

**PERCEIVED FACILITATORS AND BARRIERS TO ENROLMENT IN
HEALTH INSURANCE AMONG PEOPLE WORKING IN THE
INFORMAL SECTOR IN MOROGORO, TANZANIA**

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ABSTRACT

Health financing is an important pathway towards universal health coverage (UHC). In Tanzania, despite an improved Community Health Fund (iCHF) rollout, people in the informal sector haven't been fully enrolled. This study explored the perspectives of local-women food vendors (LWFV) and *Bodaboda* (motorcycle taxi) drivers on factors that facilitate and challenge their enrolment in iCHF. A phenomenological study was conducted in Morogoro Municipality. Fifty in-depth interviews and two focus group discussions were conducted. Participants were purposively selected based on being LWFV or *Bodaboda* drivers. The Theory of Planned Behaviour (TPB) provided a framework for the inquiry and categorization of findings. Views from LWFV and *Bodaboda* drivers regarding enrolment in iCHF converged. Enrolment facilitators on *attitude*: value for money; and increased access to affordable health care. *Subjective norms*: encouragement from already-enrolled friends and relatives. *Perceived control*: belief that enrolment premiums are affordable; and improved health care. Barriers on *attitude*: limited knowledge of how the iCHF works; and no health promotion activities. *Subjective norms*: negative views from friends and family. *Perceived control*: the iCHF is not accepted in non-government facilities; limited time to go for enrolment; and uncertainty about coverage of non-communicable diseases. Results suggest that a positive attitude towards iCHF, supported by perceived benefits and encouragement from significant others, can motivate LWFV and *Bodaboda* drivers to enroll. However, more awareness of iCHF is needed among individuals in the informal sector. There is also a need to make quality health care services available to iCHF members, including extending their coverage.

DECLARATION

I, Elisante Abraham do hereby declare to the Senate of the Nelson Mandela African Institution of Science and Technology that this Dissertation is my original work and that it has neither been submitted nor being currently submitted for degree award in any other institution.

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by the Senate of the Nelson Mandela African Institution of Science and Technology, a dissertation entitled “*Perceived Facilitators and Barriers to Enrolment in Health Insurance Among People Working in the Informal Sector in Morogoro, Tanzania*” in partial fulfillment of the requirements for the award of the Degree of Master of Science in Public Health Research of the Nelson Mandela African Institution of Science and Technology.


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LIST OF ABBREVIATIONS AND SYMBOLS

| | |
|-------|--|
| CBHI | Community-Based Health Insurance |
| CHF | Community Health Fund |
| FGDs | Focus Group Discussions |
| HI | Health Insurance |
| HMO | Health-Maintenance Organisation |
| iCHF | improved Community Health Fund |
| IDIs | In-Depth Interviews |
| IHI | Ifakara Health Institute |
| ILO | International Labour Organization |
| IRB | Institutional Review Board |
| LMICs | Low- and Middle-Income Countries |
| LWV | Local-women food vendors |
| MHI | Micro Health Insurance |
| NHIF | National Health Insurance Fund |
| NHIS | National Health Insurance |
| NIMR | National Institute for Medical Research |
| NSSF | National Social Security Fund |
| PBC | Perceived Behavioural Control |
| SHIB | Social Health Insurance Benefit |
| TPB | Theory of Planned Behaviour |
| TRA | Theory of Reasoned Action |
| UHC | Universal Health Coverage |
| UNDP | United Nations Development Programme |
| UNIDO | United Nations Industrial Development Organization |
| URT | United Republic of Tanzania |

CHAPTER ONE

INTRODUCTION

1.1 Background of the Problem

In 2005, the World Health Assembly called for universal health coverage (UHC) and defined it as securing access to adequate health care for all at an affordable price (McIntyre *et al.*, 2008). The objective of the universal health coverage policy is to ensure that all populations of a nation, regardless of their social-economic status, enjoy adequate coverage by prepaid financing systems and have access to needed health care of good quality (Abihiro *et al.*, 2014). Attaining universal health coverage requires strengthening of service delivery and overcoming significant financial and social barriers to accessing and utilizing quality health care (Mekonen *et al.*, 2018). A health insurance scheme is one of the strategies that are used globally to enhance universal health coverage. Health insurance provides an opportunity for the poor and vulnerable groups to be enrolled in the schemes and access health care without experiencing catastrophic expenditure (Meng *et al.*, 2011).

Every year, half of the world's population cannot afford essential health care (World Health Organization [WHO], 2017); Around 150 million people suffer from financial catastrophe, while around 100 million are pushed into poverty due to high out-of-pocket expenses for health care (Mekonen *et al.*, 2018). Those with low income status have been recognized as among the groups of people who have low capability to afford enrolment into health insurance and have limited resilience to cope with health care needs during emergencies or shocks (WHO, 2017).

Most low and middle income countries (LMICs) in Sub-Saharan Africa (SSA) have embarked on health system reforms aimed at achieving UHC to ensure that all populations, including those working in the informal sector, have access to needed health care of good quality through pre-paid financing systems (Abihiro *et al.*, 2014). The objective of UHC is reflected in UN Sustainable Development Goal number 3: "Ensure healthy lives and promote well-being for all at all ages" (United Nation[UN], 2015). Through raising revenue, pooling funds, and purchasing services, several LMICs have implemented community-based health insurance (CBHI) schemes to reduce high out-of-pocket expenses for health care among their members (Ekman & Economics, 2004; Abihiro *et al.*, 2014). However, providing access to affordable health care among those in the informal sector remains a considerable challenge for many low-income countries striving to make progress towards UHC (Borghi *et al.*, 2015). Health insurance has been promoted as a potential step in the transition towards UHC in low-income countries with a system of user fees at

government facilities (Borghi *et al.*, 2015; De Allegri *et al.*, 2006; Mirach & Biks, 2019). Being implemented in most LMICs, the health insurance schemes are constantly challenged by low uptake, coverage, and sustainability issues (Mirach *et al.*, 2019).

In its efforts to achieve UHC, the government of Tanzania, through its health financing strategy, has ensured the availability of health insurance policies targeting the vulnerable, poor groups and the population in the formal and informal sectors. Those in the informal sector comprise more than 60% of the population (Andersen & Lybæk, 2018). Some groups of people in the informal sector have unstable income or low income, and may have poor education backgrounds or live in a social-cultural environment that may influence their decision to prioritize their investment in health insurance (Mushi & Millanzi, 2019). Thus, it was important to explore what facilitates or hinders enrolment into health insurance schemes among those in the informal sector such as local women food vendors (LWFFV) and *Bodaboda* (motorcycle taxi) drivers.

Since independence in 1961, Tanzania has been making efforts to ensure high-quality, accessible and affordable health care for all citizens. Many reforms, including the introduction of cost-sharing in 1993, have been made to the health system's financing structure (*Health Financing*, 2018). Under the cost-sharing policy, everyone with the ability to pay is required to contribute to the cost of health care, except for special groups, such as children under five and the elderly, who are exempt. The introduction of cost-sharing was followed by the establishment of prepayment schemes, starting with the Community Health Fund (CHF), which was piloted in 1996 in Igunga district (Waheke, 2015) before a national CHF law was enacted five years later. The National Health Insurance Fund (NHIF) was also established in 1999 for government employees (Kapologwe *et al.*, 2019). From 2001, CHF was implemented at the level of the community (where it also targeted people working in the informal business sector (Mtei, 2019) before it was reformed into the improved Community Health Fund (iCHF) in 2010. The iCHF is a voluntary health insurance scheme meant to be an alternative scheme to NHIF with a specific focus on the informal sector and rural households, characterized by community members pooling funds to offset the cost of healthcare (Mtei, 2019). Improvements to CHF have been made in the areas of administration and management, data management system, enrolment, benefit package and awareness creation (Table 1). These changes in iCHF show that there is a big difference between the standard CHF and the iCHF.

Prepayment health financing schemes in Tanzania are constantly challenged by low uptake, low coverage and sustainability issues (Mtei & Mulligan, 2007); for example, the coverage of the iCHF is only 25% nationally (United Republic of Tanzania [URT], 2019). Although several studies (Kamuzora & Gilson, 2007; Kapologwe *et al.*, 2017; Mulligan, 2014; Kajala, 2015; Kalolo *et al.*,

2018 & Lekashingo, 2012) have been conducted on determinants of enrolment into the CHF (standard CHF) among the general population, there are still limited studies that have been conducted to understand the facilitators and challenges linked to enrolment into the health insurance schemes for some sensitive groups in the informal sector, such as LWFV and *Bodaboda* drivers. This missing information is affecting the government's determination to attain UHC.

Table 1: Differences between the standard (old) CHF and the improved CHF

| Standard CHF | improved CHF |
|---|--|
| <ul style="list-style-type: none"> ▪ 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) ▪ Weak data management system ▪ Passive enrolment strategy based on health facilities ▪ Restricted benefit package with card applicable at the enrolled facility and rarely involving hospital services ▪ Passive to no community sensitisation campaigns ▪ Identity card given to head of the household (only one card for the household) | <ul style="list-style-type: none"> ▪ Reorganized structure that displays the different roles of purchaser (CHF) and health care provider (health facilities) ▪ Reform of data management system by installation and use of an insurance management system with a central server with online and offline mode ▪ Active close-to-client strategy with village-level enrolment officers ▪ Expanded range of services to include hospitalisation and portability of CHF cards within the region and nationwide ▪ Active mobilisation campaigns with social marketing strategies that involve both community-based campaigns and mass media campaigns ▪ Each member of the household is given individual membership cards |

Kalolo *et al.* (2018)

1.2 Statement of the Problem

Though Tanzania has made good progress in establishing and supporting health insurance schemes as one of the important strategies for pursuing the attainment of the UHC (Kapologwe *et al.*, 2017), Enrolment in the iCHF among people in the informal sector is limited. The coverage of the iCHF is only 25% nationally (URT, 2019). Although not all groups in the informal sector have difficulty

enrolling in health insurance, the majority of them, especially those with low income (Mushi & Millanzi, 2019) may experience the challenge. The LWFV and *Bodaboda* drivers are examples of the social groups in the informal sector in Tanzania that are in great need of health insurance since the nature of their work may constantly expose them to health risk and well-being problems such as road accidents and disease outbreaks through their intense social interactions. The health risk can be most intense among the *Bodaboda* drivers due to their intense mobility on the roads.

Currently, there are limited studies that have been done to understand the health insurance enrolment behaviours of the LWFV and *Bodaboda* drivers. To the best of my knowledge, it is Mushi and Millanzi (2019) who have studied LWFV, while the *Bodaboda* drivers have remained unstudied. There is, therefore, limited concrete evidence to inform program and policy decisions regarding factors that limit enrolment in the health insurance schemes for these groups. Results of a study by Mushi and Millanzi (2019) show that most participants (82.9%) could not afford health insurance. This study also indicates that attitudes did not affect uptake of health insurance as the majority (60.0%) agreed that health insurance is vital for their survival. However, the majority (63.4%) of participants did not know how health insurance works. Although Mushi and Millanzi (2019) beyond income uncertainties, these groups are also likely to experience social uncertainties such as limited education and health information, which may influence their attitude and willingness to enroll in the iCHF.

The lack of concrete evidence on the facilitators and barriers to enrolment in the iCHF among LWFV and *Bodaboda* drivers may represent a missed opportunity to improve the performance of the scheme, policies and programs as well as the country's efforts to achieve UHC. As the country is also heading towards mandatory health insurance (Mtei, 2019), it is important to understand what factors would facilitate or impede enrolment into the health insurance among the informal groups such as the LWFV and *Bodaboda* drivers. This study was therefore proposed to explore facilitators and barriers for enrolment into the iCHF among LWFV and *Bodaboda* drivers in Morogoro Municipality of Tanzania.

1.3 Rationale of the Study

This study aimed to understand the facilitators and barriers to enrolment in health insurance among the LWFV and the *Bodaboda* drivers in Morogoro, Tanzania. As society faces increased threats to disease and wellbeing conditions, it is important that universal health coverage is attained to ensure that all groups of people, including those in the informal sector such as the LWFV and the *Bodaboda* drivers, have access to quality health care. This is especially important in Sub-Saharan African countries, including Tanzania, where the burden of communicable and

non-communicable diseases remains high, which accelerates health care demand (Unwin *et al.*, 2001). However, accessing health care has been a big challenge, especially for certain groups of the population, including the vulnerable and poor populations in Sub-Saharan Africa, including Tanzania due to social-economic vulnerability (Atake, 2018). Some families from poor backgrounds have suffered the consequences of limited access to health care, especially during shocks and emergencies, leading to catastrophic expenditures and, consequently, more impoverishment and poor health.

Due to the nature of their work, the *Bodaboda* drivers are likely to be exposed to road accidents, and the LWFV can be easily exposed to other well-being issues such as disease outbreaks. Thus, it becomes important for these groups to have sustainable health insurance coverage to protect them from failure to access health care and catastrophic expenditures during times of health emergency and need. Despite the current efforts by the government to ensure equity in access to health insurance for all groups regardless of their social-economic status, there is limited information on the enrolment behaviours of the groups in the informal sectors such as the LWFV and the *Bodaboda* drivers. There is also limited information on the facilitators and barriers that may influence their enrolment in the iCHF. Furthermore, there is no clear information available on the attitudes, perceptions and social norms that these groups hold regarding enrolment in the iCHF. With the current effort by the government to create health insurance packages for the informal sector, where the NHIF through the iCHF scheme is offering an attractive package to its members, including out-patient and in-patient services, laboratory services, minor surgeries and treatment by referral system from a dispensary up to the national level, understanding of the facilitators and barriers to the enrolment of these informal groups into the iCHF is important for programme and policy recommendations.

1.4 Research Objectives

1.4.1 General Objective

To explore factors that facilitate and challenge enrolment into the health insurance (iCHF) scheme among local-women food vendors (LWFV) and *Bodaboda* drivers in Morogoro Municipality

1.4.2 Specific Objectives

Specific objectives were organized based on the constructs of the Theory of Planned Behaviour (TPB) as follows:

- (i) To explore the attitudes of LWFV and *Bodaboda* drivers towards enrolment in the iCHF.

- (ii) To explore how subjective norms and other social norms influence enrolment into the iCHF among LWFV and *Bodaboda* drivers.
- (iii) To explore the perceived control of LWFV and *Bodaboda* drivers towards enrolment into the iCHF.
- (iv) To identify measures/initiatives that would empower LWFV and *Bodaboda drivers* to enroll in the iCHF for programme and policy recommendations.

1.5 Research Questions

1.5.1 Main Research Question

What are the factors that facilitate and challenge enrolment into the health insurance (iCHF) scheme among local-women food vendors (LWFV) and *Bodaboda* drivers in Morogoro Municipality?

1.5.2 Specific Research Questions

- (i) What are the attitudes of LWFV and *Bodaboda* drivers towards enrolment into the iCHF?
- (ii) How do subjective norms and other social norms influence enrolment in the iCHF among LWFV and *Bodaboda* drivers?
- (iii) What is the perceived control of LWFV and *Bodaboda* drivers towards enrolment in the iCHF?
- (iv) What measures/initiatives will empower LWFV and *Bodaboda* drivers to enroll into the iCHF?

1.6 Significance of the Study

Little to no research has targeted LWFV and *Bodaboda* drivers in the context of health insurance in Tanzania. As Tanzania is currently moving towards a single health insurance scheme, this study is expected to contribute to helping policymakers make informed choices and evidence-based decisions in the attainment of equity in access to health insurance and health care. Representing the voices of people with unstable incomes, such as LWFV and *Bodaboda* drivers, is good advocacy and a way to promote inclusiveness and social inclusion in health care programs. The use of Theory of Planned Behaviour (TPB) to study behaviours that relate to enrolment into iCHF

among individuals working in the informal sector (LWFV and *Bodaboda* drivers) has additional value in the scientific arena.

1.7 Delineation of the Study

This study faced some limitations, including the COVID-19 pandemic, methodological and participant-related limitations. The setting of this study was during the first wave of the COVID-19 pandemic. Arrangements for conducting this study, which involved obtaining the study permit and recruiting participants, were slowed down by this outbreak as social gatherings were prohibited. Moreover, the protocol review process took a long time to be completed, hence study approval was obtained at the time when the study would have been completed. Some participants failed to meet the interview appointments due to their daily business schedule, as some were afraid of losing customers, and also, some participants were unwilling to be tape-recorded. This led to disruption of the interview timetable and more time and resources were required to obtain substitutes and complete the scheduled interviews.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Kombo and Tromp (2006) define "literature review" as part of the research that gives an account of what has been published by other scholars and researchers. It includes examining documents such as books, magazines, journals and dissertations that have a bearing on the study being conducted. Therefore, this Chapter presents the review of literature related to terms used in this work and the underlying factors of the community's uptake of health insurance schemes in most low- and middle-income countries including Tanzania.

2.2 Definition of Terms

2.1.1 Health Insurance

According to Encyclopedia Britannica, Health insurance is a system for the financing of medical expenses by means of contributions or taxes paid into a common fund to pay for all or part of health services specified in an insurance policy or the law. The key elements common to most health insurance plans are advance payment of premiums or taxes, pooling of funds, and eligibility for benefits on the basis of contributions or employment.

2.1.2 Informal Sector

The informal sector is regarded as a group of production units that form part of the household sector (United Nations Development Programme, United Nations Industrial Development Organization & International Labour Organization [UNDP, UNIDO & ILO], 2002). Household enterprises are units engaged in the production of goods and services that are not constituted as separate legal entities independently of the household or household members that own them. They do not have a complete set of accounts which would permit a clear distinction between the production activities of the enterprises and the other activities of their owners, or the identification of any flows of income or capital between the enterprises and their owners. The informal sector comprises informal own-account enterprises ('self-employed') and enterprises of informal employers (employing one or more employees).

2.1.3 Informal Occupations

Informal occupations consist of those working in the unorganized sector or households (Shonchoy & Junankar, 2014). Example of informal occupations include the local women food vendors (LWFV) and *Bodaboda* drivers.

2.1.4 Enrolment

Enrolment is the act of enrolling or getting enrolled in an institution, course, or program (Encyclopedia Britannica). In health insurance, enrolment can mean getting enrolled in an insurance scheme.

2.1.5 Facilitators

Facilitators refer to people or things that make an action or process easier (Collins English Dictionary). They influence or enable something to occur. In this study, facilitators are things that can help LWFV and *Bodaboda* drivers sign up for iCHF.

2.1.6 Barriers

The Free Dictionary defines barriers as obstacles or impediments that hinder something from happening. In this study, these are factors that can negatively affect enrolment in iCHF among LWFV and *Bodaboda* drivers.

2.3 Health Insurance Uptake in Low and Middle-Income Countries

In many in Low and Middle-Income Countries (LMICs), more people work in the informal sector, making it difficult to collect income taxes and wage-based health insurance contributions. A study by Macha *et al.* (2014), it is clear that in recent years, health insurance financing has been promoted in the health financing transformations in many developing countries as a mechanism for raising additional funds for essential public health services, enhancing access to care and reducing out-of-pocket payments. This is done by the government by setting certain affordable premiums for its citizens, especially those working in the informal sector, to contribute to health insurance and benefit from free health services under a renewable health insurance scheme.

In another study (a systematic review) by Fadlallah *et al.* (2018) the barriers and facilitators to implementation, uptake and sustainability of health insurance schemes in LMICs were grouped into the following levels of ecological model: individual level like consumer awareness, consumer understanding of the concept of health insurance and attitude factors; interpersonal level such as

household dynamics, social solidarity and relative relations; community level, for example, culture and community involvement in scheme implementation and management; systems level including factors like stakeholder involvement, management/administrative structure, package content and membership criteria. Other system-level factors influencing the implementation of health insurance schemes implementation from this study are the amount and timing of premiums, financial viability of the scheme, accessibility of facilities, and marketing and promotion strategies.

Despite the above studies conducted on factors affecting enrolment into health insurance schemes among people working in the formal and informal sectors, little is known about the facilitators and barriers to enrolment into health insurance among local-women food vendors (LWFV) and *Bodaboda* drivers within LMICs. This information gap is hindering the governments of LMICs from reaching the UHC policy goal.

2.4 Health Insurance Uptake in Tanzania

In 1994, health sector reforms (HSR) in Tanzania placed part of the financing responsibility on the community members with the objective of improving access to and quality of care through additional revenues. Currently, only 27% of Tanzanians are covered by various forms of health insurance (Mushi & Millanzi, 2019).

Kajala (2015) argues that, in spite of the importance of health insurance schemes to community members, enrolment has remained low across the country. This study makes it clear that Tanzania faces a low level of enrolment of the target population after many years of health insurance scheme operation, which at 10% falls far short of the 70% level envisioned by the government.

Findings from Kapologwe *et al.* (2017), suggest that locality, family monthly average income, sex, marital status, education level and family size were significantly associated with enrolment and re-enrolment in the CHF scheme. In this study, socio-demographic characteristics were important in decisions to enroll or re-enroll, but the social marketing by health care workers was not significantly associated with an increase in CHF enrolment. A study conducted in Kinondoni district by Mushi and Millanzi (2019) concludes that, limited awareness of health insurance, as well as low income of the people employed in the informal sector kept them from enrolling in health insurance.

An analysis of the CHF structures carried out by the Swiss Tropical and Public Health Institute (Swiss TPH) in Dodoma Region of Tanzania (Radermacher *et al.*, 2011), revealed a number of limitations and structural problems for the CHF, specifically with respect to design, enrolment, servicing, and sustainability of the scheme. In response to this analysis, in 2010, the government

of Tanzania decided to transform the CHF schemes into a viable social health insurance system, currently known as the "improved Community Health Fund" (iCHF), which would be able to provide social protection for the informal sector communities. The NHIF, through the iCHF scheme, is offering an attractive package to its members, including out-patient and in-patient services, laboratory services, minor surgeries, and treatment by referral system from a village dispensary up to the national level.

However, experience from the literature review shows that the health insurance uptake among people working in the informal sectors has not been well researched; groups working in the informal sectors such as LWFV and *Bodaboda* drivers have not been studied enough with regard to understanding facilitators and challenges allied to their enrolment into the iCHF scheme. This is due to the nature of their work, which makes them not easily reachable by researchers, thus making this area of study very essential. Lack of this important knowledge is distressing the governments' strategies towards attainment of universal health coverage (UHC). Anecdotal information shows that there are LWFV and *Bodaboda* drivers who have enrolled in the iCHF, and there are some who have completely failed to enroll. This study aimed to address this knowledge gap by investigating the barriers and facilitators to iCHF enrolment among LWFV and *Bodaboda* drivers in one district, Morogoro Municipality, Tanzania. As Tanzania is moving towards a single (mandatory) health insurance scheme (Mtei, 2019), this study will help policymakers make informed choices and evidence-based decisions to support equity in access to health insurance and thus achieve UHC.

CHAPTER THREE

MATERIALS AND METHODS

3.1 Location and Duration

This study was conducted in Morogoro Municipality, located in the eastern part of Tanzania. The town has a population of 315 866 according to the 2012 national census (URT, 2013). The Morogoro Municipality has six administrative divisions and twenty-nine wards. It is the headquarters of the Morogoro region where most of the administrative and socio-economic activities are implemented. The municipal environment allows various means of production, including transportation, small-scale animal and bird keeping and small-scale business, attracting LWFV and *Bodaboda* drivers to conduct their businesses. The municipality is heterogeneous, with almost all tribes from different parts of the country. However, the main ethnic group of this municipal council is Waluguru (URT, 2017). Health facilities range from dispensaries to health centers and, at the highest level, the regional referral hospital (URT, 1997). Morogoro Municipality was selected as the study area because it is among the fastest-growing towns. It is also in one of the first regions to adopt iCHF in 2016, but iCHF uptake has remained low in the area; during the selection of study location, the principal investigator had experience of 3 years of working with iCHF in Morogoro rural. This study was conducted between July 2020 and September 2020 in thirteen selected wards of the Morogoro Municipality.

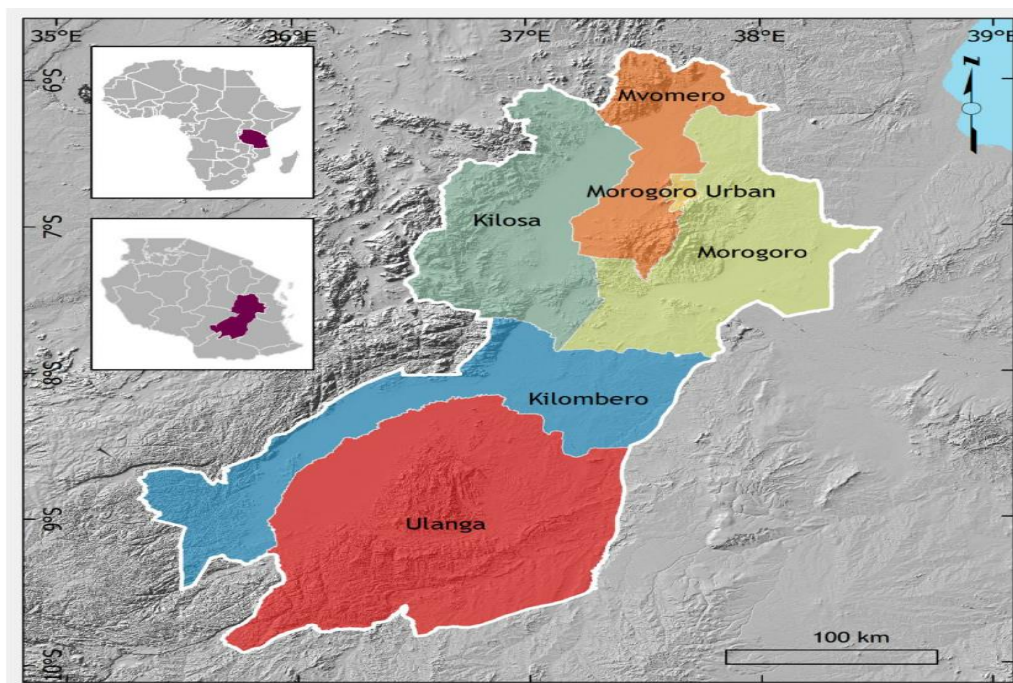


Figure 1: Map of the study location

3.2 Study Design

A phenomenological study was used to identify the facilitators and barriers to iCHF enrolment among LWFV and *Bodaboda* drivers living in Morogoro Municipality (Leavy, 2017). The data collection tools used were semi-structured in-depth interviews (IDIs) and focus group discussions (FGDs). The IDIs and FGDs are useful for capturing information from a small number of respondents through exploring their perspectives, experiences, perceptions and attitudes towards a particular idea, program, or situation (Adams & Cox, 2008). In qualitative research, multiple methods of data collection are a recognized way of ensuring the robustness of the findings (i.e., through triangulation). The Theory of Planned Behaviour (TPB) informed the construction of the topic guides for both the IDIs and FGDs (Icek, 1991).

3.3 Theoretical Framework

This study was developed under the framework of the theory of planned behaviour (TPB) (Icek, 1991). The TPB is a social psychological theory often used to study health related decision making behaviours among youths (Bremset & Berg, 1999; Bissonnette & Contento, 2001; Dennison & Shepherd, 1995; Gummesson & Conner, 1997; Lien & Komro, 2002; Liou & Contento, 2001) and adults (Mtenga *et al.*, 2015). The TPB is an extension of the Theory of Reasoned Action (TRA) (Icek & Fishbein, 1980) which has included a third construct known as perceived behavioural control (PBC). The initial TRA had only two constructs (attitude and subjective norm). The TPB model suggests that behaviour intention is influenced by three main constructs: attitude, subjective norm, and perceived behaviour control (PBC). This means that, for example, if the person has a stronger intention to use certain health care or access certain services, it is likely that the individual will perform the behaviour (Icek, 1988).

Attitude is when the individual has a favourable or unfavourable opinion of the recommended behaviour. Subjective norm is how the individual's behaviour is influenced by significant others (such as friends, relatives, health care providers and policymakers). Subjective norms show the importance of how significant others, such as friends and family members, can influence someone's decisions on performing or not performing a recommended health behaviour and one's willingness to comply with the opinions of others. The PBC is how individuals perceive the ease or difficulty of performing a recommended behaviour (in our study context, access to health insurance). In addition, PBC is thought to directly affect behaviour by accounting for factors outside an individual's control (for example, norms, cultural issues and contextual aspects) and especially for behaviours not under volitional control (Icek & Madden, 1986). Like many health behaviours, enrolment in health insurance is not under complete volitional control; there are many

factors that can affect the enrolment of those in the informal sector, specifically for LWFV and *Bodaboda* drivers. As a result, perceived behavioural control in the TPB becomes a determinant of behaviour (Icek, 1991). The TPB has also been applied in Tanzania to study health behaviour related to HIV prevention among adults (Mtenga *et al.*, 2015). Limited studies have used the TPB framework to study enrolment behaviours for health insurance. This is another important aspect that this study contributes to.

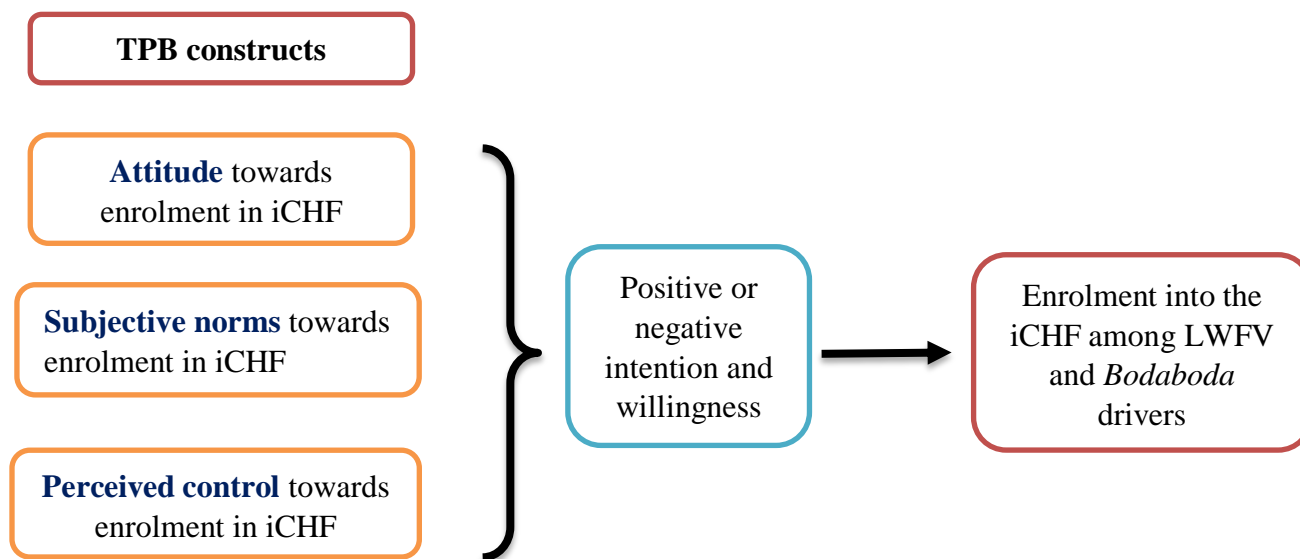


Figure 2: Conceptual framework of factors that influence enrolment of people working in informal sectors (LWFV and *Bodaboda* drivers) in health insurance (iCHF)

3.3.1 Description of the Conceptual Framework

The conceptual framework has been developed by adapting the social constructs from the TPB theory (Icek, 1991). The main assumption is that the three constructs (attitude, perceived control and subjective norm) of the TPB can influence an individual's intention and willingness to adopt the recommended health behavior (enrolment in health insurance). Intentions or willingness to engage in positive or negative behavior are influenced by:

(i) Attitude

The study investigated whether LWFV and *Bodaboda* drivers have favourable or unfavourable attitudes toward iCHF enrollment, as well as the reasons for those attitudes.

(ii) Subjective Norm

The study explored individuals' perceptions of whether their friends, relatives and neighbours are in favour of the recommended behaviour (enrolment into the iCHF) and how this influences their intention to enroll in the iCHF.

(iii) Perceived Control

The study explored an individual's perceived capacity to enroll in the iCHF and factors that challenge or facilitate their enrolment.

In the current study, individual positive or negative opinions (attitude), the influence of significant others on behaviour practices and choices (subjective norms), and personal belief in one's ability to overcome barriers to engaging in the recommended behavior practices (perceived control) were explored to understand the facilitators and barriers to enrolment in iCHF among LWFV and *Bodaboda* drivers.

3.4 Study Participants

This study included LWFV and *Bodaboda* drivers working in Morogoro Municipality aged between 18 and 59 years. The reason behind using participants from this age group was to obtain responses from adult members but not those in the elderly group, which starts at 60 years of age, as they would be out of the health insurance schemes due to an exemption policy. These participants included both members and non-members of iCHF. Involving members of iCHF ensured obtaining information on their experience of belonging to such a scheme, while including non-members of iCHF in this study helped to get information behind their unwillingness to join the scheme.

3.5 Sampling, Recruitment and Sample Size

Based on an estimated saturation point (Francis *et al.*, 2010), purposive sampling was used to select and recruit 50 IDI participants (n = 26 males and n = 24 females) and 16 participants (n = 8 males and n = 8 females) for two FGDs. All the males were *Bodaboda* drivers, and all the females were LWFV. The IDIs participants were selected from 13 wards (Boma, Chamwino, Kichangani, Kihonda Maghorofani, Kilakala, Kingo, Kiwanja cha Ndege, Mafiga, Mafisa, Mji Mkuu, Mji Mpya, Mwembesongo and Sabasaba) out of 29 wards of the municipality, while FGD participants were selected from one ward (Kilakala) of the thirteen using purpose sampling too. Selection criteria were used to ensure that people of working age (18–59 years) – single, married, enrolled or not enrolled in iCHF – were included. All participants were recruited with the help of local government leaders, LWFV and *Bodaboda drivers'* leaders. Leaders were told about the purpose of the study and the eligibility rules before they started recruiting people. This way, they could find the right people to take part in the study.

3.6 Pre-Testing of Data Collection Tools

According to Kothari (2004) it is constantly important to do pre-testing of the data collection tools before the actual data collection because it helps convey the weaknesses of the tools, and from the understanding gained in this process, improvement of the tools can be effected. Therefore, before fieldwork, the guides for this study were pre-tested in one of the selected wards (Kichangani) by the principal investigator and improvements were made. Improvements made included changing the name “Motorcyclists” to “*Bodaboda* drivers” and some questions were adjusted to properly fit under each study objective organized based on the constructs of the Theory of Planned Behaviour (TPB). Schwab (1998) states that pre-testing of data collection tools can be classified into two types: The first one is participatory pre-testing that needs the researcher to let respondents know that the pre-testing is being done, and the second is unsaid pre-testing, which obliges the researcher not to inform the respondents of the pre-testing exercise. In this respect, the unsaid pre-testing of data collection tools was engaged in this study.

3.7 Data Collection, Management and Analysis

Two different but matched topic guides (one for LWFV and one for *Bodaboda* drivers) containing semi-structured questions and probes based on TPB constructs were used to conduct the interviews. The plan was to implement IDIs only, but in the course of the interviews, it was clear that the FGDs would be needed to explore further some insights from IDIs. A different guide, which comprised fewer questions extracted from the IDIs guide, was used to facilitate FGDs. Participant characteristics were collected at the start of the IDI or FGD. To improve interactions and avoid potential gender hierarchies, separate FGDs for men and women were held. All IDIs and FGDs were conducted by the principal investigator (Elisante Abraham) in the Kiswahili language in private locations that were chosen by the participants as convenient to their place of work. The IDIs were conducted by EA until information saturation was achieved at the 50th interview and no new insights emerged. The IDIs were completed before the FGDs, and emerging findings from the IDIs informed the FGD guide. All IDIs and FGDs were recorded digitally with participant consent. The audio recordings were transcribed verbatim. Elisante Abraham initially read each transcript line-by-line to gain an initial impression of the insights that emerged from the participants’ narratives. A deductive approach was used to identify themes based on TPB constructs (attitudes towards iCHF enrolment; the influence of subjective and other social norms on iCHF enrolment; and perceived control of enrolment into the iCHF). An inductive approach was used to identify strategies that might be used to improve LWFV and *Bodaboda* drivers’ enrolment into the iCHF. An open coding framework was developed by EA and, with support from the Supervisor, the codes

were grouped into facilitators and barriers of iCHF enrolment and strategies to promote enrolment of LWFV and *Bodaboda* drivers into the iCHF. Kiswahili was used to analyze all of the data. Themes were compared between LWFV and *Bodaboda* drivers. Four people who had participated in the IDIs (one man, one woman) and FGDs (one man, one woman) checked the themes for accuracy (Birt *et al.*, 2016).

3.8 Ethical Considerations

Ethical approval for the study was obtained from the Institutional Review Board (IRB) of the Ifakara Health Institute (IHI) and the National Institute for Medical Research (NIMR) in Tanzania. Written informed consent was attained from all participants prior to the beginning of the interviews and FGDs. Names of participants were not recorded so as to lessen the possibility of participants' views being easily linked to their personal identities. Instead, each participant was assigned a unique identification number (ID). The FGDs were conducted, including only males and females. Also, in order to ensure confidentiality, participants in the FGDs were discouraged from discussing each other's views outside. The guidelines for reporting qualitative research (COREQ) have been adhered to. This includes all items under: research team and reflexivity; study design; and analysis and findings.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Results

Results are presented along the following dimensions: (a) demographic characteristics of study participants; (b) attitudes of LWFV and *Bodaboda* drivers towards enrolment into the iCHF; (c) influence of subjective norms (significant others) and other social norms on enrolment in the iCHF among LWFV and *Bodaboda* drivers; (d) perceived control of LWFV and *Bodaboda* drivers towards enrolment into the iCHF; and (e) how to improve enrolment into iCHF among LWFV and *Bodaboda* drivers. To illustrate key findings, chosen quotations from the transcripts have been incorporated into this section in order to give power of speech to participants.

4.1.1 Demographic Characteristics of Study Participants

A total of 66 people (34 males and 32 females) participated in the study. As Table 2 shows, their age ranged from 18 to 59 years, and most (63.64%) had at least a primary level education. About one-third had secondary education. Only a few participants (24.24%) were iCHF beneficiaries, while the rest (75.76%) were not enrolled. Some of those who had no insurance cards were dropouts from health insurance schemes, but the rest had not enrolled in any health insurance scheme at all. The majority were married with one to five children. More than half were Christians and had lived in the study area for more than two years. These characteristics were anticipated to have an impact on the factors that facilitate and challenge enrolment into the health insurance scheme among LWFV and *Bodaboda* drivers.

Table 2: Demographic characteristics of study participants

| Variable | Frequency | Percentage |
|-----------------------------------|-----------|------------|
| Sex | | |
| Male | 34 | 51.52% |
| Female | 32 | 48.48% |
| Age | | |
| 18-25 | 11 | 16.67% |
| 26-35 | 29 | 43.93% |
| 36-45 | 17 | 25.75% |
| 45-59 | 09 | 13.65% |
| Education level | | |
| Illiterate | 00 | 00% |
| Primary | 42 | 63.64 |
| Secondary | 22 | 33.33% |
| College | 02 | 03.03% |
| Main occupation | | |
| LWFV | 32 | 48.48% |
| Motorcyclist | 34 | 51.52% |
| With other occupation | 25 | 37.88% |
| Without other occupation | 41 | 62.12% |
| Health insurance status | | |
| Insured | 16 | 24.24% |
| Not insured | 50 | 75.76% |
| Marital status | | |
| Married | 40 | 60.61% |
| Divorced | 02 | 3.03% |
| Widowed | 03 | 4.55% |
| Never married | 21 | 31.81% |
| Number of children | | |
| 00 | 11 | 16.7% |
| 01-02 | 26 | 3.03% |
| 03-05 | 24 | 36.36% |
| > 05 | 05 | 7.58% |
| Religion | | |
| Christian | 39 | 59.1% |
| Muslim | 27 | 40.9% |
| Duration lived in the site | | |
| < 1 year | 11 | 16.7% |
| 2-5 years | 16 | 24.2% |
| 5-10 years | 21 | 31.8% |
| >10 years | 18 | 27.3% |

Field data (2020)**4.1.2 Attitudes of Local-Women Food Venders and *Bodaboda* Drivers towards Enrolment into improved Community Health Fund**

Attitude refers to an individual's positive or negative opinion about something or their own behavioural practice.

(i) Attitude Facilitators/Enablers of Enrolment

In the study context, facilitators are factors that can positively influence enrolment in iCHF among LWFV and *Bodaboda* drivers. The word “facilitators” in this study is used interchangeably with “enablers.” Almost two-thirds of IDI participants possessed positive opinions regarding iCHF benefits, as they spoke positively about the scheme (both LWFV and *Bodaboda* drivers). Most people said that the many benefits of joining the iCHF scheme made them want to join.

Value for Money

Participants who were already insured exhibited an extremely positive attitude towards the iCHF. Many felt that enrolling made good financial sense. It was clear from the participants' view that most LWFV and *Bodaboda* drivers appreciated health insurance because of the value attached to it. One *Bodaboda* driver described how the iCHF helped people get the healthcare they needed when they did not have ready access to cash.

There are many benefits [...]. Whenever you face health problems, you do not need to wait until the next day or to find money; you simply visit a facility and get instant service at a low cost [IDI 14, Bodaboda driver, insured]

Interestingly, some people drew parallels between the iCHF and a savings scheme. Enrolling in iCHF was seen as saving someone's health and life at large. It is clear from this observation that most LWFV and *Bodaboda* drivers do understand and appreciate the importance of enrolling in iCHF. One *Bodaboda* driver described how he viewed it as a way of investing money in his health. The same driver said that the upfront investment gave him peace of mind because he knew he could get the health care he needed when and how he needed it.

Health insurance [iCHF] is something good! Those who introduced it thought it very well because you could have something [money] today and tomorrow you may not have it. So, it acts like a savings for your health since health is vital in human life [IDI 41, Bodaboda driver, insured]

Improvement of Affordable Health Care Access

Accessing health care at an affordable cost was another sentiment provided by participants as a benefit of iCHF. The iCHF insurance allows one to pay for health care (paid in advance via enrolment premium). The majority of the insured participants appreciated being enrolled in iCHF due to the fact that visiting a health facility just with a card was seen as almost getting health care for free.

Truly, health insurance [iCHF] is super! Personally, it has now been about seven years since we were insured, and when we get any [health] problem, we simply go to any good hospital in town with bus fare and get well attended to. The iCHF has simplified the accessibility of affordable health care. So, I see it is very beneficial [IDI 07, LWFV, insured]

Subsequently, with the improved access to affordable health care, as reported by the participants, one is able to spend less on health care; without insurance, one would be forced to access health care through out-of-pocket payment. A similar highlight given by most participants was that iCHF saves money.

The purpose of health insurance [iCHF] is to help a citizen minimize health care costs incurred in treatment. Someone who has been injured or fallen sick and has no cash at that moment has health insurance that can help him access treatment. You see, I think that is the purpose [IDI 29, Bodaboda driver, insured]

(ii) Attitude Barriers/Challenges of Enrolment

The words "barriers" and "challenges" are used interchangeably in this study. These are factors that can negatively affect enrolment in iCHF among LWFV and *Bodaboda* drivers. The main challenge reported by most participants was being unsatisfied with the operationalization of iCHF.

Limited Awareness of the Operationalization of improved Community Health Fund

Although many participants appreciated the implementation of iCHF and the benefits associated with the scheme, others had negative opinions about it. Participants reported limited awareness of the iCHF operationalization; in particular, some did not know how to enroll and how much the scheme costs. They considered this to be an important challenge which excludes some people simply through their lack of awareness of the enrolment procedures.

Interestingly, some participants made it clear that some people had money but were not enrolled in iCHF because of limited awareness about the scheme. One of them said:

There is a lack of awareness among most of us about this scheme [iCHF]. Some of us have money, but we don't know much about health insurance. I don't even know where their offices are located. We have not been provided with enough education, so it will be difficult for us to join [IDI 07, LWFV, uninsured]

In addition, some participants mentioned that people are unaware of the cost of the enrolment premium for iCHF. Others were surprised to hear that the iCHF premium is only Tanzanian

shillings 30 000 per year for a household of up to six members, which many considered affordable. Being unaware of the cost of the enrolment premium acted as a barrier towards enrolment because some had preconceived ideas that enrolling cost a lot and only those with a high income could afford health insurance.

I was unaware of the amount paid for iCHF enrolment. Personally, I recently learnt that the enrolment premium is 30 000/= for six people per year! I think I will be the first to enroll and inspire my friends [IDI 03, Bodaboda driver, uninsured]

Lack of Health Promotion Activities

Also, participants reported a lack of health promotion activities that specifically target LWFV and *Bodaboda* drivers. Both LWFV and *Bodaboda* drivers felt the responsible authorities had not put much effort into promoting iCHF to informal workers like them. Most health promotions have targeted the general population. Unfortunately, the sensitization meetings or awareness-creating campaigns are conducted at the village or mtaa (local government lowest administrative area) meeting grounds, where the LWFV and the *Bodaboda* drivers are always on their business and rarely attend these meetings/campaigns.

I cannot tell much about the social norms, but we [Bodaboda drivers] have not been given education about that insurance, so it is difficult for Bodaboda drivers to enroll themselves in the insurance [iCHF]. If one had received the education or knew the benefits and the risks [of not enrolling in iCHF], they would have enrolled themselves [FGD 05, Bodaboda driver, uninsured]

4.1.3 Subjective Norms and Other Social Norms Influence on Enrolment into improved Community Health Fund

Subjective norms mean the perceived expectations from others that influence someone's behaviour and choices.

(i) Subjective Norms Facilitators/Enablers of Enrolment

Themes of factors functioning as facilitators under subjective norms are presented as follows:

Encouragement from Already-enrolled Friends and Relatives

Most participants reported having been inspired to enroll in iCHF after seeing their close friends and relatives join the scheme, and after receiving positive recommendations from them. It is common for some people to avoid adopting new lifestyles or behaviours until they have seen what

happens to those who take the risk of accepting new changes. Stories about the benefits of being an iCHF member from those already enrolled do inspire others to enroll too.

I see that the response of friends and relatives to joining the scheme [iCHF] is high. There has been a significant response! which also encourages me to join the scheme. My family encourages me to join iCHF. It encourages me so much by telling me that I may have problems if I don't have insurance [IDI 32, LWFV, uninsured]

(ii) Subjective Norms Barriers/Challenges of Enrolment

Negative Views from Friends and Family Regarding improved Community Health Fund

Some participants spoke emotionally that the negative messages given by their friends and relatives regarding their health care experience in using iCHF demotivated them to enroll. Participating individuals specifically mentioned that they were informed by their friends and relatives that when one visits a health facility with an iCHF card, they face difficulties in receiving the care they need on time. Sometimes they are told that their insurance is incapable of covering all services. Several cases were reported by the enrolled participants, including missing some prescribed drugs and not being given first priority as promised during the enrolment process. One was in the position of getting partial health care and would be required to seek other care from another facility or buy from a private vendor.

Our response to the iCHF is not so good. Because of the nature of care provided to those who are enrolled, our friends and relatives have discouraged us from enrolling in health insurance. They [friends and relatives] told us that those with iCHF cards have disturbances in getting specific health care at the required time. Sometimes they're told their insurance did not cover all the services. However, I am not sure if it doesn't cover all services, and that's why I'm saying we still need to be educated about this [IDI 26, Bodaboda driver, uninsured]

(iii) Influence of other Social Norms on Enrolment

Based on the analysis conducted, there were no any emerging social norms influencing enrolment into iCHF obtained from IDIs and FGDs. Interestingly, during an inquiry process, some participants specifically mentioned that socio-cultural norms and beliefs are no longer existing in urban setting due to integration of various tribes and exposure to urban life and media:

In our surroundings here, on my side, I think that they (social-cultural norms) exist in the villages where people still stick to elements of their origins. Here in town, the majority are

civilized because they are exposed to the media. In short, there is no cultural belief that can hinder someone from enrolling in health insurance [FGD 04, Bodaboda, uninsured]

4.1.4 Perceived Control of Local-Women Food Venders and *Bodaboda* Drivers towards Enrolment into improved Community Health Fund

A personal belief that allows one to overcome barriers of recommended behavior practices and choices is referred to as perceived control.

(i) Perceived Control Facilitators/Enablers of Enrolment

The following text presents themes of factors functioning as facilitators under perception control:

Belief that Enrolment Premiums are Affordable Despite Existing Challenges

The affordability of the iCHF premium is one of the common themes that emerged during the interviews. Most participants mentioned that the premium paid for iCHF insurance is affordable, and this affordability surpasses other existing barriers that would discourage them from enrolling. Despite the inability to overcome the challenges of enrolling in iCHF, the amount paid for enrolment into the scheme was seen to be affordable among most LWFV and *Bodaboda* drivers. Enrolment premiums for LWFV and *Bodaboda* drivers were seen as a good thing by most of the people who took part in the study.

In my opinion, thirty thousand shillings [13 USD] is a very small amount to support health care [iCHF] for the whole year for more than five people [in the family]. Imagine you and your children—a total of six! This is affordable for someone with a low income. Even for me, a local female food vendor. The affordability of the iCHF surpasses all other challenges associated with the iCHF. Sometimes it is only stubbornness that makes people not join the insurance [IDI 03, LWFV, insured]

Improved Health Care

Although some participants reported poor health care to iCHF members as told by their enrolled friends and families, other participants had different opinions due to preconceived information by iCHF awareness creation officials that the health services were being improved. Participants conveyed that good services provided at the facilities have a positive contribution towards those not enrolled in health insurance by making them desire to be enrolled so that they can access such services too.

I have not yet started using insurance [iCHF], but I desire to enroll as those officials who came for campaigns said that services are being improved [IDI 33, Bodaboda driver, uninsured]

(ii) Perceived Control Barriers/Challenges of Enrolment

Participants felt that there are some challenges related to iCHF which are beyond their capacity, such as iCHF not being accepted in non-government health facilities, limited time to go to the enrolment centers, especially for motorcyclists due to the nature of their work, and uncertainty about coverage of non-communicable diseases (NCDs) by iCHF. Perceived control barriers are summarized as follows:

The improved Community Health Fund is not Accepted in Non-government Facilities

Although there are plans to incorporate iCHF into non-government facilities, currently iCHF is not accepted for service provision in non-government facilities. Participants stated that, despite the availability of good health care at non-government health facilities, iCHF cannot be used to access health care at those facilities. This was reported by participants as hindering their desire to enroll in the scheme due to the lack of freedom of choice of health care provider.

Improved Community Health Fund insurance is unacceptable in private hospitals, and you find that these facilities are close to us. They also provide good services, but people don't go there because their services are expensive and they don't accept this small insurance [iCHF]. This discourages us... and it is beyond our capacity. It is the government which needs to solve this [IDI 03, LWFV, uninsured]

Lack of Time to go for Enrolment

Another barrier reported by most *Bodaboda* drivers was that the "on-demand" nature of their work made it hard for them to go to iCHF offices during opening hours. They further stressed that their long working days (from early morning through the night) made it almost impossible for them to enroll in the scheme, but one suggested that this problem might be overcome if iCHF providers were able to come to their place of work.

I can say that for us [Bodaboda drivers], time is a problem. I can't leave my job to go for enrolment! I wish they [iCHF registrars] would go to all the places where we park our motorcycles, just like you are doing now, and tell them what to do for enrolment and enroll them at their stations [IDI 21, Bodaboda driver, uninsured]

Uncertainty about Coverage of Non-communicable Diseases by improved Community Health Fund

Concerns regarding iCHF health care coverage were reported by LWFV and *Bodaboda* drivers. Their main concern was that they were not sure whether iCHF covered non-communicable diseases (NCDs) or not. Others mentioned that when they go to a health facility with such conditions, the only care they get is registration and care provider consultation, and they need to buy medicine for themselves. This discourages them from re-enrolling in the scheme since NCDs are now common. Participants thought that this obstacle was too big for them to deal with and that the government should deal with it.

That insurance [iCHF] does not cover these diseases like diabetes and hypertension. I am also a victim of chronic diseases and heart problems, but when I go to the hospital with an insurance card, the only help that I get is registration and doctor consultation, and I need to pay for the rest. When I take a doctor's drug sheet to the pharmacy, I don't get even a single drug, so I go to buy it outside the hospital... The government should work on this [FGD 10, LWFV, insured]

4.1.5 Other Themes that do not Fit in Theory of Planned Behaviour Constructs

The TPB theory was useful in guiding understanding of factors that facilitate and challenge enrolment in iCHF insurance. However, there are some important constructs that emerged that could not fit into the TPB theoretical constructs, such as "carelessness" about the iCHF and "unwillingness." Therefore, the theory needs to be expanded to include these important emerging constructs. Some participants admitted there are various people who are careless because they have heard about iCHF and the important information about enrolment, but they have ignored the scheme.

What I see is carelessness in decision-making. A local female food vendor cannot fail to get thirty thousand shillings per year. So, it is carelessness in decision-making! We are used to being careless, but if we're motivated, we can enroll. Someone may have a good income but keeps saying, 'I will go' and then she ignores him [IDI 39, LWFV, uninsured]

Unwillingness towards enrolment was another barrier/challenge of enrolment among LWFV and *Bodaboda* drivers which was raised by the participants. It was discovered that, apart from other factors affecting enrolment in iCHF among these individuals under perceived control, unwillingness towards enrolment contributed to low enrolments in iCHF schemes.

To me, it was not difficult to join, only that I wasn't ready to do so, but there was no difficulty. There is no willingness..... [IDI 09, Bodaboda driver, uninsured]

4.1.6 How to Improve Enrolment in improved Community Health Fund among Local-Women Food Venders and *Bodaboda* Drivers

When asked to give their suggestions/opinions on the factors that would empower (facilitate) LWFV and *Bodaboda* drivers to enroll in iCHF, the participants said that enrolment can be improved through the following strategies: increasing education/raising awareness of iCHF; improving enrolment services; improving the quality and range of health care available through iCHF; and monitoring of iCHF operations within health care facilities. The themes of the factors that were recommended to empower LWFV and *Bodaboda* drivers to enroll in iCHF are also presented below:

(i) Increasing Education/Raising Awareness of improved Community Health Fund

In order to create awareness about iCHF, some participants had the following opinions:

They [iCHF implementers] should try their best to conduct seminars. They should go to public gatherings and educate people on health insurance [iCHF]. Income is not a problem for some people; they lack the knowledge [IDI 27, LWFV, uninsured]

(ii) Improving Enrolment Services

Making the enrolment service available near to their working places or residences would enable LWFV and *Bodaboda* drivers to enroll in the iCHF scheme. Some participants advised that enrolment officers should be visiting their working places to inspire and enroll them on the spot.

I can say that for us, Bodaboda drivers, time is a problem. I can't leave my job to go for enrolment! I wish they [iCHF registrars] would go to all the places where Bodaboda riders park their motorcycles, just like you are doing now, and tell them what to do for enrolment and enroll them at their stations [IDI 21, Bodaboda driver, uninsured]

(iii) Improving the Quality and Range of Health Care Available through Improved Community Health Fund

Other participants said that people with iCHF cards should be able to get all the health care they need at the health centers.

What's important is to improve iCHF services at the facilities because people are getting discouraged by the current situation. The government should set up special units with care providers and drugs for the iCHF members [FGD 14, LWFV, insured]

(iv) Monitoring of improved Community Health Fund Operations within Health Care Facilities

Participants also advised that, in order to improve enrolment in iCHF, it is important to have a proper monitoring system for iCHF operations within healthcare facilities. Participants were of the opinion that the iCHF management team needs to arrange time-to-time visits to health care facilities to see if the iCHF insurance is doing as required.

I advise them [iCHF implementers] to make a follow-up of health insurance [iCHF] operations so as to know how things are implemented. That is to see if iCHF is properly utilized as required or it is provided as intended, because one can go to the health facility and find nothing and he has already paid for insurance.” [IDI 25, Bodaboda driver, uninsured]

4.2 Discussion

4.2.1 Attitudes of Local-Women Food Venders and Bodaboda Drivers towards Enrolment in improved Community Health Fund

This study suggests that iCHF has gained recognition among LWFV and *Bodaboda* drivers despite some implementation challenges. Many LWFV and *Bodaboda* drivers appeared to appreciate the benefits of the scheme, which is an important motivational factor for enrolment and re-enrolment. Our findings are consistent with previous studies from Ethiopia reporting that health insurance was viewed as better than out-of-pocket payments for health care (Gidey *et al.*, 2019; Mitiku & Geberetsadik, 2019). Likewise, in Kenya, health insurance was perceived to have many advantages, such as providing financial protection to members and making them feel at ease when their relatives were in hospitals (Mulupi *et al.*, 2013); and a study from Ghana revealed that community members saw the National Health Insurance Scheme (NHIS) as a form of protection from potentially catastrophic healthcare payments (Kotoh *et al.*, 2018).

An important barrier to iCHF enrolment among LWFV and *Bodaboda* drivers appeared to be low awareness about the iCHF scheme, including where and how to enroll, and the cost of enrolment. Limited information about iCHF implementation represents a missed opportunity towards achieving universal health coverage in Tanzania since this may deter informal sector workers from

joining the scheme, even when, as participants who were already enrolled made it clear, the annual payments are affordable. As Tanzania is currently moving towards a single health insurance scheme, this finding can help policymakers make informed choices and evidence-based decisions in the attainment of equity in access to health insurance and health care. These findings are consistent with a study from Ghana where some community members said that they had not heard of any scheme operating in their area (Kotoh *et al.*, 2018). Similarly, in rural South-western Uganda, households with limited access to information, such as how much they needed to pay, had a higher likelihood of not enrolling or renewing their health insurance membership than those who were better informed (Nshakira-rukundo *et al.*, 2019b). Other studies from Ethiopia also suggested a positive association between information and enrolment/re-enrolment in health insurance schemes (Id *et al.*, 2020; Mirach *et al.*, 2019).

4.2.2 Influence of Subjective Norms on Enrolment into improved Community Health Fund among Local-Women Food Venders and *Bodaboda* Drivers

The current study suggests that despite some negative opinions, many people who are already enrolled in the iCHF are extremely positive about it and that recommendations from trusted people could motivate LWFV and *Bodaboda* drivers to sign up. This finding is consistent with a study in Ghana (Jehu-Appiah *et al.*, 2012) which revealed that close relatives positively influenced enrolment and re-enrolment in the National Health Insurance Scheme (NHIS). Likewise, research in rural Uganda reported that having a neighbor enrolled in a Community Based Health Insurance (CBHI) scheme increased the likelihood of membership renewal (Nshakira-rukundo *et al.*, 2019). Involving those already enrolled in the scheme to describe their experiences during awareness campaigns may therefore help to promote iCHF uptake among informal workers. On the other hand, if relatives, friends and neighbours have a negative view of the iCHF, this may adversely impact enrolment. There is evidence in Tanzania that subjective norms influence access to other health services, such as HIV's (Mtenga *et al.*, 2015). A study in Ethiopia revealed that community members rated low quality of health care services and that the benefit package of the CBHI scheme did not meet their needs (Mebratie *et al.*, 2015).

4.2.3 Perceived Control of Local-Women Food Venders and *Bodaboda* Drivers towards Enrolment into Improved Community Health Fund

This study found that perceptions of poor quality and limited health care options for iCHF members can demotivate people to enroll. This is consistent with a systematic review of health insurance in LMICs which indicated that poor satisfaction with health services dissuaded people from joining schemes and led to the discontinuation of memberships (Fadlallah *et al.*, 2018). Lack of coverage

of NCDs has emerged as a particular concern, and other research has found that people are motivated to enroll when health insurance includes NCD coverage (Mirach *et al.*, 2019). These findings are important as universal health coverage aims to ensure access to health care for all people regardless of their socio-economic backgrounds and health conditions, and iCHF is one way to provide this. A systematic review reported that good quality health services can attract more vulnerable people to enroll in health insurance (Fadlallah *et al.*, 2018). Therefore, concerns among informal sector workers about the quality and coverage of the services available will impede optimal use of health insurance schemes and the achievement of better health for all in Tanzania.

Also, this study found that despite the availability of good health care at non-government health facilities, one cannot access health care at those facilities using iCHF. This finding is significant considering that UHC aims to ensure access to quality health care for all people regardless of their social-economic backgrounds. Treatment costs in non-government facilities are higher, which means that the majority of poor citizens are unlikely to afford treatment from them. Also, in some areas, government facilities are limited and the only available facilities are non-government facilities. This finding is parallel to a previous study conducted in Northern Ethiopia (Gidey *et al.*, 2019) in which some of the participants expressed their unwillingness to pay for health insurance. The participants indicated that the cost of health care was fair in public health facilities compared to private ones, and since CBHI operates in public health facilities, they did not see any reason to enroll. Thus, it is important to improve the coverage of health care through iCHF to include non-government facilities.

4.2.4 Improving Enrolment into improved Community Health Fund among Local-Women Food Venders and *Bodaboda* drivers

In addition to improving the quality of health care available, other suggestions to increase iCHF enrolment among LWFV and *Bodaboda* drivers included running local awareness-raising campaigns and bringing the enrolment procedures to their places of work. A study in Southern Nigeria provided similar recommendations, suggesting that enrolment can be improved through awareness-raising and bringing enrolment services to the people (Omotowo *et al.*, 2016). Enhancing monitoring of how iCHF is being implemented at health facilities was also recommended by participants, which echoes a study in Kenya reporting that health insurance providers should be able to demonstrate proper financial management and monitoring of healthcare services (Mulupi *et al.*, 2013). As observed from the suggestions given by participants, representing the voices of people with unstable incomes, such as LWFV and *Bodaboda* drivers, is good advocacy and a way to promote inclusiveness and social inclusion in health care programs.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

This study's findings suggest that a positive attitude toward iCHF due to the associated benefits of being enrolled, the perceived control of enrolling as seen in the affordability of premiums and improved health care, as well as encouragement from friends, neighbors, and relatives, can influence enrolment among LWFV and *Bodaboda* drivers.

On the other hand, the findings of this study show that limited awareness of iCHF operationalization, iCHF not being accepted in non-government health facilities, and negative views from friends and relatives are among the barriers to enrolment in iCHF among LWFV and *Bodaboda* drivers.

The study also suggests that, as the country's health sector strategic plan (HSSP V) is focusing on achieving universal health coverage, the health insurance schemes can build on the perceived benefits of iCHF, which were reported by participants as motivators to enroll in the iCHF scheme. Furthermore, in order to improve enrolment into iCHF among LWFV and *Bodaboda* drivers, it is important for iCHF management and implementers to work on the suggestions given by participants.

5.2 Recommendations

As the country is heading towards a single health insurance plan, policymakers are recommended to make informed choices and evidence-based decisions in the attainment of equity in access to health insurance and health care.

This study recommends awareness creation among individuals working in the informal sector on the enrolment and re-enrolment procedures that specifically target LWFV and *Bodaboda* drivers, going hand in hand with making the enrolment service available near to their working places. Availing quality health care to iCHF members and monitoring of iCHF operations within health care facilities is crucial. Also, making arrangements for non-government health facilities to accept iCHF members is recommended to policymakers.

REFERENCES

- Abihiro, G. A., Mbera, G. B., & De Allegri, M. (2014). Gaps in universal health coverage in Malawi: A qualitative study in rural communities. *BMC Health Services Research*, 14(1), 234. <https://doi.org/10.1186/1472-6963-14-234>
- Adams, A., & Cox, A. L. (2008). Questionnaires, in-depth interviews and focus groups. In P. Cairns, & L. A. Cox (Eds), *Research Methods for Human Computer Interaction* (pp. 17–34). Cambridge, UK. *Cambridge University Press*. <https://www.google.com>
- Ajzen, I., & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behavior*. <https://www.google.com>
- Ajzen, I. (1988). *Attitudes, Personality and Behavior*. <https://www.google.com>
- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179–211. [https://doi.org/10.1016/0749-5978\(91\)90020-T](https://doi.org/10.1016/0749-5978(91)90020-T)
- Ajzen, I., & Madden, T. J. (1986). Prediction of goal-directed behavior: Attitudes, intentions, and perceived behavioral control. *Journal of Experimental Social Psychology*, 22(5), 453–474.
- Andersen, K., & Lybæk, K. (2018). *Labour Market Profile: Tanzania - Zanzibar*. Danish Trade Council for International Development and Cooperation. <https://www.google.com>
- Atake, E. (2018). Health shocks in Sub-Saharan Africa: Are the poor and uninsured households more vulnerable ? *Health Economics Review*, 8(26), 1-13
- Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, 26(13), 1802–1811. <https://doi.org/10.1177/1049732316654870>
- Bissonnette, M. M., & Contento, I. R. (2001). Adolescents' Perspectives and Food Choice Behaviors in Terms of the Environmental Impacts of Food Production Practices: Application of a Psychosocial Model. *Journal of Nutrition Education*, 33(2), 72–82. [https://doi.org/10.1016/S1499-4046\(06\)60170-X](https://doi.org/10.1016/S1499-4046(06)60170-X)
- Borghi, J., Makawia, S., & Kuwawenaruwa, A. (2015). The administrative costs of community-based health insurance: A case study of the community health fund in Tanzania. *Health Policy and Planning*, 30(1), 19–27. <https://doi.org/10.1093/heapol/czt093>

- Bremset, G., & Berg, O. K. (1999). Three-dimensional microhabitat use by young pool-dwelling Atlantic salmon and brown trout. *Animal Behaviour*, 58(5), 1047–1059. [https:// doi. org/ 10. 1006/ anbe.1999.1218](https://doi.org/10.1006/anbe.1999.1218)
- De Allegri, M., Kouyaté, B., Becher, H., Gbangou, A., Pokhrel, S., Sanon, M., & Sauerborn, R. (2006). Understanding enrolment in community health insurance in sub-Saharan Africa: A population-based case-control study in rural Burkina Faso. *Bulletin of the World Health Organization*, 84, 852–858. <https://doi.org/10.1590/S0042-96862006001100009>
- Dennison, C. M., & Shepherd, R. (1995). Adolescent food choice: An application of the Theory of Planned Behaviour. *Journal of Human Nutrition and Dietetics*, 8(1), 9–23. [https:// doi. org/ 10. 1111/j. 1365-277X. 1995.tb00292.x](https://doi.org/10.1111/j.1365-277X.1995.tb00292.x)
- Ekman, B. (2004). Community-based health insurance in low-income countries: A systematic review of the evidence. *Health Policy and Planning*, 19(5), 249–270. [https:// doi. org/ 10. 1093/ heapol/czh031](https://doi.org/10.1093/heapol/czh031)
- Fadlallah, R., El-Jardali, F., Hemadi, N., Morsi, R. Z., Abou Samra, C. A., Ahmad, A., Arif, K., Hishi, L., Honein-AbouHaidar, G., & Akl, E. A. (2018). Barriers and facilitators to implementation, uptake and sustainability of community-based health insurance schemes in low- and middle-income countries: A systematic review. *International Journal for Equity in Health*, 17(13), 1-18. <https://doi.org/10.1186/s12939-018-0721-4>
- Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, 25(10), 1229–1245. [https://doi. org/10. 1080/08870440903194015](https://doi.org/10.1080/08870440903194015)
- Gidey, M. T., Gebretekle, G. B., Hogan, M. E., & Fenta, T. G. (2019). Willingness to pay for social health insurance and its determinants among public servants in Mekelle City, Northern Ethiopia: A mixed methods study. *Cost Effectiveness and Resource Allocation*, 17(2), 1–11. <https://doi.org/10.1186/s12962-019-0171-x>
- Gummeson, L., Jonsson, I., & Conner, M. (1997). Predicting intentions and behaviour of Swedish 10-16-year-olds at breakfast. *Food Quality and Preference*, 8(4), 297–306. [https:// doi. org/ 10. 1016/ S0950-3293\(97\)00013-X](https://doi.org/10.1016/S0950-3293(97)00013-X)

- Id, D. N., Tefera, K., & Gutema, K. (2020). Enrollment in community based health insurance program and the associated factors among households in Boricha district, Sidama Zone, Southern Ethiopia: A cross-sectional. *PLOS ONE*, 81, 1–14. <https://doi.org/10.1371/journal.pone.0234028>
- Jehu-Appiah, C., Aryeetey, G., Agyepong, I., Spaan, E., & Baltussen, R. (2012). Household perceptions and their implications for enrolment in the National Health Insurance Scheme in Ghana. *Health Policy and Planning*, 27(3), 222–233. <https://doi.org/10.1093/heapol/czr032>
- Kajala, V. (2015). *Community Health Fund Enrolment Determinants the Case of Mvomero District*. <https://www.google.com>
- Kalolo, A., Gautier, L., Radermacher, R., Stoermer, M., Jahn, A., Meshack, M., & De Allegri, M. (2018). Implementation of the redesigned Community Health Fund in the Dodoma region of Tanzania: A qualitative study of views from rural communities. *International Journal of Health Planning and Management*, 33(1), 121–135. <https://doi.org/10.1002/hpm.2403>
- Kamuzora, P., & Gilson, L. (2007). Factors influencing implementation of the Community Health Fund in Tanzania. *Health Policy and Planning*, 22(2), 95–102. <https://academic.oup.com/heapol/article-lookup/doi/10.1093/heapol/czm001>
- Kapologwe, N. A., Kagaruki, G. B., Kalolo, A., Ally, M., Shao, A., Meshack, M., Stoermer, M., Briet, A., Wiedenmayer, K., & Hoffman, A. (2017). Barriers and facilitators to enrollment and re-enrollment into the community health funds/Tiba Kwa Kadi (CHF/TIKA) in Tanzania: A cross-sectional inquiry on the effects of socio-demographic factors and social marketing strategies. *BMC Health Services Research*, 17(308), 1-9. <https://doi.org/10.1186/s12913-017-2250-z>
- Kapologwe, N. A., Kalolo, A., Kibusi, S. M., Chaula, Z., Nswilla, A., Teuscher, T., Aung, K., & Borghi, J. (2019). Understanding the implementation of Direct Health Facility Financing and its effect on health system performance in Tanzania: A non-controlled before and after mixed method study protocol. *Health Research Policy and Systems*, 17(11), 1-13. <https://doi.org/10.1186/s12961-018-0400-3>
- Kotoh, A. M., Aryeetey, G. C., & Geest, S. (2018). Original Article Factors That Influence Enrolment and Retention in Ghana National Health Insurance Scheme. *Kerman University of Medical Sciences*, 7(5), 443–454. <https://doi.org/10.15171/ijhpm.2017.117>

- Leavy, P. (2017). *Research Design: Quantitative, Qualitative, Mixed Methods, Arts-Based, and Community-Based Participatory Research Approaches*. The Guilford Press. [https:// www.google.com](https://www.google.com)
- Lekashingo, L. D. (2012). *Exploring The Effects of User Fees, Quality of Care and Utilization of Health Services on Enrolment in Community Health Fund, Bagamoyo District, Tanzania*. <https://www.google.com>
- Lien, N., Lytle, L. A., & Komro, K. A. (2002). Applying theory of planned behavior to fruit and vegetable consumption of young adolescents. *American Journal of Health Promotion*, 16(4), 189–197. <https://doi.org/10.4278/0890-1171-16.4.189>
- Liou, D., & Contento, I. R. (2001). Usefulness of psychosocial theory variables in explaining fat-related dietary behavior in Chinese Americans: Association with degree of acculturation. *Journal of Nutrition Education and Behavior*, 33(6), 322–331. [https://doi.org/10.1016/s1499-4046\(06\)60354-0](https://doi.org/10.1016/s1499-4046(06)60354-0)
- Macha, J., Kuwawenaruwa, A., Makawia, S., Mtei, G., & Borghi, J. (2014). Determinants of community health fund membership in Tanzania: A mixed methods analysis. *BMC Health Services Research*, 14(1), 1–11. <https://doi.org/10.1186/s12913-014-0538-9>
- McIntyre, D., Garshong, B., Mtei, G., Meheus, F., Thiede, M., Akazili, J., Ally, M., Aikins, M., Mulligan, J. A., & Goudge, J. (2008). Beyond fragmentation and towards universal coverage: Insights from Ghana, South Africa and the United Republic of Tanzania. *Bulletin of the World Health Organization*, 86(11), 871–876. <https://doi.org/10.1590/S0042-96862008001100017>
- Mebratie, A. D., Sparrow, R., Yilma, Z., Alemu, G., & Bedi, A. S. (2015). Dropping out of Ethiopia's community-based health insurance scheme. *Health Policy and Planning*, 30(10), 1296–1306. <https://doi.org/10.1093/heapol/czu142>
- Mekonen, A. M., Gebregziabher, M. G., & Teferra, A. S. (2018). The effect of community based health insurance on catastrophic health expenditure in Northeast Ethiopia: A cross sectional study. *Plos One*, 13(10), e0205972. <https://doi.org/10.1371/journal.pone.0205972>
- Meng, Q., Yuan, B., Jia, L., Wang, J., Yu, B., Gao, J., & Garner, P. (2011). Expanding health insurance coverage in vulnerable groups: A systematic review of options. *Health Policy and Planning*, 26(2), 93–104. <https://doi.org/10.1093/heapol/czq038>
- Mirach, T. H., Demissie, G. D., & Biks, G. A. (2019). Determinants of community-based health

- insurance implementation in west Gojjam zone, Northwest Ethiopia: A community based cross sectional study design. *BMC Health Services Research*, 19(544), 1-8. [https:// doi. org/ 10. 1186/s12913-019-4363-z](https://doi.org/10.1186/s12913-019-4363-z)
- Mitiku, K. K., & Geberetsadik, S. M. (2019). Household satisfaction with community-based health insurance scheme and associated factors in piloted Sheko district: Southwest Ethiopia. *Plos One*, 14(5), e0216411. <https://doi.org/10.1371/journal.pone.0216411>
- Mtei, G., & Mulligan, J. A. (2007). *Community health funds in Tanzania: A literature review*. (Ifakara Health Institute, Dar es Salaam). <https://www.google.com>
- Mtei, G. (2019). *Direct Health Facility Financing as a practical approach for strengthening strategic purchasing in Tanzania*. <https://www.google.com>
- Mtenga, S. M., Exavery, A., Kakoko, D., & Geubbels, E. (2015). Social cognitive determinants of HIV voluntary counselling and testing uptake among married individuals in Dar es Salaam Tanzania: Theory of Planned Behaviour. *BMC Public Health*, 15(213), 1–8. [https:// doi. org/ 10. 1186/s12889-015-1545-4](https://doi.org/10.1186/s12889-015-1545-4)
- Mtenga, S. M., Pfeiffer, C., Merten, S., Mamdani, M., Exavery, A., Haafkens, J., Tanner, M., & Geubbels, E. (2015). Prevalence and social drivers of HIV among married and cohabitating heterosexual adults in south-eastern Tanzania: Analysis of adult health community cohort data. *Global Health Action*, 8(1), 1-11. <https://doi.org/10.3402/gha.v8.28941>
- Mulligan, J., & Mtei, G. (2014). *Community Health Funds in Tanzania: A literature review*. *Community Health Funds in Tanzania: A literature review*. <https://www.google.com>
- Mulupi, S., Kirigia, D., & Chuma, J. (2013). Community perceptions of health insurance and their preferred design features: Implications for the design of universal health coverage reforms in Kenya. *BMC Health Services Research*, 13(474), 1-12. <https://doi.org/10.1186/1472-6963-13-474>
- Mushi, L., & Millanzi, P. (2019). *Health insurance for informal workers: What is hindering uptake? Perspectives from female food vendors in Kinondoni District, Tanzania*. [https:// www. google. com](https://www.google.com)
- Nshakira-rukundo, E., Mussa, E. C., Nshakira, N., & Gerber, N. (2019a). Determinants of Enrolment and Renewing of Community- Based Health Insurance in Households With Under-5 Children in Rural South-Western Uganda. *International Journal of Health Policy and*

- Management*, 8(10), 593–606. <https://doi.org/10.15171/ijhpm.2019.49>
- Nshakira-rukundo, E., Mussa, E. C., Nshakira, N., & Gerber, N. (2019b). Original Article Determinants of Enrolment and Renewing of Community- Based Health Insurance in Households With Under-5 Children in Rural South-Western Uganda. *Kerman University of Medical Sciences*, 8(10), 593–606. <https://doi.org/10.15171/ijhpm.2019.49>
- Omotowo, I. B., Ezeoke, U. E., Obi, I. E., Uzochukwu, B. S. C., Agunwa, C. C., Eke, C. B., Idoko, C. A., Umeobieri, A. K., Omotowo, I. B., Ezeoke, U. E., Obi, I. E., Uzochukwu, B. S. C., Agunwa, C. C., Eke, C. B., Idoko, C. A., & Umeobieri, A. K. (2016). Household Perceptions, Willingness to Pay, Benefit Package Preferences, Health System Readiness for National Health Insurance Scheme in Southern Nigeria. *Health*, 08(14), 1630–1644. <https://doi.org/10.4236/health.2016.814159>
- Schwab, D. (1998). From the Patient's Point of View. *Journal of Prosthodontics*, 7(3), 221–222. <https://doi.org/10.1111/j.1532-849X.1998.tb00208.x>
- UN. (2015). *Sustainable Development Goals post 2015. July 2013*. <https://www.google.com>
- UNDP, UNIDO, & ILO. (2002). *Roadmap Study of the Informal Sector in Mainland Tanzania*. <https://www.google.com>
- Unwin, N., Setel, P., Rashid, S., Mugusi, F., Mbanya, J., Kitange, H., Hayes, L., Edwards, R., Aspray, T., & Alberti, K. G. M. M. (2001). Policy and Practice Theme Papers Noncommunicable diseases in sub-Saharan Africa: Where do they feature in the health research agenda? *World Health*, 79(00), 947–953.
- URT. (2013). *The United republic of Tanzania. National Beaural of Statistics: 2012 Population and Housing Census Population Distribution by Administrative areas*. <https://www.google.com>
- URT. (2019). *Embassy of Switzerland in Tanzania Health Financing Mid Term Review of the Health Sector Strategic Plan IV 2015-2020*. <https://www.google.com>
- URT. (2018). Health Financing. <https://www.hpss.or.tz/index.php/what-we-do/health-financing>
- URT. (2017). History|Morogoro Municipal Council. <http://morogoromc.go.tz/history>
- URT. (1997). *Morogoro region socio-economic profile*. <https://www.google.com>

Waheke, W. J. (2015). *Effects and Challenges of Community Health Fund on Accessibility To Health Care Services: A Case of Songea District, Tanzania*. <https://www.google.com>

WHO. (2017). *World Bank and WHO: Half the world lacks access to essential health services, 100 million still pushed into extreme poverty because of health expenses*. <https://www.google.com>

APPENDICES

Appendix 1: In-Depth Interview Guide for Local Women Food Vendors

THE NELSON MANDELA AFRICAN INSTITUTION OF SCIENCE AND TECHNOLOGY

PERCEIVED FACILITATORS AND BARRIERS TO ENROLMENT IN HEALTH INSURANCE AMONG PEOPLE WORKING IN THE INFORMAL SECTOR IN MOROGORO

Name of Candidate: Elisante Abraham

IN-DEPTH INTERVIEW GUIDE FOR LOCAL WOMEN FOOD VENDORS

(Greetings) I am _____ (introduce self).

Thank you for your agreement to participate in this interview. I am a student from the Nelson Mandela African Institution of Science and Technology. I am conducting a study on perceived facilitators and barriers to enrolment to health insurance among people working in informal sector in Morogoro Municipality. Specifically, the study will focus on the local women food vendors (LWFV) and the *Bodaboda* drivers. The purpose of this study is to explore factors that challenge and facilitate enrolment into the iCHF scheme among LWFV and *Bodaboda* drivers in Morogoro Municipality. The interview will take about 30 to 35 minutes. There is no wrong response. All your responses will be valued, therefore feel free to respond.

If it is acceptable to you, I will be tape recording our conversation. The aim of this is so that I can get all the information but at the same time be able to carry on an attentive dialogue with you. I guarantee that all your views will remain confidential. At the end of the interview I will compile a report which will contain all participants' comments without any reference to individuals. If you agree to participate in this interview and the tape recording, please sign this consent form (provide the consent form).

SECTION A: DEMOGRAPHIC INFORMATION

1. How old are you?
2. Are you married?

3. What is your education level?
4. What is your tribe?
5. Your religion please?
6. How long have you lived here?
7. Were you born here or you moved from somewhere else?
8. What is your other occupation?
9. Do you have children? How many? (if answer is Yes)
10. Have you been enrolled in health insurance?

SECTION B: ATTITUDES OF LWFV TOWARDS ENROLMENT INTO THE iCHF

1. Please tell me what you know about health insurance.
2. What is your view about iCHF insurance?
3. What do you think is the purpose of iCHF?
4. Are there benefits of enrolment into the iCHF? If yes, what are they?
5. What is your opinion about NCDs coverage by the iCHF insurance? (*probe NCDs examples to assist response*)
6. How rare or often do you/your friends/relatives receive NCDs treatment by iCHF insurance?
7. Do you think other LWFV experience the same challenges like you? If yes why and if no what do you think are the reasons for the variation?
8. Do you think more LWFV are motivated to enroll into the scheme? If yes what motivates them? If no what demotivates them?
9. Are there any cultural beliefs that make LWFV not to enroll into iCHF? If yes, please explain.

SECTION C: INFLUENCE OF SUBJECTIVE NORMS AND OTHER SOCIAL NORMS AMONG LWFV ON ENROLMENT INTO THE iCHF

1. How are your close relatives and friends responding to the enrolment into the iCHF?
Probe: what do they say?
2. Does seeing some of your friends and relatives enrolled into the iCHF motivate you to be enrolled into the health insurance? If yes, why?
3. What do your neighbours say about enrolment into the iCHF?
4. How do your friends, relatives and neighbours influence your intention to enroll in the iCHF?
5. How does the health seeking behaviour among people with iCHF insurance inspire you to enroll in the scheme?
6. How far do your cultural beliefs affect your willingness to enroll into the iCHF?
7. What role do your society's customs and traditions play to influence your enrolment to iCHF?

8. Who else can influence your decision to enroll into the iCHF and why?

SECTION D: PERCEIVED CONTROL OF LWFV TOWARDS ENROLMENT INTO THE iCHF

1. How easy/difficult is it for you to afford health services during an emergency?
2. What is your opinion about the amount (premium) paid for iCHF?
3. How has it been difficult/easy for you to enroll into the iCHF? If difficult, why? If easy, what has made it easy?
4. How difficult or easy is it for you to sustain your enrolment into iCHF?
5. What factors do you consider favourable for you to enroll into iCHF?
6. What challenge(s) do you think LWFV face towards enrolment to iCHF?

SECTION E: FACTORS THAT WOULD EMPOWER LWFV TO ENROLL TO THE iCHF

1. In your opinion, what factors do you think can empower LWFV to enroll into the iCHF?
2. Any other suggestions or opinions about implementation of iCHF scheme among LWFV please?

This marks the end of our interview. Thank you for your esteemed cooperation. Do you have any question?

Appendix 2: In-Depth Interview Guide for *Bodaboda* Drivers

THE NELSON MANDELA AFRICAN INSTITUTION OF SCIENCE AND TECHNOLOGY PERCEIVED FACILITATORS AND BARRIERS TO ENROLMENT IN HEALTH INSURANCE AMONG PEOPLE WORKING IN THE INFORMAL SECTOR IN MOROGORO

Name of Candidate: Elisante Abraham

IN-DEPTH INTERVIEW GUIDE FOR *BODABODA* DRIVERS

(Greetings) I am _____ (introduce self).

Thank you for your agreement to participate in this interview. I am a student from the Nelson Mandela African Institution of Science and Technology. I am conducting a study on perceived facilitators and barriers to enrolment to health insurance among people working in informal sectors in Morogoro Municipality. Specifically, the study will focus on the local women food vendors (LWFV) and the *Bodaboda* drivers. The purpose of this study is to explore factors that challenge and facilitate enrolment into the iCHF scheme among LWFV and *Bodaboda* drivers in Morogoro Municipality. The interview will take about 30 to 35 minutes. There is no wrong response. All your responses will be valued, therefore feel free to respond.

If it is acceptable to you, I will be tape recording our conversation. The aim of this is so that I can get all the information but at the same time be able to carry on an attentive dialogue with you. I guarantee that all your views will remain confidential. At the end of the interview I will compile a report which will contain all participants' comments without any reference to individuals. If you agree to participate in this interview and the tape recording, please sign this consent form (provide the consent form).

SECTION A: DEMOGRAPHIC INFORMATION

1. How old are you?
2. Are you married?
3. What is your education level?
4. What is your tribe?
5. Your religion please?
6. How long have you lived here?
7. Were you born here or you moved from somewhere else?

8. What is your other occupation?
9. Do you have children? How many? (if answer is Yes)
10. Have you been enrolled in health insurance?

SECTION B: ATTITUDES OF *BODABODA* DRIVERS TOWARDS ENROLMENT INTO THE iCHF

1. Please tell me what you know about health insurance.
2. What is your view about iCHF?
3. What do you think is the purpose of iCHF?
4. Are there benefits of enrolment into the iCHF? If yes, what are they?
5. What is your opinion about NCDs coverage by the iCHF insurance?
6. How rare or often do you/your friends/relatives receive NCDs treatment by iCHF insurance?
7. Do you think other *Bodaboda* drivers experience same challenges like you? If yes why and if no what do you think are the reasons for the variation?
8. Do you think more *Bodaboda* drivers are motivated to enroll into the scheme? If yes what motivates them? If no what demotivates them?
9. Are there any cultural beliefs that make *Bodaboda* drivers not to enroll into iCHF? If yes explain.

Section C: INFLUENCE OF SUBJECTIVE NORMS AND OTHER SOCIAL NORMS AMONG *BODABODA* DRIVERS ON ENROLMENT INTO THE iCHF

1. How are your close relatives and friends responding to the enrolment into the iCHF?
Probe: what do they say?
2. Does seeing some of your friends and relatives enrolled into the iCHF motivate you to be enrolled into the health insurance? If yes, why?
3. What do your neighbors say about enrolment to iCHF?
4. How do your friends, relatives and neighbours' influence your intention to enroll in the iCHF?
5. How does the health seeking behaviour among people with iCHF insurance inspire you to enroll in the scheme?
6. How far do your cultural beliefs affect your willingness to enroll into the iCHF?
7. What role do your society's customs and traditions play to influence your enrolment to iCHF?
8. Who else can influence your decision to enroll into the iCHF and why?

Section D: PERCEIVED CONTROL OF *BODABODA* DRIVERS TOWARDS ENROLMENT INTO THE iCHF

1. How easy/difficult is it for you to afford health services during an emergency?
2. What is your opinion about the amount (premium) paid for CHF?
3. How has it been difficult/easy for you to enroll into the iCHF? If difficult, why? If easy, what has made it easy?
4. How difficult or easy is it for you to sustain your enrolment into iCHF?
5. What factors do you consider favourable for you to enroll into iCHF?
6. What challenge(s) do you think motorcyclists face towards enrolment to iCHF?

Section E: FACTORS THAT WOULD EMPOWER *BODABODA* DRIVERS TO ENROLL INTO THE iCHF

1. In your opinion, what factors do you think can empower *Bodaboda* drivers to enroll into the iCHF?
2. Any other suggestions or opinions about implementation of iCHF scheme among *Bodaboda* drivers please?

This marks the end of our interview. Thank you for your esteemed cooperation. Do you have any question?

Appendix 3: A Guide for Focus Group Discussion (Local-Women Food Vendors)

THE NELSON MANDELA AFRICAN INSTITUTION OF SCIENCE AND TECHNOLOGY

PERCEIVED FACILITATORS AND BARRIERS TO ENROLMENT IN HEALTH INSURANCE AMONG PEOPLE WORKING IN THE INFORMAL SECTOR IN MOROGORO

Name of Candidate: Elisante Abraham

A GUIDE FOR FOCUS GROUP DISCUSSION (LOCAL-WOMEN FOOD VENDORS)

(Greetings) I am _____ (introduce self).

Thank you for your agreement to participate in this interview. I am a student from the Nelson Mandela African Institution of Science and Technology. I am conducting a study on perceived facilitators and barriers to enrolment to health insurance among people working in informal sector in Morogoro Municipality. Specifically, the study will focus on the Local-Women Food Vendors (LWFFV) and the *Bodaboda* drivers. The purpose of this study is to explore factors that challenge and facilitate enrolment into the iCHF scheme among LWFFV and *Bodaboda* drivers in Morogoro Municipality. The discussion will take about 30 to 45 minutes. There is no wrong response. All your responses will be valued, therefore feel free to respond.

If it is acceptable to you, I will be tape recording our conversation. The aim of this is so that I can get all the information but at the same time be able to carry on an attentive dialogue with you. I guarantee that all your views will remain confidential. At the end of the discussion I will compile a report which will contain all participants' comments without any reference to individuals. If you agree to participate in this interview and the tape recording, please sign this consent form (provide the consent form).

SECTION A: DEMOGRAPHIC INFORMATION

(To be filled in a special form by all participants before starting discussion session)

1. How old are you?
2. Are you married?
3. What is your education level?
4. What is your tribe?
5. Your religion please?
6. How long have you lived here?

7. Were you born here or you moved from somewhere else?
8. What is your other occupation?
9. Do you have children? How many? (if answer is Yes)
10. Have you been enrolled in health insurance?

SECTION B: ATTITUDES OF LWFV TOWARDS ENROLMENT INTO THE iCHF

1. What is your opinion about NCDs coverage by the iCHF insurance? (*probe NCDs examples to assist response*)
2. How rare or often do you/your friends/relatives receive NCDs treatment by iCHF insurance?
3. Do you think more LWFV are motivated to enroll into the scheme? If yes what motivates them? If no what demotivates them?
4. Are there any cultural beliefs that make LWFV not to enroll into iCHF? If yes, please explain.

Section C: INFLUENCE OF SUBJECTIVE NORMS AND OTHER SOCIAL NORMS AMONG LWFV ON ENROLMENT INTO THE iCHF

9. Does seeing some of your friends and relatives enrolled into the iCHF motivate you to be enrolled into the health insurance? If yes, why?
10. How do your friends, relatives and neighbours' influence your intention to enroll in the iCHF?
11. How far do your cultural beliefs affect your willingness to enroll into the iCHF?
12. What role do your society's customs and traditions play to influence your enrolment to iCHF?

SECTION E: FACTORS THAT WOULD EMPOWER *BODABODA* DRIVERS TO ENROLL INTO THE iCHF

1. In your opinion, what factors do you think can empower LWFV to enroll into the iCHF?

This marks the end of our discussion. Thank you for your esteemed cooperation. Do you have any question?

Appendix 4: A Guide for Focus Group Discussion (*Bodaboda* Drivers)

THE NELSON MANDELA AFRICAN INSTITUTION OF SCIENCE AND TECHNOLOGY PERCEIVED FACILITATORS AND BARRIERS TO ENROLMENT IN HEALTH INSURANCE AMONG PEOPLE WORKING IN THE INFORMAL SECTOR IN MOROGORO

Name of Candidate: Elisante Abraham

A GUIDE FOR FOCUS GROUP DISCUSSION (*BODABODA* DRIVERS)

(Greetings) I am _____ (introduce self).

Thank you for your agreement to participate in this discussion. I am a student from the Nelson Mandela African Institution of Science and Technology. I am conducting a study on perceived facilitators and barriers to enrolment to health insurance among people working in informal sector in Morogoro Municipality. Specifically, the study will focus on the local women food vendors (LWFV) and the *Bodaboda* drivers. The purpose of this study is to explore factors that challenge and facilitate enrolment into the iCHF scheme among LWFV and *Bodaboda* drivers in Morogoro Municipality. The discussion will take about 30 to 45 minutes. There is no wrong response. All your responses will be valued, therefore feel free to respond.

If it is acceptable to you, I will be tape recording our conversation. The aim of this is so that I can get all the information but at the same time be able to carry on an attentive dialogue with you. I guarantee that all your views will remain confidential. At the end of the discussion I will compile a report which will contain all participants' comments without any reference to individuals. If you agree to participate in this interview and the tape recording, please sign this consent form (provide the consent form).

SECTION A: DEMOGRAPHIC INFORMATION

(To be filled in a special form by all participants before starting discussion session)

1. How old are you?
2. Are you married?
3. What is your education level?
4. What is your tribe?
5. Your religion please?
6. How long have you lived here?

7. Were you born here or you moved from somewhere else?
8. What is your other occupation?
9. Do you have children? How many? (if answer is Yes)
10. Have you been enrolled in health insurance?

SECTION B: ATTITUDES OF *BODABODA* DRIVERS TOWARDS ENROLMENT INTO THE iCHF

1. What is your opinion about NCDs coverage by the iCHF insurance? (*probe NCDs examples to assist response*)
2. How rare or often do you/your friends/relatives receive NCDs treatment by iCHF insurance?
3. Do you think more *Bodaboda* drivers are motivated to enroll into the scheme? If yes what motivates them? If no what demotivates them?
4. Are there any cultural beliefs that make motorcyclists not to enroll into iCHF? If yes, please explain.

SECTION C: INFLUENCE OF SUBJECTIVE NORMS AND OTHER SOCIAL NORMS AMONG *BODABODA* DRIVERS ON ENROLMENT INTO THE iCHF

1. Does seeing some of your friends and relatives enrolled into the iCHF motivate you to be enrolled into the health insurance? If yes, why?
2. How do your friends, relatives and neighbours' influence your intention to enroll in the iCHF?
3. How far do your cultural beliefs affect your willingness to enroll into the iCHF?
4. What role do your society's customs and traditions play to influence your enrolment to iCHF?

SECTION E: FACTORS THAT WOULD EMPOWER *BODABODA* DRIVERS TO ENROLL INTO THE iCHF

1. In your opinion, what factors do you think can empower *Bodaboda* drivers to enroll into the iCHF?

This marks the end of our discussion. Thank you for your esteemed cooperation. Do you have any question?

Appendix 5: Mwongozo Wa Mahojiano Ya Kina Kwa Mama Lishe

TAASISI YA SAYANSI NA TEKNOLOJIA YA NELSON MANDELA

VIWEZESHI NA VIZUIZI VYA KUJIUNGA NA BIMA YA AFYA KWA WATU WANAOFANYA KAZI KWENYE SEKTA ISIYO RASMI MANISPAA YA MOROGORO

Jina la Mwanafunzi: Elisante Abraham

MWONGOZO WA MAHOJIANO YA KINA KWA MAMA LISHE

(Salaam) Naitwa _____ (jitambulisha).

Asante kwa kukubali kushiriki katika mahojiano haya. Mimi ni mwanafunzi kutoka Taasisi ya Kiafrika ya Sayansi na Teknolojia ya Nelson Mandela. Ninafanya utafiti juu ya viwezeshi na vizuizi vya kujiunga na bima ya afya kwa watu wanaofanya kazi kwenye sekta isiyo rasmi katika Manispaa ya Morogoro. Utafiti huu utajikita hasa kwa Mama Lishe na Madereva bodaboda. Lengo la utafiti huu ni kuchunguza vitu vinavyoweza na vinavyokwamisha kujiunga na CHF iliyoboreshwa kwa mama lishe na Madereva bodaboda katika Manispaa ya Morogoro. Mahojiano yatachukua takribani dakika 30 hadi 45. Majibu yote ni sahihi. Majibu yako yote yatathaminiwa, hivyo jisikie huru kujibu.

Kama ni sawa kwako, nitakuwa nikirekodi mazungumzo yetu. Dhumuni lake ni ili niweze kupata taarifa zote lakini wakati huohuo niweze kuwa makini kufanya mahojiano na wewe. Ninakuhakikishia kuwa mawazo yako yote yatabaki kuwa siri. Mwishoni nitaandaa ripoti itakayokuwa na maoni ya washiriki wote bila rejea ya mtu mmojammoja. Kama unakubali kushiriki katika mahojiano haya na kurekodiwa, tafadhali saina fomu hii ya ridhaa (mpatie fomu ya ridhaa).

Sehemu A: TAARIFA ZA KIDEMOGRAFIA

1. Una miaka mingapi?
2. Umeoa/umeolewa?
3. Una elimu gani?
4. Wewe kabila gani?
5. Dini yako tafadhali?
6. Umeishi hapa muda gani?

7. Ulizaliwa hapa au ulihamia kutoka sehemu nyingine?
8. Unafanya kazi gani nyingine?
9. Una watoto? Wangapi? (kama jibu ni ndio)
10. Umejiunga na bima ya afya?

SEHEMU B: MITAZAMO YA MAMA LISHE JUU YA KUJIUNGA NA CHF ILIYOBORESHWA

1. Tafadhali niambie unachofahamu kuhusiana na bima ya afya.
2. Ni nini mtazamo wako kuhusiana na CHF iliyoboreshwa?
3. Je, unafikiri lengo la CHF iliyoboreshwa ni nini?
4. Kuna faida za kujiunga na CHF iliyoboreshwa? Kama ndio, ni zipi hizo?
5. Una maoni gani kuhusiana na matibabu ya magonjwa yasiyoambukiza kwa kutumia CHF iliyoboreshwa? (*taja mifano ya magonjwa yasiyoambukiza ili kurahisisha kujibu*)
6. Ni kwa kiasi gani wewe/rafiki zako/ndugu wanapata matibabu ya magonjwa yasiyoambukiza kwa bima ya CHF iliyoboreshwa?
7. Unafikiri Mama Lishe wengine wanapata changamoto kama zako? Kama ndio, kwa nini na kama hapana, unafikiri ni zipi sababu za huo utofauti?
8. Je, unafikiri mama lishe wengi wanahamasika kujiunga na mfuko? Kama ndio, ni nini kinachowapa hamasa? Kama sio, ni nini kinachowavunja moyo?
9. Kuna imani tamaduni zozote zinazowafanya Mama Lishe wasijiunge na CHF iliyoboreshwa? Kama ndio, elezea tafadhali.

SEHEMU C: ATHARI ZA KANUNI ZA KUHSIKA NA KANUNI NYINGINE ZA KIJAMII KUHSIANA NA MAMA LISHE KUJIUNGA NA CHF ILIYOBORESHWA

1. Mwitikio wa ndugu zako wa karibu kujiunga na CHF iliyoboreshwa ukoje? (wanasemaje?)
2. Je, unapowaona baadhi ya rafiki zako na ndugu wamejiunga na CHF iliyoboreshwa unahamasika kujiunga na bima ya afya? Kwa nini?
3. Majirani zako wanasemaje kuhusiana na kujiunga na CHF iliyoboreshwa?
4. Ni kwa namna gani rafiki zako, ndugu na majirani wanaathiri nia yako ya kujiunga na CHF iliyoboreshwa?
5. Ni kwa namna gani tabia ya kutafuta matibabu kati ya watu wenye bima ya CHF iliyoboreshwa hukuhamasisha kujiunga na bima ya afya?
6. Ni kwa kiasi gani imani za kitamaduni za jamii yako huathiri nia yako ya kujiunga na CHF iliyoboreshwa?

7. Mila na desturi za jamii yako zina nafasi gani katika kukuhamasisha kujiunga na CHF iliyoboreshwa?
8. Ni nani mwingine/wengine anaweza/wanaweza kuathiri maamuzi yako ya kujiunga na CHF iliyoboreshwa?

SEHEMU D: UDHIBITI ULIOTAMBULIWA WA MAMA LISHE KUJIUNGA NA CHF ILIYOBORESHWA

1. Ni kwa jinsi gani ni rahisi/vigumu kwako kumudu huduma za afya wakati wa dharura?
2. Ni nini maoni yako kuhusiana na kiasi kinacholipwa kwa ajili ya CHF iliyoboreshwa?
3. Je, ni kiviipi imekuwa vigumu/rahisi kwako kujiunga na CHF iliyoboreshwa? Kama vigumu, kwa nini? Kama rahisi, ni nini kimefanya iwe rahisi?
4. Ni kwa namna gani ni vigumu/rahisi kwako kufanya kujiunga na CHF iliyoboreshwa kuwa endelevu?
5. Ni sababu gani nzuri unazooka zinaweza kukufanya ujiunge na CHF iliyoboreshwa?
6. Unafikiri ni changamoto ipi/zipi Mama Lishe wanakumbana nazo katika kujiunga na CHF iliyoboreshwa?

SEHEMU E: SABABU ZINAZOWEZA KUWAWEZESHA MAMA LISHE KUJIUNGA NA CHF ILIYOBORESHWA

1. Kwa maoni yako unafikiri ni sababu gani zinaweza kuwawezesha Mama Lishe kujiunga na CHF iliyoboreshwa?
2. Mapendekezo mengine au maoni kuhusu utekelezaji wa mfuko wa CHF iliyoboreshwa kwa mama lishe tafadhali?

Huu ndio mwisho wa mahojiano yetu. Ahsante kwa ushirikiano wako mzuri. Je, una swali lolote?

Appendix 6: Mwongozo Wa Mahojiano Ya Kina Kwa Madereva Bodaboda

TAASISI YA SAYANSI NA TEKNOLOJIA YA NELSON MANDELA

VIWEZESHI NA VIZUIZI VYA KUJIUNGA NA BIMA YA AFYA KWA WATU WANAOFANYA KAZI KWENYE SEKTA ISIYO RASMI

MANISPAA YA MOROGORO

Jina la Mwanafunzi: Elisante Abraham

MWONGOZO WA MAHOJIANO YA KINA KWA MADEREVA BODABODA

(Salaam) Naitwa _____ (jitambulisha).

Asante kwa kukubali kushiriki katika mahojiano haya. Mimi ni mwanafunzi kutoka Taasisi ya Kiafrika ya Sayansi na Teknolojia ya Nelson Mandela. Ninafanya utafiti juu ya viwezeshi na vizuizi vya kujiunga na bima ya afya kwa watu wanaofanya kazi kwenye sekta zisizo rasmi katika Manispaa ya Morogoro. Utafiti huu utajikita hasa kwa Mama lishe na Madereva bodaboda. Lengo la utafiti huu ni kuchunguza vitu vinavyoweza na vinavyokwamisha kujiunga na CHF iliyoboreshwa kwa Mama lishe na Madereva bodaboda katika Manispaa ya Morogoro. Mahojiano yatachukua takribani dakika 30 hadi 45. Majibu yote ni sahihi. Majibu yako yote yatathaminiwa, hivyo jisikie huru kujibu.

Kama ni sawa kwako, nitakuwa nikirekodi mazungumzo yetu. Dhumuni lake ni ili niweze kupata taarifa zote lakini wakati huohuo niweze kuwa makini kufanya mahojiano na wewe. Ninakuhakikishia kuwa mawazo yako yote yatabaki kuwa siri. Mwishoni nitaandaa ripoti itakayokuwa na maoni ya washiriki wote bila rejea ya mtu mmojammoja. Kama unakubali kushiriki katika mahojiano haya na kurekodiwa, tafadhali saina fomu hii ya ridhaa (mpatie fomu ya ridhaa).

Sehemu A: TAARIFA ZA KIDEMOGRAFIA

1. Una miaka mingapi?
2. Umeoa/umeolewa?
3. Una elimu gani?
4. Wewe kabila gani?
5. Dini yako tafadhali?
6. Umeishi hapa muda gani?

7. Ulizaliwa hapa au ulihamia kutoka sehemu nyingine?
8. Unafanya kazi gani nyingine?
9. Una watoto? Wangapi? (kama jibu ni ndio)
10. Umejiunga na bima ya afya?

SEHEMU B: MITAZAMO YA MADEREVA BODABODA JUU YA KUJIUNGA NA BIMA YA AFYA

1. Tafadhali niambie unachofahamu kuhusiana na bima ya afya.
2. Ni nini mtazamo wako kuhusiana na CHF iliyoboreshwa?
3. Je, unafikiri lengo la CHF iliyoboreshwa ni nini?
4. Kuna faida za kujiunga na CHF iliyoboreshwa? Kama ndio, ni zipi hizo?
5. Una maoni gani kuhusiana na matibabu ya magonjwa yasiyoambukiza kwa kutumia bima ya CHF iliyoboreshwa? *(taja mifano ya magonjwa yasiyoambukiza ili kurahisisha kujibu)*
6. Ni kwa kiasi gani wewe/rafiki zako/ndugu wanapata matibabu ya magonjwa yasiyoambukiza kwa bima ya CHF iliyoboreshwa?
7. Unafikiri Madereva bodaboda wengine wanapata changamoto kama zako? Kama ndio, kwa nini na kama hapana, unafikiri ni zipi sababu za huo utofauti?
8. Je, unafikiri Madereva bodaboda wengi wanahamasika kujiunga na mfuko? Kama ndio, ni nini kinachowapa hamasa? Kama sio, ni nini kinachowavunja moyo?
9. Kuna imani tamaduni zozote zinazowafanya Wendesha pikipiki wasijiunge na CHF iliyoboreshwa? Kama ndio, elezea tafadhali.

SEHEMU C: ATHARI ZA KANUNI ZA KUHSIKA NA KANUNI NYINGINE ZA KIJAMII KUHSIANA NA MADEREVA BODABODA KUJIUNGA NA CHF ILIYOBORESHWA

1. Mwitikio wa ndugu zako wa karibu kujiunga na CHF iliyoboreshwa ukoje? (wanasemaje?)
2. Je, unapowaona baadhi ya rafiki zako na ndugu wamejiunga na CHF iliyoboreshwa unahamasika kujiunga na bima ya afya? Kwa nini?
3. Majirani zako wanasemaje kuhusiana na kujiunga na CHF iliyoboreshwa?
4. Ni kwa namna gani rafiki zako, ndugu na majirani wanaathiri nia yako ya kujiunga na CHF iliyoboreshwa?
5. Ni kwa namna gani tabia ya kutafuta matibabu kati ya watu wenye CHF iliyoboreshwa hukhamasisha kujiunga na bima ya afya?
6. Ni kwa kiasi gani imani za kitamaduni za jamii yako huathiri nia yako ya kujiunga na CHF iliyoboreshwa?

7. Mila na desturi za jamii yako zina nafasi gani katika kukuhamasisha kujiunga na CHF iliyoboreshwa?
8. Ni nani mwingine/wengine anaweza/wanaweza kuathiri maamuzi yako ya kujiunga na CHF iliyoboreshwa na kwa nini?

SEHEMU YA D: UDHIBITI ULIO TAMBULIWA WA MADEREVA BODABODA KUJIUNGA NA CHF ILIYOBORESHWA

1. Ni kwa jinsi gani ni rahisi/vigumu kwako kumudu huduma za afya wakati wa dharura?
2. Ni nini maoni yako kuhusiana na kiasi kinacholipwa kwa ajili ya CHF iliyoboreshwa?
3. Je, ni kivipi imekuwa vigumu/rahisi kwako kujiunga na CHF iliyoboreshwa? Kama vigumu, kwa nini? Kama rahisi, ni nini kimefanya iwe rahisi?
4. Ni kwa namna gani ni vigumu/rahisi kwako kufanya kujiunga na CHF iliyoboreshwa kuwa endelevu?
5. Ni sababu gani nzuri unazooka zinaweza kukufanya ujiunge na CHF iliyoboreshwa?
6. Unafikiri ni changamoto ipi/zipi Madereva bodaboda wanakumbana nazo katika kujiunga na CHF iliyoboreshwa?

SEHEMU E: SABABU ZINAZOWEZA KUWAWEZESHA MADEREVA BODABODA KUJIUNGA NA CHF ILIYOBORESHWA

1. Kwa maoni yako unafikiri ni sababu zipi zinaweza kuwawezesha Madereva bodaboda kujiunga na CHF iliyoboreshwa?
2. Mapendekezo mengine au maoni kuhusu utekelezaji wa mfuko wa CHF iliyoboreshwa kwa waendesha pikipiki tafadhali?

Huu ndio mwisho wa mahojiano yetu. Ahsante kwa ushirikiano wako mzuri. Je, una swali lolote?

Appendix 7: Mwongozo Wa Majadiliano Ya Makundi Mahsusi (Mama Lishe)

TAASISI YA SAYANSI NA TEKNOLOJIA YA NELSON MANDELA

VIWEZESHI NA VIZUIZI VYA KUJIUNGA NA BIMA YA AFYA KWA WATU WANAOFANYA KAZI KWENYE SEKTA ISIYO RASMI MANISPAA YA MOROGORO

Jina la Mwanafunzi: Elisante Abraham

MWONGOZO WA MAJADILIANO YA MAKUNDI MAHSUSI (MAMA LISHE)

(Salaam) Naitwa _____ (jitambulisha).

Asante kwa kukubali kushiriki katika majadiliano haya. Mimi ni mwanafunzi kutoka Taasisi ya Kiafrika ya Sayansi na Teknolojia ya Nelson Mandela. Ninafanya utafiti juu ya viwezeshi na vizuizi vya kujiunga na bima ya afya kwa watu wanaofanya kazi kwenye sekta isiyo rasmi katika Manispaa ya Morogoro. Utafiti huu utajikita hasa kwa Mama lishe na Madereva bodaboda. Lengo la utafiti huu ni kuchunguza vitu vinavyoweza na vinavyokwamisha kujiunga na CHF iliyoboreshwa kwa mama lishe na Madereva bodaboda katika Manispaa ya Morogoro. Majadiliano yatachukua takribani dakika 30 hadi 45. Majibu yote ni sahihi. Majibu yenu yote yatathaminiwa, hivyo jisikieni huru kujibu.

Kama ni sawa kwenu, nitakuwa nikirekodi mazungumzo yetu. Dhumuni lake ni ili niweze kupata taarifa zote lakini wakati huohuo niweze kuwa makini kufanya majadiliano nanyi. Ninawahakikishia kuwa mawazo yenu yote yatabaki kuwa siri. Mwishoni nitaandaa ripoti itakayokuwa na maoni ya washiriki wote bila rejea ya mtu mmojammoja. Kama mnakubali kushiriki katika mahojiano haya na kurekodiwa, tafadhali sainini fomu hii ya ridhaa (wapatie fomu za ridhaa).

SEHEMU A: TAARIFA ZA KIDEMOGRAFIA

(Kujazwa na kila mshiriki katika fomu maalum kabla ya kuanza kwa majadiliano)

1. Una miaka mingapi?
2. Umeoa/umeolewa?
3. Una elimu gani?
4. Wewe kabila gani?
5. Dini yako tafadhali?
6. Umeishi hapa muda gani?

7. Ulizaliwa hapa au ulihamia kutoka sehemu nyingine?
8. Unafanya kazi gani nyingine?
9. Una watoto? Wangapi? (kama jibu ni ndio)
10. Umejiunga na bima ya afya?

SEHEMU B: MITAZAMO YA MAMA LISHE JUU YA KUJIUNGA NA BIMA YA AFYA

1. Una maoni gani kuhusiana na matibabu ya magonjwa yasiyoambukiza kwa kutumia bima ya CHF iliyoboreshwa? *(taja mifano ya magonjwa yasiyoambukiza ili kurahisisha kujibu)*
2. Ni kwa kiasi gani wewe/rafiki zako/ndugu wanapata matibabu ya magonjwa yasiyoambukiza kwa bima ya CHF iliyoboreshwa?
3. Kuna imani tamaduni zozote zinazowafanya Mama lishe wasijiunge na CHF iliyoboreshwa? Kama ndio, elezea tafadhali.

**SEHEMU C: ATHARI ZA KANUNI ZA KUHUSIKA NA KANUNI NYINGINE ZA
KIJAMII KUHUSIANA NA MAMA LISHE KUJIUNGA NA BIMA YA
AFYA**

1. Ni kwa kiasi gani imani za kitamaduni za jamii yako huathiri nia yako ya kujiunga na CHF iliyoboreshwa?
2. Mila na desturi za jamii yako zina nafasi gani katika kukuhamasisha kujiunga na CHF iliyoboreshwa?

Huu ndio mwisho wa majadiliano yetu. Ahsanteni kwa ushirikiano wenu mzuri. Je, mna swali lolote?

Appendix 8: Mwongozo Wa Majadiliano Ya Makundi Mahsusi (Madereva Bodaboda)

TAASISI YA SAYANSI NA TEKNOLOJIA

YA NELSON MANDELA

VIWEZESHI NA VIZUIZI VYA KUJIUNGA NA BIMA YA AFYA KWA WATU

WANAOFANYA KAZI KWENYE SEKTA ISIYO RASMI

MANISPAA YA MOROGORO

Jina la Mwanafunzi: Elisante Abraham

MWONGOZO WA MAJADILIANO YA MAKUNDI MAHSUSI (MADEREVA BODABODA)

(Salaam) Naitwa _____ (jitambulisha).

Asante kwa kukubali kushiriki katika majadiliano haya. Mimi ni mwanafunzi kutoka Taasisi ya Kiafrika ya Sayansi na Teknolojia ya Nelson Mandela. Ninafanya utafiti juu ya viwezeshi na vizuizi vya kujiunga na bima ya afya kwa watu wanaofanya kazi kwenye sekta isiyo rasmi katika Manispaa ya Morogoro. Utafiti huu utajikita hasa kwa Mama Lishe na Madereva bodaboda. Lengo la utafiti huu ni kuchunguza vitu vinavyoweza na vinavyokwamisha kujiunga na CHF iliyoboreshwa kwa mama lishe na Madereva bodaboda katika Manispaa ya Morogoro. Majadiliano yatachukua takribani dakika 30 hadi 45. Majibu yote ni sahihi. Majibu yenu yote yatathaminiwa, hivyo jisikieni huru kujibu.

Kama ni sawa kwenu, nitakuwa nikirekodi mazungumzo yetu. Dhumuni lake ni ili niweze kupata taarifa zote lakini wakati huohuo niweze kuwa makini kufanya majadiliano nanyi. Ninawahakikishia kuwa mawazo yenu yote yatabaki kuwa siri. Mwishoni nitaandaa ripoti itakayokuwa na maoni ya washiriki wote bila rejea ya mtu mmojammoja. Kama mnakubali kushiriki katika mahojiano haya na kurekodiwa, tafadhali sainini fomu hii ya ridhaa (wapatie fomu za ridhaa).

Sehemu A: TAARIFA ZA KIDEMOGRAFIA

(Kujazwa na kila mshiriki katika fomu maalum kabla ya kuanza kwa majadiliano)

1. Una miaka mingapi?
2. Umeoa/umeolewa?
3. Una elimu gani?
4. Wewe kabila gani?
5. Dini yako tafadhali?
6. Umeishi hapa muda gani?

7. Ulizaliwa hapa au ulihamia kutoka sehemu nyingine?
8. Unafanya kazi gani nyingine?
9. Una watoto? Wangapi? (kama jibu ni ndio))
10. Umejiunga na bima ya afya?

SEHEMU B: MITAZAMO YA MADEREVA BODABODA JUU YA KUJIUNGA NA CHF ILIYOBORESHWA

1. Una maoni gani kuhusiana na matibabu ya magonjwa yasiyoambukiza kwa kutumia bima ya CHF iliyoboreshwa? *(taja mifano ya magonjwa yasioyoambukiza ili kurahisisha kujibu)*
2. Ni kwa kiasi gani wewe/rafiki zako/ndugu wanapata matibabu ya magonjwa yasiyoambukiza kwa bima ya CHF iliyoboreshwa?
3. Kuna imani tamaduni zozote zinazowafanya Madereva bodaboda wasijiunge na CHF iliyoboreshwa? Kama ndio, elezea tafadhali.

SEHEMU C: ATHARI ZA KANUNI ZA KUHSIKA NA KANUNI NYINGINE ZA KIJAMII KUHUSIANA NA MADEREVA BODABODA KUJIUNGA CHF ILIYOBORESHWA

1. Ni kwa kiasi gani imani za kitamaduni za jamii yako huathiri nia yako ya kujiunga na CHF iliyoboreshwa?
2. Mila na desturi za jamii yako zina nafasi gani katika kukuhamasisha kujiunga na CHF iliyoboreshwa?

Huu ndio mwisho wa majadiliano yetu. Ahsanteni kwa ushirikiano wenu mzuri. Je, mna swali lolote?

**THE NELSON MANDELA
AFRICAN INSTITUTION OF SCIENCE AND TECHNOLOGY**

**PERCEIVED FACILITATORS AND BARRIERS TO ENROLMENT IN HEALTH
INSURANCE AMONG PEOPLE WORKING IN THE INFORMAL SECTOR IN
MOROGORO**

INFORMED CONSENT FORM

ID No: _____

Greetings,

My name is Elisante Abraham. I'm a student at the Nelson Mandela African Institution of Science and Technology studying Master of Science in Public Health Research. Currently, I am doing research on perceived facilitators and barriers to enrolment to health insurance among people working in informal sector in Morogoro Municipality. Specifically, the study will focus on the Local-Women Food Vendors (LWFFV) and the *Bodaboda* riders by exploring factors that facilitate and challenge their enrolment into the health insurance schemes. The interview with you will take about 30 to 35 minutes, and I will be tape recording our conversation so that I can get all the information but at the same time be able to carry on an attentive dialogue with you. At the end of the interview I will compile a report which will contain all participants' comments without any reference to individuals.

Purpose of the study

The purpose of the study is to explore factors that facilitate and challenge enrollment in the health insurance scheme among Local-Women Food Vendors (LWFFV) and *Bodaboda* riders in Morogoro Municipality.

Participation

If you agree to participate in the study you will be involved in In-depth interviews. We would like to hear your thoughts about the enrollment in the health insurance scheme among female food vendors and motorcyclists. We will ask some questions and you will be free to respond based on your opinion.

Confidentiality

Your information will be treated with great confidentiality and will be used for study purpose only. Personal identifiers including names will not be attached to any of the reports.

Benefits

Your views and those of other people with regard to the enrollment in the health insurance scheme among female food vendors and motorcyclists will help to inform program and policy for improvement of the implementation of health insurance schemes, enrollment and access to quality health care especially by vulnerable groups. Although this is not a direct personal benefit but we hope that the entire community and nation will benefit from the improvement of the implementation of health insurance schemes.

Risks

We do not anticipate any major risk in this study. However, you may feel free not to answer questions which you may feel uncomfortable to answer.

Right to withdraw and alternatives

To participate in this study is completely voluntary. You can freely choose not to participate in this study and even if you have already accepted to participate in this study you can quit at any time if it is necessary. No penalty or loss will be encountered upon refusal to participate or withdraw from the study.

Who to consult

If you ever have questions about this study, feel free to contact the student, Elisante Abraham (Principal Investigator) at the Nelson Mandela African Institution of Science and Technology (NM-AIST), Ifakara Health Institute Campus, P O Box 74, Bagamoyo, Mobile number: 0687 720 502 or Dr. Sally Mtenga (the study Supervisor), in her mobile number (0713 304 374) or in her email (smtenga@ihi.or.tz).

Do you have any question?

If you agree to participate in this study you are requested to indicate by signing below:

I have been informed about this study and my questions have been answered and I am satisfied. I agree to participate in this study and I have not violated my rights by signing [this consent form].

Name_____Signature/thumb print_____Date_____

Witness_____Signature_____Date_____

Researcher_____Signature_____Date_____

**TAASISI YA SAYANSI NA TEKNOLOJIA
YA NELSON MANDELA**

**VIWEZESHI NA VIZUIZI VYA KUJIUNGA NA BIMA YA AFYA KWA WATU
WANAOFANYA KAZI KWENYE SEKTA ISIYO RASMI MANISPAA YA
MOROGORO**

FOMU YA RIDHAA

Namba ya Utambulisho: _____

Salaam,

Ninaitwa Elisante Abraham. Ni mwanafunzi wa Shahada ya Uzamili ya Sayansi ya Utafiti katika Afya ya Jamii, Taasisi ya Sayansi na Teknolojia ya Nelson Mandela. Kwa sasa, ninafanya utafiti juu ya viwezeshi na vizuizi vya kujiunga na bima ya afya kwa watu wanaofanya kazi kwenye sekta isiyo rasmi katika Manispaa ya Morogoro. Utafiti huu utajikita hasa kwa Mama Lishe na Madereva bodaboda kwa kuchunguza vitu vinavyowawezesha na vinavyowakwamisha kujiunga na bima ya afya. Mahojiano na wewe yatachukua takribani dakika 30 hadi 35, na nitakuwa nikirekodi mazungumzo yetu ili niweze kupata taarifa zote lakini wakati huohuo niweze kuwa makini kufanya mazungumzo na wewe. Mwishoni mwa mahojiano nitaandaa ripoti itakayokuwa na maoni ya washiriki wote bila rejea ya mtu mmojammoja.

Madhumuni ya utafiti

Utafiti huu unalenga kuchunguza vitu vinavyowezesha na vinavyokwamisha kujiunga na bima ya afya kwa Mama lishe na Waendesha pikipiki katika manispaa ya Morogoro.

Ushiriki

Ukikubali kushiriki kwenye utafiti huu utajumuishwa kwenye mahojiano ya kina. Tungependa kusikia maoni yako kuhusu kujiunga na bima ya afya kwa mama lishe na Madereva bodaboda. Tutaauliza maswali machache na utakuwa huru kuyajibu kulingana na mtazamo wako.

Usiri

Taarifa zitakazokusanywa kupitia dodoso hili zitakua siri na hakuna mtu yeyote atakayeambiwa.

ulichosema. Taarifa zitaingizwa kwenye ngamizi kwa kutumia namba za utambulisho. Taarifa zako zitachukuliwa kwa usiri mkubwa na zitatumika kwa madhumuni ya utafiti tu. Utambulisho binafsi ikiwa ni pamoja na majina hayatajumuishwa katika ripoti yoyote.

Faida

Maoni yako na yale ya watu wengine yanayohusiana na kujiunga na bima ya afya kwa mama lishe na waendesha pikipiki yatasaidia kutaarifu programu na sera kwa ajili ya uboreshaji wa utekelezaji wa mifuko ya bima za afya, kujiunga, na upatikanaji wa huduma bora za afya hasa kwa makundi hatarishi. Ingawa hii siyo faida ya moja kwa moja kwa mtu binafsi lakini tunatumaini kuwa jamii yote na taifa vitanufaika kutokana na uboreshwaji wa utekelezaji wa mifuko ya bima za afya.

Hatari

Hatutegemei hatari yoyote kubwa kwenye utafiti huu. Aidha, unaweza kuwa huru kutokujibu maswali ambayo hutajisikia vizuri kuyajibu.

Haki ya kujitoa au vinginevyo

Ushiriki katika utafiti huu ni wa hiari. Kutokushiriki au kujitoa kutoka kwenye utafiti hakutakua na adhabu yeyote na hutapoteza stahili zako zozote endapo utaona ni vema kufanya hivyo.

Ushiriki katika utafiti huu ni wa hiari kabisa. Unaweza bila kushurutishwa kuchagua kutokushiriki katika utafiti huu hata kama umeshakubali kushiriki katika utafiti huu unaweza kujitoa wakati wowote kama ikilazimu. Hakuna adhabu au hasara itakayopatikana pindi utakapokataa kushiriki au kujitoa kwenye utafiti.

Nani wa kuwasiliana naye

Kama utakuwa na maswali kuhusu utafiti huu, jisikie huru kuwasiliana na mwanafunzi, Elisante Abraham (Mtafiti Mkuu) wa Taasisi ya Sayansi na Teknolojia ya Nelson Mandela, Kampasi ya Taasisi ya Afya Ifakara, S.L.P 74, Bagamoyo, Simu ya mkononi: 0687 720 502 au Dkt. Sally Mtenga (Msimamizi wa utafiti), kwenye simu yake ya mkononi (0713 304 374) au barua pepe yake (smtenga@ihi.or.tz).

Je, una swali lolote?

Kama unakubali kushiriki unaombwa kuthibitisha kwa kusaini hapa chini:

Nimeelezewa kuhusiana na utafiti huu na maswali yangu yamejibiwa na nimeridhika. Nakubali kushiriki katika utafiti huu na sijakiuka haki zangu kwa kusaini [fomu hii ya ridhaa].

Jina_____Sahihi/alama ya dole gumba_____Tarehe_____

Shahidi_____Sahihi_____Tarehe_____

Mtafiti_____Sahihi_____Tarehe_____

Appendix 11: Certificate of Approval

F120-IUH-v20.0

Plot 463, Kiko Avenue, Mikocheni | P.O. Box 78,373 Dar es Salaam, Tanzania | Phone: +255222774756
Email: irh@ihl.or.tz

INSTITUTIONAL REVIEW BOARD

ISO 9001:2015 certified



IFAKARA HEALTH INSTITUTE
research | training | services

June 10, 2020

National Institute for Medical Research
P O Box 9653
Dar Es Salaam
Email: headquarters@nimr.or.tz

Elisante Abraham
Ifakara Health Institute
P O Box 74
Bagamoyo

IHI/IRB/No: 30-2020

INSTITUTIONAL CLEARANCE CERTIFICATE FOR CONDUCTING HEALTH RESEARCH

On 5th June 2020, the Ifakara Health Institute Review Board (IHI-IRB) reviewed from study titled:

"Facilitators and Barriers Related to Enrollment to Health Insurance among People

Working in Informal Sector in Morogoro Tanzania" submitted by the Principal Investigator

Elisante Abraham.

The following documents were reviewed:

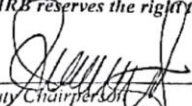
1. Protocol
2. Informed Consent Forms
3. Budget
4. Tools
5. CVs

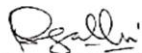
The study has been approved for implementation after IRB consensus. This certificate thus indicates that; the above-mentioned study has been granted an Institutional Ethics Clearance to conduct this study in Morogoro Municipality.

The Principal Investigator of the study must ensure that, the following conditions are fulfilled during or after the implementation of the study:

1. PI should submit a six-month progress report and the final report at the end of the project
2. Any amendment, which will be done after the approval of the protocol, must be communicated as soon as possible to the IRB for another approval
3. All research must stop after the project expiration date, unless there is prior information and justification to the IRB.
4. There should be plans to give feedback to the community on the findings
5. Any publication needs to pass through the IRB and NIMR
6. The approval is valid until 5th June 2021

The IRB reserves the right to undertake field inspections to check on the protocol compliance


Deputy Chairperson
Dr Ahmed Abdullah


IRB Secretary
Dr Mwifadhi Mrisho

Appendix 12: Data Collection Permit

JAMHURI YA MUUNGANO WA TANZANIA

OFISI YA RAIS
TAWALA ZA MIKOA NA SERIKALI ZA MITAA



HALMASHAURI YA MANISPAA MOROGORO



Unapojibu tafadhali taja:

Kumb. Na: R10/ MMC-24/VOLIII/222

Date: 22/06/2020

Elisante Abraham,
Taasisi ya Sayansi na Teknolojia ya Nelson Mandela,
Kampasi Ya Taasisi Ya Afya Ifakara,
S.L.P 47,
BAGAMOYO,



Unapojibu taja:

YAH: KIBALI CHA KUFANYA UTAFITI

Husika na mada tajwa hapo juu.

Ofisi ya Mkurugenzi wa Manispaa ya Morogoro inakiri kupokea barua ya tarehe 16/06/2020 yenye somo tajwa hapo juu.

Napenda kukujulisha kuwa kibali kimetolewa cha kufanya utafiti unaohusu **"Viwezeshaaji na Vizuizi vinavyohusiana na kujiunga na Bima ya Afya kwa watu waofanya kazi kwenye Sekta Isiyo rasmi"** katika Manispaa ya Morogoro katika Kata za hapa Manispaa.

Nakutakia mafanikio meme.

Ana P. Kobero
Kny: MKURUGENZI WA MANISPAA
MOROGORO

Ses barua ya tarehe

Napenda

Nakala: Watendaji Kata

S.L.P. 166

MANISPAA MOROGORO

unaochukua "Viwezeshaaji

na watu waofanya kazi

katika Sekta Isiyo rasmi Manispaa

(Tafadhali mpeni ushirikiano)

RESEARCH OUTPUTS

(i) Publications

Abraham, E., Gray, C., Fagbamigbe, A., Fabrizio, T., Brianna, O., Joke, H., Grace, M., Sally, M. (2021). Barriers and facilitators to health insurance enrolment among people working in the informal sector in Morogoro, Tanzania. *Open Reseach Africa*, 4(45), 1-13. <https://doi.org/10.12688/aasopenres.13289.1>

(ii) Poster Presentation