

Exploring Factors Influencing Dropping-out of Community-Based Health Insurance Schemes in Mpwapwa District, Tanzania

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Abstract

Community-Based Health Insurance schemes are meant to expand the coverage of healthcare provision to, especially, the majority poor in the rural areas of the Developing World. Despite high sensitization and mobilization campaigns, enrolment, re-enrolment and utilization of such schemes have been unexpectedly low. This is also the case with the Redesigned Community Health Fund (rCHF) in Tanzania. We took a qualitative approach to explore the reasons for the drop-outs of the rCHF in Mpwapwa District in central Tanzania. We reviewed various rCHF-related documents and used Key Informant Interviews and Focused Group Discussions to collect data from randomly selected drop-out cases. The findings suggest the availability of drugs, premium costs, quality of healthcare facilities as key reasons influencing households to enrol, re-enrol or drop-out of the rCHF. In this paper we argue that rCHF should integrate more participatory approaches to understand local concerns and re-design the scheme to address the challenges.

Keywords: Drop-outs; Community Based Health Insurance; rCHF

1. Introduction

One among the primary objectives of any government in the world is to ensure citizenry access to quality health care in the realization of the Sustainable Development Goal (SDG) Number 3 which advocates for healthy life and wellbeing. An estimated 1.3 billion people in the world cannot afford access to reliable healthcare (Jembere, 2018). While this is a significant concern, access to quality healthcare is critically challenging among the majority poor in rural areas of Sub-Saharan Africa where life is featured by high prevalence of diseases (Summers, 2015; Tang charoensathien et al., 2015; WHO, 2014).

Health sectors in the developing world consistently suffer from budgetary deficits thus fail to properly deliver guaranteed access to primary healthcare among its citizenry (World Bank, 1993; Chimezie, 2011). The costs of individual access to primary healthcare include direct payment for consultation fees, medicines, laboratory test, transport and treatment while secondary costs are associated with labour force supply and productivity (CMH, 2001; Morrisson, 2002; Asfaw, 2009). Payment for these costs is either through health insurance mechanisms or individuals pay directly as out-of-pocket spending. Majority in the rural are financially insecure and widespread poverty jeopardizes their access to necessary health care (Anaeli et al., 2013; Frumence, 2017). Effective healthcare financing mechanisms need to be in place to support rural access to health care and address the risk of serious health consequences for missing necessary health care (Bayarsaikhan & Musango, 2016; Musango, Orem, Elovainio, & Kirigia, 2013).

Tanzania's path to quality healthcare provision has been turbulent and at times was forced to undergo financing reforms in an attempt to ensure citizenry reliable access. Health sector budgets were heavily donor-dependent and health services were provided freely before the 1980s economic recessions and the 'forced' adoption and implementation of the Structural Adjustments Programmes (SAPs policies) in mid-1980s (Shaw, 2002). The decline in donor support necessitated the Government to reform health sector financing to sustain healthcare services (MOHSW, 2007). The government introduced user fees in health centres and dispensaries and later it paved way for health insurance schemes (Kapologwe et al., 2017).

In 1995, the World Bank (WB) and the government of Tanzania piloted the Community Health Insurance Fund (CHF) in some areas of Tabora region (Chee, Smith, & Kapinga, 2002). In 2001 the Government enacted the CHF Act with the following objectives; to mobilize financial resources from communities, to improve the delivery of healthcare services sustainably, to decentralize health service provision (Peter, 2013; Kaswahil, 2013; Shaw, 2002; URT, 2001). Although CHF envisaged the enrolment of more than 85% of population country-wide, it faced challenges in terms of its design, enrolment, servicing, and sustainability (Meshack et al., 2016; Mladovsky et

al., 2014), high members expectations of the CHF support in catastrophic health condition (Woldemichael and Shimeles, 2015). The CHF has then been experiencing low enrolment and high dropout rates as quantitatively observed by several authors (*see* Melaku et al., 2014; URT, 1999).

In 2012, the Government of Tanzania received financial support from the Swiss Government to promote and strengthen the health sector through the “Health Promotion and System Strengthening (HPSS) Project”. This promoted as well a restructuring of the CHF into a Redesigned CHF (rCHF). The restructuring meant addressing earlier problemes in CHF designs. In addition to all objectives of the earlier CHF, the new rCHF brought in a well-built insurance management system, portability of membership, purchase-provider spit with qualified staff; active enrolment at Village level; reimbursement and cross District claiming. Apart from mentioned features above, the rCHF has the primary role of meeting all objectives of CHF as stipulated in CHF Act of 2001. While these improvements were expected to enhance enrolment, a study by Kalolo, et al (2015) indicated that low enrolment persists. This is also reflected in the fact that overall coverage of different forms of insurance in Tanzania to be as low as 16% (Amu et al, 2018).

By 2018, Dodoma region had registered only 13.6% of active enrolment and 29.3% as a cumulative enrolment since 2012. This has depicted a picture of low enrolment and high dropout rates thus limiting the schemes financial viability and sustainability while also limiting access by those in the informal sector to access healthcare (Kapologwe et al., 2017; Chimezie, 2011). Only 49% of households targeted to enrol in rCHF in Mpwapwa had been cumulatively enrolled between January 2012 and April 2019. At the same time, only 8.0% of the targeted households have active enrolment within the same period (District Health Annual Report, 2017). This paper examines reasons that influence households to drop out of the rCHF in Mpwapwa District. the understanding of which is critical to making policy and strategic improvements towards ensuring Universal Health Coverage desired by the Government of Tanzania.

2. Literature Review

2.1 Theoretical Lenses on Community Utilization of Health Schemes

Several theories can be used to explain community decisions to utilize health schemes to access health services. Partners to this study are the Consumer Theory, the Expected Utility Theory, and the Socio-behavioral Model. The Consumer Theory operates on the assumption that if clients are well informed, they maximize their utility as a function of consuming various goods, given relative prices, their income and preferences. Changes in prices and income influence how much of different goods rational consumers will buy. Health insurance is expected to be a normal good with a positive income elasticity of demand, implying that the poor are less likely to insure. A price increase of a substitute for insurance – such as user fees – is expected to raise the insurance demand, as is a decrease in insurance premium. However, due to uncertainty about the unknown future health, insurance choice is not made based on utility alone but on consumers' expectation about factors such as their health status (Cameron et al., 1988; DeAllegri et al., 2013).

The Expected utility theory (Schoemaker, 1982) explains the individual's decision of whether to insure or not. Under this theory, demand for insurance reflects the individual's risk aversion and demand for income certainty. However, the theory is silent about the contribution of household socioeconomic status as the determinant for enrollment decision to health insurance. The theory depicts that insurance demand is a choice between an uncertain loss that occurs with probability when uninsured and a certain loss like paying a premium (Manning & Marquis, 1996). The EU theory assumes that consumers are risk-averse and make choices between taking a risk that has different implications on wealth. Despite criticisms made against the EU theory, it provides superior results based on empirical findings compared to other theories (Manning & Marquis, 1996)

Another theoretical thinking behind this study has based on the socio-behavioural model (Anderson, 1995; Anderson & Newman, 1973; Gelberg & Anderson, 2000). According to the model, there are complex and multidimensional factors that influence enrolment (Jehu-Appiah, 2011). The determinants include the nature of the coverage of the scheme, healthcare

quality and socio-demographic factors such as socio-demographic characteristics of a household which includes age, gender, sex, education, household ownership, occupation, household size, marital status, peer pressure and health beliefs and attitudes (Jehu-Appiah, 2011). Scheme factors include suitability of enrolment process, premium value and health insurance coverage benefits. Facility factors include healthcare quality, healthcare provision and attitudes of healthcare staffs. The main assumption is that these multifaceted factors interact with each other to produce enrolment decision which includes a decision to enrol and re-enrol into and dropout from rCHF. i.e utilization of rCHF. However, the outcomes may differ across socio-economic groups due to the belief that factors that contribute to the vulnerability of a given population also affect insurance enrolment decision as well as access to healthcare.

Enrolment decision in the regular period has a positive influence on the financial viability of the scheme due to more risk pooling. The more the members enrolled and re-enrol the more the revenue collected and less expenditure per unit cost, likewise the vice-versa is also true for this relationship. As the scheme successful achieved to collect more revenue through user fees from community members, it will receive a similar amount of fund from NHI as matching grand which in turn will make the scheme more financially viable. This viability is expected to lead into financial protection of households who are members of rCHF, the sustainability of the scheme and most important the reliable access to healthcare by members. The reliable access of healthcare is subjective to the financial viability of the scheme as displayed.

2.2 Empirical Studies on Community Based Health Insurance

Studies on reasons for enrolment in Community Based Health Insurance (CBHI) schemes in Tanzania have fetched varied experiences. A study by Chee (2002) in Hanang District reported low enrollment since its startup due to limited information and ineffective mobilization campaigns but significantly, civil servants who are relatively wealthier and educated had high enrollment rates. Another study which was done by Msuya et.al (2004) and colleagues in rural Tanzania. They identified income as an important factor for enrollment in CHF. The results showed that most of the members

were non-poor households, and a 1% increase in household's income increased the likelihood of a household joining the scheme by 12.5%. Studies by Chee (2002) and Savitha (2004) found that household distance to health facility encourages or discourage enrollment to CBHI. Households living far from health facility believed that CHF was not beneficial to them compared to those living near after they factored in travel costs. On the other hand, a systematic review by Panda (2015) established a positive association between household size and enrolment in CBHI in sub-Saharan Africa. This was particularly reported in Tanzania as well by Macha and colleagues (2014) who showed that households with many family members had a higher probability of enrolling and re-enrolling into compared with their colleagues with small size. Since premiums are flat rate, therefore; average contribution becomes less in large families.

Quality of healthcare services is another factor, which influences the decision to enrol in CBHI schemes, or not. In a study by Chee *et al*, (2002) in Hanang District, Tanzania, households who were not enrolled in the CHF scheme reported that absence of mission hospitals which offer high-quality health services compared to public facilities was a reason for their non-enrollment. Most of the health facilities in developing countries are attributed to poor health services provision. Also, negative attitude of health providers was reported in a study by (Basaza, Criel, & Van der Stuyft, 2008) as a constraint towards enrollment in health insurance schemes.

3. Methods and Materials

This study used an exploratory case study design with qualitative approaches at the core of data collection and analysis (Yin, 1984; McDonough

and McDonough, 1997; Creswell, 2014). The study was carried out in Mpwapwa District (Figure 1).

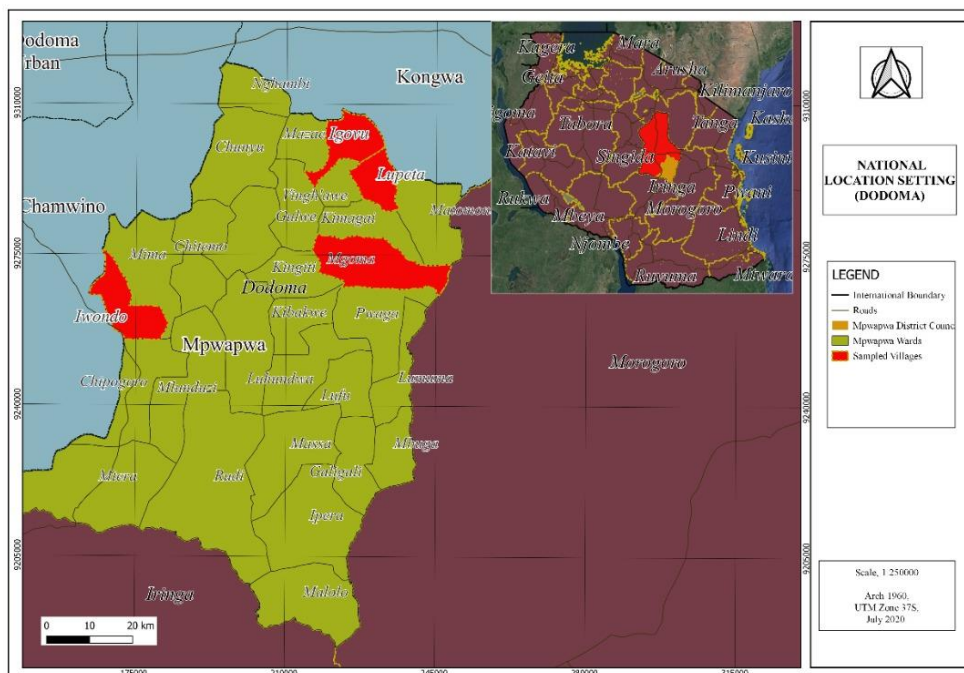


Figure 1: Study Wards

Source: Cartographic Unit, Department of Geography-University of Dar es Salaam

The study targeted drop-out heads of households once enrolled in the rCHF between 2012 and 2019 but did not re-enrol, or re-enrolled but by the time of the study in mid-2019 they were inactive members i.e. had not paid the re-enrolment fee to activate their membership. The list of drop-out cases was accessed from the office of the District coordinator for the rCHF and study cases were randomly selected four purposively picked wards which received sensitization, enrolment and re-enrollment mobilization campaigns.

Key informants and 8 focus group discussion (FGDs), two FGDs one of the males and another of females were held in each ward. Participants for these were purposively selected based on their positions, and availability convenience (Kothari, 2004; Kumar, 2011). Purposively, the study selected District Medical officer (DMO), District coordinator of rCHF (DCR) and four Health Facility In-charges (HFI), one from each study Village. Under their

positions, they were expected to provide information on reasons for why there was a high rate of dropout from rCHF among enrolled households.

This was followed by FGDs to 8 participants groups from which a crosscheck of reasons dropping out from rCHF and challenges faced by members of rCHF while accessing healthcare through rCHF were discussed. Key informants Interview was used to collect in-depth information from key informants using an interview guide (Appendix 4). Key informants included District medical officer and District coordinator of rCHF at District level, while at Village level facility in-charges from selected areas were interviewed. Participation in the study depended on the consent of the interviewees. Data analysis followed content analysis with the use of Nvivo 12.

Limitations of the Study

This study is explorative and adopted a qualitative approach rather than the assessment of quantitative determinants which are dominant in the literature on community utilization of community-based health insurance schemes. The qualitative approach provides an in-depth focus and explanation of the reasons for dropping out.

4. Results and Discussion

Study participants identified several reasons that have influenced them to drop out of the rCHF. The reasons include,

(a) *Poor Availability of Drugs:* Availability of drugs has been a central message in sensitization and mobilization of local communities to join the rCHF in Mpwapwa District. In the rural, healthcare is determined by the availability of drugs which are not affordable to many. However, sensitization and mobilization campaigns do not carry the right message of which drugs and for which diseases would be available to beneficiaries of rCHF. After, enrolment some find that some drugs are not provided as part of the scheme, for instance, drugs for Kidney diseases and some drugs for diabetes are not covered by the scheme. In addition to that, some complained that even those drugs which are covered by the scheme are sometimes not available to rCHF beneficiaries instead, members are directed to buy from

private pharmacies. FGDs participants in Iwondo ward complained poor rCHF services as one of them argued:-

“...When we are visiting health facilities, most of the time facilities fail to provide medications due to stock-outs, and they refer us to private pharmacies to purchase them for which most of us cannot afford the price...”. (FGDs with Household Heads at Iwondo Village in September 2019)

The District rCHF coordinator did not admit this weakness but insisted the fund worked hard to deliver drugs within the scheme's coverage. The coordinator indicated that whenever unavailability of drugs arises is due to logistical problems which are quickly sorted out by ensuring that health facilities and beneficiaries get access to required drugs under the scheme. This was also refuted by the DMO of Mpwapwa who argued

“...We have no serious shortage of drugs in our health facilities. Our clients of rCHF have to know that drugs are prescribed according to the level of the health facility. Example; dispensaries which are more close to locals cannot prescribe certain drugs, while the same can be prescribed at the health centre of District hospital...”. (KI with DMO of Mpwapwa District at Benjamin Mkapa Hospital in September 2019)

This problem happens to affect households differently. For instance, poor availability of drugs in health facilities exposes households with large size into more catastrophic health spending as the possibility of falling sick among its members than households with smaller size. Another example is that the majority in Mpwapwa are peasants and derive their livelihoods from smallholder farming characterised with low use of agriculture inputs and poor productivity, hence low income. Poor availability of drugs in health facilities expose them into out-of-pocket spending when they visit health facilities, thus do not find the importance of activating their insurance compared to those who depend on pastoralism. Pastorals are living in peripheral areas from their located villages; they are not often reached with sensitisation campaigns on rCHF thus have low knowledge of health insurance. As a result, they do not know the benefits covered through rCHF, thus they are expected to get all services through rCHF cards, which in practice is not the case. However; they have a high level of economic welfare compared to farmers. Thus they can afford to pay both premium cost and

drugs which are not available in health facilities. Petty traders have relative high liquidity level of income compared with farmers; hence they can afford to pay a premium cost for re-enrolling into rCHF.

(b) Affordability of premium and low benefits packages: In KII with the District rCHF coordinator, the coordinator revealed that those likely to drop out were youth whom the majority have relatively stable income compared with other age groups, thus able to accommodate premium costs. Again, this age group composed of youths characterised with the low frequency of illness.

“..Youth have a high level of body immunity compared to adults and old people, thus their probability of falling sick is very low...to them, they may risk waiting for an event of sickness rather than re-enrolling in the rCHF” (KII with rCHF inactive member/Iwondo ward/September, 2019).

The elderly are characterized by poor income and high frequency of illness compared with youths and adults. Older people are more prone to diseases due to their low body immunity level and they are less productive due to limitations attributed to old age. Therefore, they need a wider range of benefits packages and affordable premium cost. In Mpwapwa District like other African communities, the patriarchy system is common, in which males dominate in various aspects of life including a decision over resources. These phenomena favour males to have more economic power compared with females thus able to accommodate premium cost for re-enrolling into rCHF.

“....Also, males as breadwinners are expected by the community to provide family needs including medication when a household member is sick. Thus poor availability of drugs in health facilities force most males to incur out of pocket spending which may expose them into catastrophic health expenditure...”

FGDs participant/Iwondo/September, 2019.

The premium cost at the time of the study was TZS 30, 000 (equivalent to USD 12) for re-enrolling into rCHF which rose from TZS 10,000 (USD 4) in April, 2018. A review of rCHF reports at the office of the District rCHF

coordinator confirmed this. There was a feeling among study participants that the amount is unaffordable to many and discourage them from renewing or re-activating their rCHF membership status. This has been an automatic reason associated with low-income levels among the majority poor in Mpwapwa District. Almost all participants of FGDs in all four sampled villages indicated that an increase in premium amount has negatively affected both affordability of premium and re-enrolment into rCHF. One respondent from FGDs reported that:

"Premium has increased from 10,000 to 30,000 Tanzanian Shillings; a good number of us cannot afford to pay that amount. They have increase premium without improving quality healthcare, especially the availability of drugs". (FGDs with Household Heads at Mgoma Village in September 2019)

Another participant of FGD added:

"At least they could increase premium from 10,000 to 20,000 Tanzanian shillings, where the majority of us can afford. Much worse, we were not involved in raising the current premium amount as a principle of community-based health insurances demands". (FGDs with Household Heads at Lupeta Village in September 2019).

The findings may imply that members of rCHF may not be able to access healthcare through rCHF due to inability to pay the premium. Thus they are prone to catastrophic health spending and poverty due to out of pocket expenditures when they visit health facilities. Studies by Mladovsky, (2015), Criel & Waelkens (2003), Dong et al. (2009) and Chimezie (2013) reported similar findings.

(c) Unfriendly Premium Payment Options: Some respondents do not find the existing premium payment modality as friendly. A review of operational manuals and payment guidelines at the rCHF district offices direct that that, households can enrol and re-enrol into rCHF by paying Tshs. 30,000 as premium. The Premium is for the annual membership and is paid at lump sum only once within twelve months which is not affordable to many in Mpwapwa District. They, therefore, opt for out of pocket spending instead of activating or paying fees for rCHF. This consequently exposes them into poverty due to high medication cost. One FGDs emphasized that that:

“...If want to activate our membership of rCHF, we must pay Tshs. Lump-sum of Tshs. 30,000 at once. Some of us are not able to do that, but we can manage to pay that amount in the instalment of two to three phases in equal amounts...”. (FGDs with Household Heads at Igovu Village in September 2019)

Existence of extra-payment is healthcare indicator which measures the percentage of rCHF members who has health insurance but have today some amount of money at a time a service is received for service which is supposed to be covered by health insurance. Many of the respondents made extra-payments during their visit to health facilities within twelve months before this study as one of the FGD participant echoed at the support of other colleagues.

“...Though I am a member of rCHF; most often I had to incur extra-payment for drugs. Sad enough, those drugs are very expensive such that we cannot afford to buy them. However you can get cheap drugs like paracetamol without extra-payment...”. (FGDs with Household Heads at Mgoma Village in September 2019)

However, the DMO did not agree with this sentiment and indicated the need for local communities and especially beneficiaries of the rCHF to understand that drugs are prescribed by doctors and not otherwise. This discrepancy between what members of rCHF expect against what actual is served in the health facilities through their health insurance packages. This implies that the community does not understand well the operation of rCHF; therefore more members of rCHF may decide to drop out of the scheme. Hence limiting their access to healthcare and exposing them into out of pocket spending and poverty.

(d) Discrimination of rCHF members: This indicator measures proportional of members of rCHF who perceived were discriminated when seeking healthcare. Findings from a structure interview show that majority of respondents believed they were discrimination when visited health facility. Some FGDs participants argued to have experienced some forms of discrimination. This is due to the fact that, at the same level of health facility, patients who use rCHF to access healthcare get limited services. Example, they may not get some drugs while their colleagues without of pocket

spending do. Moreover; some unethical healthcare personnel complicate the matter, they have negative attitudes towards rCHF members and positive attitudes towards the patient with user fees. This implies that rCHF is not considered acceptable by the majority of its members. Therefore; the majority of members are less likely to re-enrol into the scheme and hence access healthcare with out of pocket spending.

Long waiting Time in Health Facility: Waiting time is an important indicator in assessing the effectiveness of healthcare in the provision of service to its clients. Majority of people spent more than four hours to get services during their visit to health facilities. These results may be due to the shortage of healthcare personnel and low level of infrastructures to support healthcare provision, especially at the dispensary level. This may influence some community members to utilize alternative ways of treatment like using pharmacy, self-prescription and self-medication and traditional healers instead of formal health services. It may also, discourages some members of rCHF to re-enrol into the scheme, hence exposed them into out of pocket spending which may lead to financial catastrophe and impoverishment. Participants of FGD reported spending more time waiting to get health care service. One respondent commented that:

"When I am ill, most often, I spend a whole day just to get health care services. This discourages me to visit health facility". (FGDs with Household Heads at Iwondo Village in September 2019)

Another participant added

..... On my last visit to a health facility, I went there very early in the morning assumed to get services and returning home to continue with my business early too. But I used the whole day there while given only paracetamol out of other drugs. (FGDs with Household Heads at Igovu Village in September 2019)

(f) *Frequency of illness episodes.* Several FGDs participants cited frequency of illness episodes as reasons to enrol, re-enrol or drop out altogether from rCHF. Most argued to enrol should they perceive increased risk of illness episodes.

"...To me, joining the rCHF was when I found that throughout 2016 I suffered several times and out-of-pocket spending was constraining my access to healthcare. I decided to join the scheme. ..." FGD participant/Igovu ward/March, 2019.

During times of sickness, many would enrol aware that they will have to spend more money than the premium. The findings imply that adverse selection is common to rCHF, where the more health risky households re-enrol into the scheme compared to their colleagues less risky households. It entails that more resources are consumed than saved hence compromises sustainability of the scheme and therefore access to healthcare by the rural population in the informal sector. Respondents access healthcare services while mentioned accessing pharmacies for medical advice and purchase of drugs. The findings suggest that some households would utilise formal health facilities when they were sick, some would access pharmacies for advice or self-prescribe drugs while others sought alternative medicines respectively during their ill health. This is because some households did not re-enrol into rCHF, and have no money to pay user fees if they would go to health formal facilities.

(g) *Quality of Healthcare facilities:* FGDs participants identified the quality of healthcare facilities as key to influencing their decision to either enrol, re-enrol or drop out of the rCHF. Some participants argued to have been attended by a healthcare professional (nurse, medical officer or clinical officer), while others have been attended by unprofessional healthcare personnel (medical attendants) during their visit to health facilities within last twelve months before this study. Being attended by health professionals increases their trust of the quality of healthcare and find it meaningful to re-enrol into the rCHF and vice-versa was found to be true. The results concur with others studies that there is the shortage of healthcare professional especially in rural areas (Peter, 2013; Fan & Habibov, 2009; Onwejekwe et al., 2010; Chimezie, 2013). Re-enrolment into community-based health insurance schemes depend as well on the quality of healthcare facilities. Another reason mentioned in the study is the distance from households to healthcare facilities as one of the key informants argued:

"...distance matters!... if you stay five kilometres from where the healthcare facility is....it bears difficulty getting the service on time, it is costlier as you have to pay for the transport cost as well...it depends on the severity of the disease against the cost of transport..."KII with rCHF member/Igovu/September 2019

Means of transport to health facility determines efforts, cost and time on accessing health care services. The District has 1,098 Kilometres of roads networks, of which 84% is either District or feeder roads. Almost all roads that connect villages are earth roads which are passable with difficulties especially during the rainy season, where *Bodaboda*¹ can do better than other means of transport. This finding concurs with finding by Chimezie (2013) who found that lack of reliable means of transport has posed a great challenge to community members to access primary healthcare in Isu, Nigeria. *Long Travel Time to Health Facility*: Travel time to a health facility is an important indicator in measuring the physical accessibility of healthcare. It measures the number of minutes spent by households to travel from their residence to nearby health facility. Travel time influences transport cost for households used transport machines like motorcars, motorbikes and bicycles when visiting health facilities. It also influences the consumption of human body energy for households travelled on foot. Poor households suffered more in travelling to health facilities compared to their relative wealthier households. Their expenditures on travelling cost versus their income are relatively higher compared to wealthier households, hence exposing them to catastrophic health spending and poverty. Spending money to visit nearby health facility was are constraint to some members from accessing rCHF services. This is attributed by the fact that some respondents, especially those from Lupeta and Mgoma Village are located distantly from their nearby health facility. Lupeta and Mgoma village Mgoma have no health facilities thus a majority of their community members are using health facilities of Mpwapwa Mjini and Godegode Wards respectively. Mpwapwa ward is located about seven kilometres from Lupeta. From Lupeta to Mpwapwa Mjini, *Bodaboda* is only reliable means of transport. However; such distance and transport means increase transport costs thus exposing poor households

¹ Commercially used motorcycles

into catastrophic health expenditure and therefore compromise their access to healthcare.

5. Conclusions

Our study shed more lights on the in-depth reasons behind drop-outs in rural Tanzania and Mpwapwa in particular. The redesigned CHF was expected to address earlier challenges of dropout however this study reveals that local communities do not find the scheme as satisfactory and worth re-enrolment. They find issues such as unguaranteed availability of drugs; relatively high premium costs; unfriendly payment modalities; and low quality of healthcare services as discouraging them to maintain their rCHF membership. The rCHF should redesign the scheme based by integrating participatory approaches that reflect context-specific requirements instead of generic guidelines that largely ignore local concerns.

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