implementation process ranged from enrolling in the scheme, pushing for their rights to the benefit package once enrolled, demanding village-level structures of accountability, and dropping out of the scheme in case of total dissatisfaction.

5) Factors that influence beneficiary community views and reactions are a combination of characteristics of the program, implementation approaches and contextual factors such as socio-cultural issues and health system challenges and 6) only adoption and satisfaction could predict enrolment outcomes in the regression model.

The study findings demonstrate the importance of process evaluations in detecting implementation weaknesses that could be adjusted in the course of implementation or as the interventions are scaled up to other settings. The contextual and design factors that shape the implementation processes could be identified and fixed. This study could promote interests in the process evaluation of MHI interventions in Tanzania and beyond.