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The Role of Furniture Production in Enhancing Households' Health Services Affordability: A Case of Small-Scale Producers in Mafinga Town Council, Tanzania

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Abstract

This study explored the role of furniture production in enhancing households' health services affordability among small-scale furniture producers in Mafinga Town Council. Structured

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questionnaires, key informant interviews, and documentary reviews were used to collect data. Statistical Product for Social Solutions (SPSS) Version 27 was used to analyze quantitative data while content analysis was used to analyze qualitative data. The findings indicate that engagement in furniture production led to increased ability of individuals to afford healthcare services. To further enhance productivity in the furniture sector, the implementation of affordable insurance plans and community health programs can provide essential services to the community. The process of improving the furniture sector will not only contribute to income growth but also promote the overall well-being of households engaged in furniture production.

Keywords: Furniture, Furniture Production, Small-scale Producers, Health Services Affordability, Mafinga Town Council

1. Background of The Study

Furniture is a significant tool for different purposes ranging from functions to social needs of human beings. Study by Aiyeloja *et al*. (2014) found that items like beds, chairs, tables, and doors are transformed from raw materials into crafted pieces of furniture that satisfy needs of a human being. Guadagno *et al*. (2019) found that small scale enterprises in many developing countries provide basic goods and services such as furniture production, which are less costly compared to goods and services provided by large scale producers in meeting needs of the community.

Asia and the Pacific region accounted for more than half of the global furniture manufacturing, whereby China is the world's largest producer of furniture, with the United States of America, Germany, and Italy trailing after at a distance (Centre for Industrial Studies, 2022). In the Asian context, China’s wood furniture industry comprising about 58% of the furniture sector, dispersed with numerous small producers and a small number of large corporations in the country,

while maintaining a significant market share in China (Xiong *et al*., 2017). In Sri Lanka, the domestic market was experiencing a surge in demand for low- to medium-quality wooden furniture due to population growth and the expansion of the middle class, which was supported by rising per capita income. Therefore, it was observed that many jobs were created and eventually helped in increasing the Gross Domestic Product (GDP) of the country.

In Africa, the wood furniture industry had a potential to contribute significantly to the GDP through proper utilization of many indigenous and local resources such as forest resources and local skills which are possessed by small-scale furniture producers. Helsinki *et al*. (2015) showed that the performance of the furniture sector was significant to employment and growth of the economy. Additionally, Tafesse *et al*. (2016) conducted a study in Ethiopia, which showed that the furniture industry contributed to the country's 3.8% GDP, which was beneficial to the economy in provision of social services required by the community including health services. Also, Sambe *et al*. (2022) discovered that through profits made by furniture producers, their capacity in affording social services and basic needs was well improved.

In Tanzania, the wood and furniture industry employed roughly 8,000 workers, representing 6% of the total manufacturing employment in 2016 (Guadagno *et al*., 2019). Except for some relatively large firms which import and manufacture furniture for the domestic market, many businesses in Tanzania are Small and Medium Sized Enterprises (SMEs) which are located in clusters. The process of reducing poverty through employment creation can be achieved in the country, with many individuals engaging in furniture production (Mhede, 2012). According to Mafinga Town Council (2018) statistics show that small businesses contributed about 8% of the total GDP of the district, which highlighted how significant the small businesses are to the economy of the town council. The role of small-scale furniture production in enhancing health

services affordability has garnered increasing attention in recent years, particularly in developing regions where such activities serve as vital sources of income (Ngowi & William, 2020). In Mafinga Town Council, the furniture production industry is not only a significant economic activity but also a critical contributor to the livelihood of many families.

For many families, income derived from furniture production enabled access to health services, thereby improving the overall quality of life (Akbar *et al*., 2017). Additionally, some studies indicated that households involved in productive activities often experience enhanced better health outcomes due to increased financial resources (Babalola, 2018; Gordon *et al*., 2018). However, little has been studied whether furniture production among small-scale furniture producers in Mafinga enhances their health service affordability. Therefore, understanding the dynamics of furniture production in Mafinga Town Council, this study was essential to come up with relevant information on the matter under the study.

2. Literature Reviews

2.1 Theoretical Framework

This study was guided by the Keynesian theory of income and employment which was developed in 1936 According to Keynes (1936) theory, investment in productive sectors contributes to improvement in income level, which enhances access to essential services, including healthcare When small-scale furniture producers experience financial stability, they can invest in medical insurance, preventive healthcare, and quality treatment. Keynes emphasized the role of government spending in supporting public services, suggesting that policies aimed at subsidizing healthcare for workers in small-scale industries can improve their well-being and productivity.

2.2 Empirical Literature Review

A Study by Purnomo *et al*. (2018) shows that stable income from furniture production plays an important role in enhancing household access to healthcare services. As earnings from furniture production grow, families are better equipped to pursue both curative and preventive care, subscribe to health insurance schemes, and manage unexpected medical expenses. All of these, contribute to improved physical health and psychological resilience (Zafar & Mustafa, 2017; Manzoor *et al*., 2019). When income is stable, families are more likely to invest in health-related services such as doctor consultations, prescribed medications, and hospitalization, contributing to improved overall well-being and reduced anxiety over unexpected medical needs (Zafar & Mustafa, 2017). Access to reliable financial resources helps mitigate the burden of healthcare costs and fosters proactive approaches to health management.

Stable incomes enable families to invest in health services which can help in attaining overall wellbeing. Manzoor *et al*. (2019) found that assessing a reliable income source can help in reducing burden of healthcare costs and fosters good approaches to management of health by community members. However, Bintabara *et al*. (2018) emphasize that in many African countries, affordability of health services remains a key challenge for low-income families. Most individuals consume their income on basic needs, hence little amount is left for health services, which makes the community vulnerable to affording costs of health services This contrast underscores the critical link between income stability and healthcare equity among small scale businesses.

A study conducted by Ke Liu (2020) observes that furniture producers with higher profits often channel their incomes into private healthcare, which gives access to quality health services treatments that can improve overall health outcomes. In contrast, Lazar and Davenport (2018) note that lower-income furniture producers typically depend on public hospitals with inconsistent service availability, hence hindering access to quality care. This divide in healthcare investment

not only highlights systemic inequalities but also affects the productivity of these small-scale furniture producers and long-term economic stability.

Studies show that self-employed furniture producers prioritize health services differently based on their income levels. Sinaga and Sitorius (2023) found that individuals with stable income can afford regular check-ups of their health, while those with lower earnings often delay treatment due to cost concerns. Additionally, transportation costs further limit access to healthcare services, as self-employed workers in remote areas struggle to afford private transport to medical facilities (Ngowi & William, 2020). Majority of small-scale furniture producers face various health risks due to limited safety programs, with many exposed to wood dust and machinery injuries (Burger & Christian, 2018). Without employer-provided healthcare, most of them depend on personal income for medical expenses, which makes financial stability crucial for their health.

3. Research Methodology

3.1 Study Area

The study was conducted in Mafinga Town Council, which is found in the Iringa Region, and it is bordered by Mufindi District Council on the South, West, and East, and Iringa District Council on the Northern part. The study area has a population of 122,329 people according to the 2022 National Census with most of them relying on agricultural activities for income generation (URT, 2022). In the study area there are many forest resources and a joint program known as PFP which was facilitated by the governments of Tanzania and Finland in adding values to 10 small-scale enterprises in the furniture industry in efforts of increasing employment as well as alleviating poverty (Participatory Plantation Forestry Programme, 2024). The presence of the program and abundance of forest resources sparked the interest of the researcher in finding a contribution of

furniture production on improving households' capacities in affording health services among the small-scale furniture producers.

3.2 Research Approach and Design

The study employed a mixed approach which included both quantitative and qualitative research approaches. The study employed a descriptive cross-sectional design which helps in identifying the specific features of a population. In addition, a study utilized a cross-sectional design whereby data were collected from sample respondents at a single point in time.

3.3 Population of Study

The target population of the study was small-scale furniture producers. They were selected among small-scale furniture producers in three sampled wards within Mafinga Town Council which were Kinyanambo, Boma and Changarawe. Morover, the study involved key informants who possess adequate knowledge on communities' issues. The key informants were selected among the Community Development Officers (CDOs) in Mafinga Town Council.

3.4 Sample Size and Sampling Techniques

The sample of the study was selected among a population of small-scale furniture producers who resided in Mafinga Town Council. A total of 96 respondents were selected from the study area. The study employed both probability and non-probability sampling methods which included simple random sampling and purposive sampling respectively. Simple random sampling was applied in the selection of small-scale furniture producers. Selection of key informants was done purposely by including seven (7) CDOs who have adequate information for the study.

3.5 Data Collection Methods and Analysis

In the study, quantitative data were collected through the deployment of questionnaires which were distributed to small-scale furniture producers. Also, there was some data which was

collected through documentary reviews. Moreover, qualitative data was collected through interviews conducted with CDOs in Mafinga Town Council. The study involved analysis of both quantitative and qualitative data. Quantitative data were analyzed by using SPSS. The tool provided descriptive statistics for data in percentage and frequencies and presented key findings of the study in tables and figures. Qualitative data was analyzed by using content analysis method. The process involved several steps which included collection of data, classification by familiarization with data, provision of codes, and generation of common themes from the codes, reviewing of themes and presenting the results.

4. Results and Discussions

4.1 Sex and Age Groups of Respondents

The results (Table 1) highlight that small-scale furniture production is predominantly male led, with 93.8% of participants being men and only 6.2% women. Age distribution shows a significant concentration of furniture producers between 26 and 35 years old (41.7%), followed by 25% in the 36 – 45 age group. Meanwhile, 19.8% are younger than 25, and only 13.5% are older than 45. This suggests that the sector attracts younger and middle-aged individuals, while fewer older producers. This implies potential gender barriers that limit female participation in the industry, possibly due to cultural norms or economic constraints.

Table 1: Sex and Age groups of respondents

Item	Frequency	Percent (%)
Sex		
Male	90	93.8
Female	6	6.2
Total	**96**	**100.0**
Age		
Below 25	19	19.8

26 - 35	40	41.7
36 - 45	24	25.0
Above 45	13	13.5
Total	**96**	**100.0**

The results of the study concur with the studies by Tafesse *et al*. (2016) and Sambe *et al*. (2022) whereby the domination of active age groups was discovered to be important in furniture production activities. To enhance health services affordability, there should be interventions in expanding potential opportunities for women in the study area. Also, skill development programs can be implemented for youths, to improve their sustainability in furniture production.

4.2 Education Level of Respondents

The results presented in Table 2 show that most furniture producers have a primary education (44.8%), followed by secondary education (25.0%). Only 21.9% have tertiary education, while 8.3% have never attended school. The findings suggest that many small-scale furniture producers rely on practical skills rather than formal education for their activities.

Table 2: Education level of respondents

Education Level	Frequency	Percent (%)
Not Attended School	8	8.3
Primary	43	44.8
Secondary	24	25.0
Tertiary	21	21.9
Total	**96**	**100.0**

The findings of the study concur with Aiyeloja *et al*. (2014) with results presenting 86.67% of people with tertiary and secondary, which was very important for keeping records and adoption

of new technologies. The low tertiary education rate suggests that higher degrees are not essential for success in the industry. Therefore, combining formal education with skill-based training can help furniture producers in improving their businesses and contribute to industry growth.

4.3 Marital Status and Household Size of Respondents

The findings (Table 3) show that most furniture producers are married (61.5%), while 15.6% are single. Separated individuals make up 13.5%, and smaller percentages are divorced (6.3%) or widowed (3.1%). The findings imply that the sector attracts individuals from various marital backgrounds, with married people forming the largest group. The results indicate that furniture production can provide adequate income for families and ability to afford health services. Also, the study findings (Table 3) show that most respondents live in households of three to four members (36.5%), while 30.2% have five to six members. Smaller households of one to two people make up 22.9%, and only 10.4% have more than six members. This suggests that many households involved in furniture production fall within medium-sized family structures.

Table 3: Marital status of respondents

Variable	Frequency	Percent (%)
Marital Status		
Single	15	15.6
Married	59	61.5
Divorced	6	6.3
Separated	13	13.5
Widow/widower	3	3.1
Total	**96**	**100.0**
Household Size		
1 – 2	22	22.9
3 – 4	35	36.5
5 – 6	29	30.2

Total	**96**	**100.0**

Findings of the study corroborated by Mhede (2012) who asserted that furniture production can enhance health services affordability by offering financial stability. Support programs for single, separated, and widowed individuals can strengthen their economic security. In household size, the findings are supported by the National Census of 2022 with results showing that Mafinga Town Council had an average of 3.4 household size (URT, 2022). The predominance of three to six member households indicates that furniture production is likely to support families with moderate household sizes in affording health services.

4.4 Household Monthly Income from Different Sources

The findings presented in Table 4 reflects a diverse spectrum of household income levels, with the largest proportion 35.4% earning between 300,001 and 600,000 Tanzanian Shillings (TZS) monthly, closely followed by 31.3% of households in the 600,001 to 900,000 TZS group. A smaller segment, comprising 13.5%, earns between 900,001 and 1,200,000 TZS, while 12.5% report incomes exceeding 1,200,000 TZS, suggesting the presence of a relatively affluent minority. On the lower end of the scale, only 7.3% of households earn less than 300,000 TZS per month, highlighting a modest economically vulnerable group. Altogether, the income distribution implies socioeconomic diversity within the population and the varying level of financial well-being across households, which may be critical for informing inclusive policymaking and development strategies.

Table 4: Household monthly income from different sources

Income Level (TZS)	Frequency	Percent (%)
Below 300,000	7	7.3
300,001 - 600,000	34	35.4
600,001 - 900,000	30	31.3

900,001 - 1,200,000	13	13.5
Above 1,200,000	12	12.5
Total	**96**	**100.0**

The dominance of mid-range income levels shows that many households have moderate financial stability which are obtained from various sources. According to URT (2019), the income generated was adequate for sustaining households' needs, with a report suggesting that in Iringa the average consumption amount was approximately TZS 307,000 for food purposes. The relatively small percentage earning below 300,000 TZS highlights that very low-income households are less common, though they may still face financial challenges. Through various programs such as entrepreneurship, financial literacy, and access to resources can help households achieve economic stability hence improved health services affordability.

4.5 Preference for Health Services

The study results in Table 5 show that most respondents (93.7%) preferred public health services before engaging in furniture production, while only a small portion (6.3%) sought private healthcare. This indicates a strong reliance on public health facilities within the surveyed group before engaging in furniture production. Furthermore, results highlight that after engaging in furniture production, 75.0% of respondents still prefer public health services, while 25.0% now opt for private healthcare. This indicates an increase in private health services centers compared to the previous preference, suggesting improved financial capacity among some furniture producers.

Table 5: Preference for health services before and after engaging in furniture production

Health Center	Frequency	Percent (%)
Before Engaging		
Private	6	6.3

Public	90	93.7
Total	**96**	**100.0**
After Engaging		
Private	24	25.0
Public	72	75.0
Total	**96**	**100.0**

The findings concur with the study by Finkelstein *et al*. (2022) whereby people with high income can have the opportunity to access the services at good hospitals and afford extended health services which can help in improving their health status. Moreover, the rise in private health services preference suggests that increased income from furniture production may allow more individuals to access private medical services. These findings of the study concur with studies by Traoré (2022) and Chokshi (2018) which showed how income can have the effect on preference of the health services for the household. Improving health services access for furniture producers is essential to sustain productivity and well-being.

4.6 Affordability for Health Services

Results (Table 6) show that before engaging in furniture production, 76.0% of respondents could afford health services, while 15.6% had partial affordability. A smaller portion (8.3%) found health services unaffordable. This suggests that most individuals had access to health services, though a small segment faced financial challenges. Additionally, the results show that after engaging in furniture production, 87.5% of respondents could afford health services, an increase from previous levels. Only 10.4% had partial affordability, while a minimal 2.1% found health services unaffordable. This suggests that improved financial stability has enhanced health services affordability for most individuals.

Table 6: Affordability for health services before and after engaging in furniture production

Response	Frequency	Percent (%)
Before Engaging		
No	8	8.3
Somehow	15	15.6
Yes	73	76.0
Total	**96**	**100.0**
After Engaging		
No	2	2.1
Somehow	10	10.4
Yes	84	87.5
Total	**96**	**100.0**

In supporting these findings, the interview conducted by the CDO showed that the ability of affording costs of health services varies from one individual to others. Some of the arguments made by CDO from Boma Ward were quoted as follows.

> *"In reality, the ability of an individual to afford health services depends much on the level of income which he/she earns from the economic activities engaged… Majority of these furniture producers earn enough income which can enable them to afford services in the health centers which are less costly in relation to their incomes."*

Another CDO from Kinyanambo Ward mentioned the effect of family size on affording the health services as explained during the interview.

> *"The family size can have an impact on the choice of health services. In most cases, those with a high number of family members are more likely to opt for public health services which*

are less costly than the private centers… Since the income generated in furniture activities is not constant, many of them might opt for public health services plans which are affordable than private ones which costs are always high…"

The study results align with Sato (2016) who asserted the role of economic factors in influencing health care quality. The findings show that individuals struggling with health services costs may have relied on public health services or limited medical care due to financial constraints. Moreover, the rise in affordability indicates that furniture production has positively impacted income levels, allowing more furniture producers to afford health services. This concurs with Kumar and Seth (2021) who found that furniture production helps in improving household wellbeing in all social aspects of life. The decline in those struggling with health services costs suggests that increased income succeeded in reducing financial barriers to medical services.

4.7 General Opinions on Affordability for Health Services

The results in Table 7 show that 41.7% believe health services are expensive, and an additional 11.5% consider it very expensive, reflecting a strong perception of financial strain related to medical costs. Meanwhile, 37.5% regard health services expenses as fair, indicating a moderate level of satisfaction or acceptance. Only 9.4% view health services as cheap, suggesting that very few find them truly affordable. The study findings imply that there were individuals who were able to manage health services costs, with majority seeing it as expensive to afford.

Table 7: Opinions of health services affordability

Item	Frequency	Percent (%)
Cheap	9	9.4
Fair	36	37.5
Expensive	40	41.7

Very Expensive	11	11.5
Total	**96**	**100.0**

A study by Odey *et al*. (2019) discovered that the engagement of individuals in small-scale furniture activities can help in accessing and affording health services. Those with higher incomes may find healthcare reasonable, while lower-income individuals are likely to struggle with medical costs, affecting their access to essential services. The results suggest the need for new plans for health services which are affordable for many small-scale furniture producers and other individuals in small businesses. Thus, the findings suggest that improving health services' affordability can be helpful in making services affordable to all small-scale producers.

5. Conclusion and Recommendations

Affordable health services are essential for well-being of the community. Stable income among small-scale producers can help in accessing and affording medical care, though private healthcare costs remain a challenge to many small-scale producers. Therefore, special health plans and community-based services can ease this burden on small-scale furniture producers in Mafinga Town Council. Promoting preventive health care can further help long-term health status among households, supporting productivity and further economic growth in the area.

Ensuring healthcare access and affordability for small-scale furniture producers is significant for wellbeing. Presence of high costs often delay medical attention, so affordable insurance plans and community health programs can provide essential services to the community. Moreover, this study could serve as a valuable resource for future researchers exploring small-scale furniture production and health services affordability. Additionally, further research could assess the significance of health insurance, particularly its role as a barrier preventing some individuals from accessing high-quality healthcare services predominantly offered by private hospitals.

Conflict of Interest: The corresponding author, on behalf of second author, confirms that there are no conflicts of interest to disclose.

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