

**CONTRIBUTION OF MOBILE COMMUNICATION
TECHNOLOGIES ON MEMBERS ENROLLMENT TO HEALTH
INSURANCE IN TANZANIA'S INFORMAL SECTOR**

**CASE OF SMALL-SCALE ENTREPRENEURS ENROLLED IN THE
NATIONAL HEALTH INSURANCE FUND (NHIF)**

By

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REQUIREMENTS FOR THE AWARD OF MASTER'S DEGREE IN SOCIAL OF
THE INSTITUTE OF SOCIAL WORK**

DECEMBER, 2024

DECLARATION

I, Fridolin Edward, declare that this research report is my own work and that has not been submitted by any report for Masters of Social Work in any Higher Learning Institution or University

Signature.....

Candidate.

Date.....

CERTIFICATION

The undersigned certifies that, he has read and hereby recommends for acceptance by the institute of Social Work a research report entitled “***Contribution of Mobile Communication Technologies on Members Enrolment to Health Insurance in Tanzania’s Informal Sector***” in fulfilling of the awards of Master’s Degree in Social Work

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I would also like to thank the staff at the NHIF Kinondoni Regional Office, who cooperated with me in collecting data from the small-scale entrepreneur members of HIB, thereby giving this research report substance for evaluation.

However, I take full responsibility for any errors found in this research report.

DEDICATION

To my beloved family my wife and daughters, Anna Mosses, Apollonia Fridolin, and Aileen Fridolin who have been with me every step of the way in spirit throughout my studies. May Almighty God bless them abundantly.

ABBREVIATIONS

ANC	Antenatal Care
BP	Benefits Package
CAG	Controller Attorney General
CPR	Contraceptive Prevalence Rate
DFS	Digital Financial Services
DOI	Diffusion of Innovation
EPI	Expanded Program on Immunization
E-Wallet	Electronic Wallet
GOG	Government of Ghana
HIB	Health Insurance Bundle
ICHF	Improved Community Health Fund
ICLS	International Conference of Labour Statisticians
ICT	Information Communication Technology
ISW	Institute of Social Work
LMICs	Low- and Middle-Income Countries
LWV	Local Women Food Vendors
MOH	Ministry of Health
MCT	Mobile Communication Technology
MPCT	Mobile Phone Communication Technology
MSW	Masters of Social Work
NBS	National Bureau Statistics
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NMB	National Microfinance Bank Plc
PNC	Postnatal Care
PPR	Premium Price Rates

SMS	Short Messages
SPSS	Statistical Package for Social Science
SSE	Small Scale Entrepreneur
UHC	Universal Health Coverage
UNDP	United National Development Programme
WHO	World Health Organization
WTP	Willing to Pay

ABSTRACT

This study assesses the contribution of mobile communication technologies on members' enrolment in health insurance in Tanzania's informal sector. The target population consists of small-scale entrepreneurs at the NHIF Kinondoni Regional Office from five wards. A descriptive case study approach was employed. Both quantitative and qualitative research methods were utilised, with simple random sampling used to select the five wards in Kinondoni Municipality. Purposive sampling was applied to select a participant sample of 12 NHIF officers, who guided the researcher in identifying small-scale entrepreneur members of HIB for the study. Data collection tools included in-depth interviews, Focus Group Discussions, key informant interviews, documentary reviews, and questionnaires featuring both closed and open-ended questions. The data was reviewed, cleaned, and coded to minimise errors and facilitate easy entry and analysis. The Statistical Package for the Social Sciences (SPSS) version 23 was used to organise the data and conduct statistical analyses. The study findings revealed that member enrolment is significantly affected by the low skills of small-scale entrepreneurs in using mobile phone communication technology for HIB enrolment. Additionally, the premium price rates are not aligned with the economic status of small-scale entrepreneurs. The benefits package designed for health insurance bundles is also a factor contributing to low coverage, as it is not comprehensive enough to meet the needs of members. The study recommends that decision-makers modify NHIF policies by reviewing mobile communication technology (MCT) and marketing strategies to accommodate those with limited or no education regarding mobile app usage. Communication campaigns should be conducted to raise awareness and knowledge about health insurance bundles. Furthermore, it is essential to review premium pricing and enhance the benefits package tailored for HIB to attract more small-scale entrepreneurs in the informal sector to enrol in NHIF. In conclusion, the need for mobile phone communication technology in NHIF member enrollment in Tanzania's informal sector has been confirmed, although manual operations remain predominant. The Fund should make greater efforts to implement modern mobile phone communication technology strategies to improve the quality of service for its members.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE PROBLEM

1.1 Introduction

This study focuses on the contribution of mobile communication technologies on member's enrolment in health insurance in Tanzania's informal sector. The study primarily aimed to assess the contribution of mobile communication technologies on health insurance bundles enrolment to small scale entrepreneurs, to examine the impacts of premium price rates on health insurance bundles enrolment for small scale entrepreneur and investigate small scale entrepreneur perceptions on NHIF medical benefits package special for health insurance bundles. This chapter provides an introduction, background to the problem, statement of the problem, research objectives, research questions, and significance of the study.

1.2 Background to the Problem

The life of a human being passes through various stages. One of the most critical and challenging stages is dealing with health-related problems. For a long time, governments and private entities around the world have financed health services (Gilson, 1998). Recognising the challenges faced by communities and governments in financing these services, a new approach was introduced: the health insurance system. The World Health Organization (WHO) focuses on core functions of health financing, including revenue rising from various sources such as government budgets, compulsory or voluntary prepaid insurance schemes, direct out-of-pocket payments by users, and external aid (WHO, 2019).

Health insurance schemes are increasingly recognised as a tool for financing healthcare provision in many countries (WHO, 2000). Given the high latent demand for quality healthcare services and the extreme under-utilization of health services in several countries, it has been argued that social health insurance may improve access to acceptable-quality healthcare. In contrast, alternative forms of health financing, such as user fees, have faced criticism from many authors (Gilson, 1998). The option of insurance appears to be a promising alternative, allowing for the pooling of risks and transferring unforeseen healthcare costs to fixed premiums (Griffin, 1992; WHO, 2021). However, some evidence suggests that neither purely statutory social health insurance nor commercial insurance schemes alone can significantly increase coverage rates and improve access to healthcare (Jütting, 2001).

The introduction of health insurance globally began in Japan (WHO, 2021). Japan is unique among advanced countries in having a publicly managed universal health insurance system, which was established before the country entered a period of advanced economic growth. This serves as a useful example for developing countries. A notable feature of Japan's public medical insurance system is its universal coverage, which enables “anyone, anywhere, anytime” to receive the same quality of medical treatment for a small out-of-pocket contribution (Gilson, 1998). It is worth noting that the introduction of health insurance in Japan and elsewhere initially relied on manual systems for member enrollment and service provision.

Tanzania is also among the countries supporting the UN efforts to achieve Universal Health Coverage (UHC) by 2030, ensuring that all citizens can access health services and thereby reduce out-of-pocket expenditures (Gikanya *et al.*, 2024). As a strategy to achieve UHC, the National Health Insurance Fund (NHIF) introduced new premium packages in September 2019, named TIMIZA AFYA, NAJALI AFYA, and WEKEZA AFYA, to accommodate individuals in Tanzania’s informal sector as well as those in the formal sector without access to health insurance (NHIF, 2019).

The introduction of mobile telephone communication began in the United Kingdom with Sir Ernest Harrison. Technology has always played a significant role in modern society, but no other technology has had such an impact on health insurance service provision as the mobile phone (Rasel, 2022). The advent of telephone communication has transformed and improved service delivery systems, including health services.

Africa has made numerous efforts to tackle the challenges facing its health sector. The introduction of health insurance is one of the strategies adopted by various African countries (Musah *et al.*, 2023). Like other developing continents, Africa is experiencing rapid technological growth. For example, in Ghana, the mobile phone-based health insurance renewal system is improving coverage in the National Health Insurance Scheme (NHIS), particularly for members who previously were less likely to renew their membership (Musah *et al.*, 2023). Policymakers need to devise innovative ways for new members and all categories of members to enrol using this payment system to accelerate progress toward attaining universal health coverage (Boateng *et al.*, 2023).

Moreover, Ghana’s public sector is rapidly evolving in terms of ICT. Government agencies with a strong offline reputation are increasingly leveraging their brand value

to provide online services. The Ghanaian government is committed to modernising public service delivery through electronic government technologies. The Ministry of Health has developed a list of goals for the country's Universal Health Coverage (UHC) plan, and authorities have been tasked with using ICTs and other e-government solutions as part of the E-Ghana plan modules (Nketiah, 2022). In line with the Government of Ghana's digitisation plan, the National Health Insurance Scheme (NHIS) launched the Mobile Renewal Service on December 17, 2018, to facilitate easier renewal of coverage for members. This innovative method aims to increase NHIS enrollment and retention rates (Nketiah, 2022).

The National Health Insurance Fund (NHIF) in Tanzania emerged from a study conducted between 1990 and 1992 on long-term options for financing health services (MHCDGEC, 2018). Established by Act No. 8 of 1999, the scheme commenced operations on July 1, 2001, when members and their employers began contributing. Before the introduction of mobile technology in the health sector, operations were conducted through manual processes (Nketiah, 2022). Mobile phone technology at NHIF was first introduced in 2017 when the Fund announced to the public that members could use mobile phones for payments and registration applications (NHIF, 2017). Through mobile communication strategies, new members can be enrolled and generate a reference number for payments to the National Microfinance Bank Plc (NMB). Members can follow the instructions of this system by dialling *152*00# through mobile networks such as Airtel, Vodacom, and Zantel (NHIF, 2017). NHIF also introduced a free assistance hotline for clients, available at the telephone number 199.

Despite the introduction of mobile phone communication strategies in the provision of health insurance services in Tanzania's informal sector, enrolment of small-scale entrepreneurs through the health insurance bundle remains relatively low. For example, enrolment statistics for the financial year 2022-2023 show that there were 78,256 health insurance bundle members at NHIF in the informal sector compared to 487,228 members in the formal sector (NHIF, 2023).

In order to increase NHIF enrolment and improve the quality of health insurance services, the Fund should improve mobile communication technology strategies, review premium price rates and medical benefits package special for members of health insurance bundles. These areas seemed as the problem in Tanzania's informal sector coverage in NHIF.

1.3 Statement of the Problem

The enrollment coverage of Tanzania's informal sector in health insurance remains at an alarming low, with only 8% of the population covered by the National Health Insurance Fund (NHIF) as of 2021. Despite the NHIF's efforts to enhance its enrollment strategy through mobile communication technologies aimed at increasing membership, the contribution of these mobile platforms to actual enrollment remains limited. Numerous studies have explored the intersection of health insurance and mobile communication technology, highlighting both the challenges and potential benefits for communities. Nketiah, 2022; Musah *et al.*, 2023; Boateng *et al.*, 2023; Gilson L, 1998). For example, (Musah *et al.*, 2023, and Boateng *et al.* 2023) focused on the benefits of health insurance services and mobile phones. However, despite various initiatives, including diverse premium price rates and expanded insurance schemes designed to accommodate informal sector workers, coverage of Tanzania's informal sector remains disproportionately low compared with the formal sector, which continues to benefit more significantly. For example, statistics show that for the financial year 2022-2023, members from the informal sector, through the health insurance bundle, NHIF enrolled 78,256 compared to 487,228 members in the formal sector (NHIF, 2023). In the financial year 2023-2024, members from the informal sector through health insurance bundle, NHIF enrolled 81,372 compared to 492,477 in the formal sector (NHIF, 2024).

This disparity underscores the critical issue that health insurance systems often do not favour vulnerable populations, effectively excluding small-scale entrepreneurs from necessary coverage. Affordability emerges as a key barrier, as highlighted in multiple studies indicating that low enrollment is a common challenge in developing countries, including Tanzania informal sector workers, particularly small- small-scale entrepreneurs, face significant obstacles when attempting to enrol in health insurance. Their work environments expose them to various health risks, yet they remain largely uninsured.

Based on the mentioned challenges, this study is therefore examining the current mobile communication strategies aimed at enrolling small-scale entrepreneurs in health insurance, particularly regarding the impact of premium rates on enrolment and perceptions of the NHIF's medical benefits package. Addressing these gaps is crucial for improving health insurance access and equity in Tanzania's informal sector.

1.4 Research Objectives

1.4.1 General Objective

To assess the contribution of mobile communication technologies on health insurance bundle enrolment to small-scale entrepreneurs

1.4.2 Specific Objectives

- i. To assess the current state of mobile phone communication strategy on enrolment of small-scale entrepreneurs through health insurance bundles.
- ii. To examine the impacts of premium price rates on health insurance bundle enrolment for small-scale entrepreneurs.
- iii. To investigate small-scale entrepreneur perceptions on NHIF medical benefits package special for health insurance bundles.

1.4.3 Research Questions

- i. What are the current states of mobile phone communication strategy on enrolment of small-scale entrepreneurs through health insurance bundles?
- ii. What are the impacts of premium price rates on health insurance bundle enrolment for small-scale entrepreneurs?
- iii. What are the perceptions of small-scale entrepreneurs on the NHIF medical benefits package for health insurance bundles?

1.5 Significance of Study

This study is expected to assist policymakers in making informed choices and evidence-based decisions aimed at achieving equity in access to health insurance. It will represent the voices of individuals in the informal sector, particularly small-scale entrepreneurs, who face limitations in accessing NHIF services.

1.5.1 Significance to NHIF

This study highlights the challenges associated with mobile phone communication strategies in the NHIF enrolment process. Policymakers and the Management of NHIF can use these insights as a starting point for improving health insurance bundle coverage.

1.5.2 Significance to the Public

Additionally, the study contributes to the knowledge base for researchers and academics regarding mobile phone communication technology and NHIF enrolment. Its findings will serve as a valuable reference for future studies in this area.

1.5.3 Significance to the Researcher

Furthermore, this study has enabled the researcher to expand his knowledge and fulfil the requirements for obtaining a Master's degree in Social Work (MSW) from the Institute of Social Work (ISW).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature review relevant to this study. It begins with definitions of key concepts, followed by the theoretical framework, empirical literature reviews, and identification of research gaps. The chapter showcases various literatures written and researched by other scholars.

2.2 Definition of Concepts Related to the Study

This section defines the concepts related to the study. It is essential for enhancing the reader's understanding of the diverse terms used in this research. Below are some of the key concepts addressed in this study.

2.2.1 Mobile Phone Communication

Mobile phones enable instant communication with friends, family, coworkers, and a significant portion of the global population. Unlike previous communication devices, mobile phones are readily accessible and can be used anywhere a signal is available (Goodman, 2023).

2.2.2 The National Health Insurance Fund (NHIF)

The National Health Insurance Fund (NHIF) is a Social Health Insurance Institution established under the National Health Insurance Act, No 8 of 1999, Cap 395, with the primary objective of ensuring accessible healthcare services for the public. It operates as a government entity under the Ministry of Health (MOH) (NHIF, 2022).

2.2.3 Health Insurance Services

Health insurance services can have various interpretations. In this study, the operational definition of health insurance refers to the services provided by the National Health Insurance Fund. These services are governed by laws enacted by the National Assembly. According to the National Health Insurance Fund (2019), health insurance services are designed to mitigate risks associated with health-related issues faced by individuals.

2.2.4 Facilitators

Facilitators are individuals or factors that make an action or process easier (Collins English Dictionary). They influence or enable something to occur. In this study, facilitators refer to elements that can assist the NHIF and individuals in the informal sector in accessing health insurance services without difficulty.

2.2.5 Barriers

According to The Free Dictionary, barriers are obstacles or impediments that hinder progress. In this study, barriers are factors that negatively affect enrolment in the NHIF among people in the informal sector through health insurance bundles.

2.2.6 Enrolment

Enrolment is the act of registering or getting accepted into an institution, course, or program (Encyclopedia Britannica). In the context of health insurance, enrolment refers to the process of joining an insurance scheme.

2.2.7 Informal Sector

The definition of the informal sector is the one adopted by the 15th ICLS in 1993 with some modifications to suit the situation in Tanzania. Informal sector comprises all units/enterprises that are engaged in production of goods or services aiming at generation of employment and incomes for persons concerned. (NBS, 2019).

2.2.8 Health Insurance Bundles

The NHIF health insurance bundles categorised into three packages, namely Najali Afya, Wekeza Afya and Timiza Afya. These bundles packages allow individual or family to choose and contribute for medical services before sickness. (NHIF, 2021).

2.2.9 Small Scale Entrepreneur

Small-scale entrepreneurs are business owners present in all countries, whether developed, developing, or underdeveloped. They are characterised by their modest capital investment and small number of employees. Their prevalence is significant due to their role in reducing unemployment, inequality, and poverty (Kura *et al.*, 2023). In NHIF small scale entrepreneur is identified as Tanzania's who work at the informal sector and has special medical benefits package and annual premium.

2.3 Theoretical Framework

This study is guided by the Diffusion of Innovation (DOI) Theory. Developed by E.M. Rogers in 1962, this theory is one of the oldest in social science (LaMorte, 2022). It originated in communication to explain how, over time, an idea or product gains momentum and spreads through a specific population or social system. The

result of this diffusion is that individuals, as part of a social system, adopt new ideas, behaviours, or products.

According to Halton (2023), the Diffusion of Innovation Theory describes how new ideas, behaviours, technologies, or goods spread gradually through a population rather than all at once. Adoption begins with innovators, followed by the early majority, late majority, and finally, laggards, who are the last to adopt an innovation. Furthermore, the theory can be applied to marketing strategies, such as influence of NHIF member enrolment and simplify provision of services. While it has limitations, the theory focus on an innovation and it ignores other complex factors such as culture, and economic conditions.

In this study, the theory has been successfully applied across various fields, including communication, agriculture, public health, criminal justice, social work, and marketing (LaMorte, 2022). Its application in the enrollment of health insurance bundles and the provision of services to people in the informal sector is particularly important. This study aims to assess the contribution of mobile communication technologies on member's enrollment to health insurance in Tanzania's informal sector through health insurance bundles, thereby improving service provision and increasing coverage. In today's fast-paced world, people seek quicker access to services and prefer modern solutions. As technology advances rapidly, its applications in various fields, including health insurance, become increasingly relevant. Thus, the specific objectives of this study align with the principles of the theory, providing effective guidance for the research.

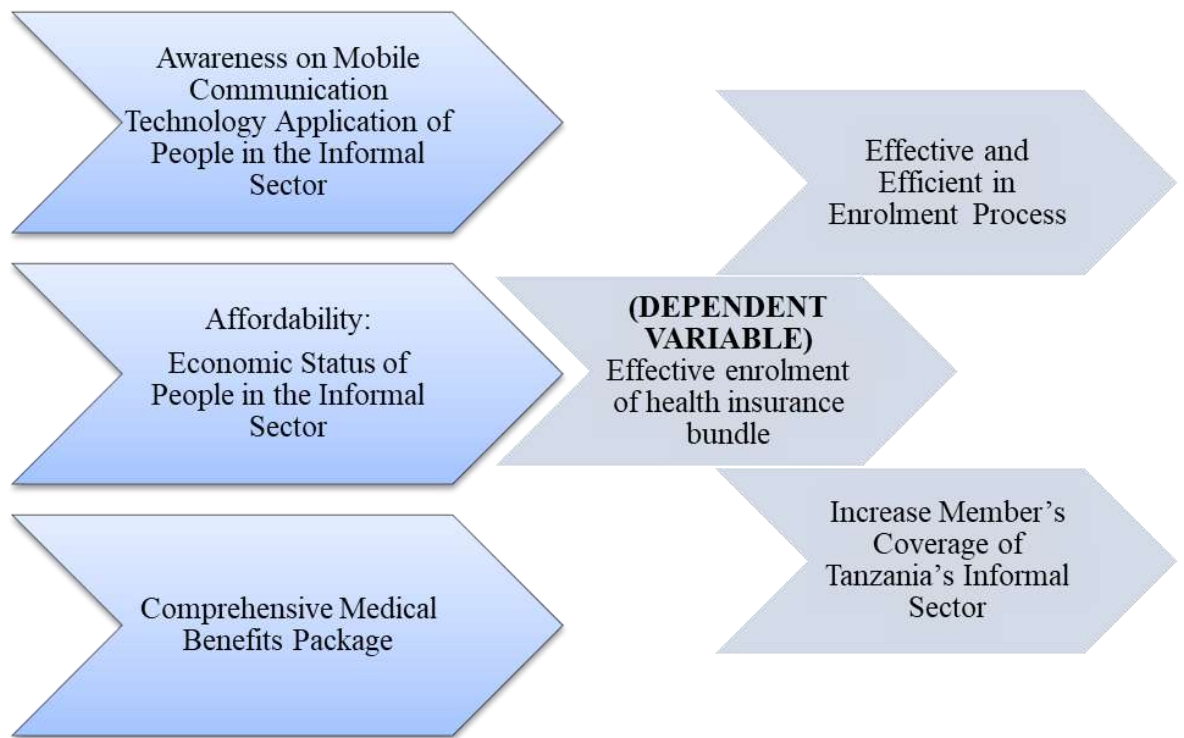
2.4 Conceptual Framework (Conceptual Model)

The conceptual framework for this study consists of variables related to mobile communication strategies and their connection to NHIF enrollment among small-scale entrepreneurs. This framework illustrates the different variables being assessed, their relationships, and how they relate to the research questions and problem statement. It demonstrates how the independent variables influence the dependent variable and illustrates their interconnections (see Figure 1).

Figure 2.1 Variables involved in mobile communication strategies in the enrolment process

INDEPENDENT VARIABLES

OUTCOME



Source: Researcher's construction, 2024

Therefore, the effective enrolment of small-scale entrepreneurs in health insurance bundles depends on several variables, including awareness of mobile communication technology among people in the informal sector, the economic status of these individuals, and the limitations of the medical benefits package. The expected outcomes of successful enrolment in health insurance bundles for people in the informal sector include a more efficient enrolment process and an increase in membership coverage within Tanzania's informal sector.

2.5 Measurement of Variables

Variables in this research were measured through a study on the enrolment of small-scale entrepreneurs in health insurance bundles at the NHIF Kinondoni Regional office. Information was collected from respondents who participated in the registration process. The data obtained was then compared with the theoretical framework and other relevant cases related to this study.

2.6 Empirical Literature Reviews

This part presents different empirical reviews that carried information related to the selected study. The reviews consist of national and international studies, journals and books. To cement the relevance of this study, different information from scientific studies was gathered and analysed. The following are the presentations and analyses concerning the information related to the current study.

2.6.1 An Overview of Mobile Phone Communication Strategies on Members Enrolment.

Wilson *et al.* (2023) conducted a study on digital financial services (DFS) for health in support of universal coverage in Kenya and Rwanda. Several implementation considerations emerged as facilitators or barriers to the successful implementation of DFS for health, including the importance of multi-sectorial investments in general ICT infrastructure, the value of leveraging existing community resources to boost enrolment and bridge the digital divide, and the significance of building trust among government and private sector organisations.

In Kenya, the NHIF has implemented additional flexible payment options, such as M-Pesa (mobile money) and electronic wallets (e-wallets), to increase enrolment and retain informal sector workers. With these payment platforms, informal sector workers and other contributing members now have greater flexibility in making contributions. Today, NHIF consumers in Kenya can easily make contributions via banks, M-Pesa, or e-wallets (Nyaronga, 2018).

Barasa *et al.* (2017) argue that inadequate and inconsistent communication by the NHIF presents a significant challenge. Participants noted that NHIF did not effectively communicate important information to its members and the general public, including current and prospective members. This included details on registration requirements, service entitlements, healthcare provider networks, premium payments, and penalties for default. Inconsistent information across different NHIF branches contributed to this problem, creating barriers for prospective members and frustration for existing ones.

Andrea (2019) conducted a study on the use of mobile technology in health sectors, employing a cross-sectional research design in the Dodoma region at Mirembe National Hospital. His study highlighted the inevitable need for mobile communication technology strategies in health sectors for client enrolment, financial

transactions, and other related uses. However, the study did not specifically address mobile communication strategies within National Health Insurance services.

Additionally, Raithatha *et al.* (2021) expanded on the necessity of mobile technology in health service provision in Tanzania through a qualitative research approach and case study design. The current study aims to assess the application of mobile phone technology in the enrolment of small-scale entrepreneurs through health insurance bundles in Tanzania.

Daniso *et al.* (2020) emphasised that mobile phones are crucial modern technologies for developing countries. They allow rural households to access various services, including marketing, agricultural extension, and health services, promptly. Furthermore, Mwambingu (2019) found that 71.8% of rural households used mobile phones for marketing services. The study suggested that the Ministry of ICT should develop mobile-based market price information dissemination systems to enhance marketing products and price information delivery to farmers. Notably, farmers with higher education levels perceived mobile phone use as effective for accessing rural innovation services.

Uddin (2017) studied the impact of mobile phone-based technology on improving health, population, and nutrition services in rural Bangladesh. This study aimed to develop and test a mobile phone-based system to enhance service delivery. It employed a quasi-experimental pre-post design with intervention and comparison areas, assessing indicators such as antenatal care, delivery care, postnatal care, neonatal care, immunisation coverage, and contraceptive prevalence. While mobile phone-based technology has been recognised for improving healthcare delivery globally, data on its effects in resource-poor settings remain limited.

Several studies, including those by Wilson (2018), Nielsen (2016), and Tomlinson *et al.* (2013), have shown promising findings regarding mobile phone technology in health services. This technology provides an accessible alternative to physical examinations for assessing various health indicators. Despite its potential benefits, widespread clinical adoption faces numerous challenges.

The current study focuses on the contribution of mobile communication technologies on members' enrollment in health insurance in Tanzania's informal sector, specifically targeting small-scale entrepreneurs.

2.6.2 The Impacts of Premium Price Rates on Enrolment of Health Insurance Bundles

The NHIF premium levels and contribution mechanisms present a financial barrier to current and prospective members in Kenya. Healthcare providers often discriminate against NHIF members compared to cash payers or private insurance holders (Rogo *et al.*, 2017).

Mwanga (2019) conducted a study estimating the willingness to pay (WTP) for NHIF coverage among Bodaboda operators. Using a descriptive study design, the research highlighted that the estimated cost of premiums, the benefits package, and the methods of premium payment significantly influence uptake. This study indicates that premiums are closely interrelated with WTP.

Abraham (2022) explored perceived facilitators and barriers to health insurance enrolment among individuals working in the informal sector in Morogoro, Tanzania, focusing on the Improved Community Health Fund (iCHF). His study suggested that a positive attitude toward CHF—stemming from the associated benefits of enrolment, perceived affordability of premiums, and improved healthcare—can influence enrolment among local women’s food vendors (LWFFV) and Bodaboda drivers. The findings revealed that there is limited knowledge about how the iCHF operates and a lack of time for individuals in the informal sector, especially LWFFV and Bodaboda drivers, to enrol. Therefore, increasing awareness of the iCHF is essential among individuals in these sectors.

2.6.3 Small Entrepreneur Perceptions of NHIF Medical Benefits Package.

According to UNDP (2021), case studies highlight that African governments are increasingly engaging with and experimenting with contributory social protection schemes for informal workers. Promising trends include the collection of national statistics on informal employment and efforts to understand the needs and constraints of informal workers to inform program design and implementation. Notable developments involve lowering and allowing more flexible contributions, improving benefits packages, and leveraging technological innovations to reduce transaction costs. However, it is essential to proceed carefully to ensure that those unable to access such technology are not excluded. Additionally, governments are ambitious about building trust and raising awareness regarding social insurance schemes. If these efforts succeed, the uptake among informal workers could expand significantly. Nevertheless, challenges remain, as many schemes are vulnerable due to their sole focus on informal workers, resulting in a risk pool that is too narrow.

Nassor (2021) conducted a study on access to healthcare services and associated factors among NHIF clients at Mwananyamala Regional Referral Hospital in Dar es Salaam. Using a descriptive cross-sectional design with a quantitative approach, the study found that access to healthcare services for NHIF users is affected by institutional factors, including inadequate drug supply, insufficient laboratory equipment, and a shortage of healthcare workers. Attitudes of healthcare workers towards NHIF clients also influenced access to services, alongside client factors such as age, sex, and occupation.

Huisman *et al.* (2022) explored a digital mobile health platform aimed at increasing efficiency and transparency toward achieving universal health coverage (UHC) in low- and middle-income countries. Achieving UHC remains challenging due to insufficient, temporary, and fragmented funding, as well as limited access to quality healthcare. Leveraging a mobile health platform could be a powerful tool to address these issues.

Globally, numerous efforts are being made to realise UHC. Despite an overarching commitment, low- and middle-income countries (LMICs) struggle to meet basic health goals. Limited access, poor quality, and the unaffordability of healthcare remain significant obstacles to providing a minimum basic health package for all. Sustained political commitment and innovation are crucial challenges in many LMIC settings, further complicating the situation. Key drivers limiting access include physical distance to health facilities, financial affordability, and social and cultural norms, which affect a large share of the population.

Nsiah-Boateng *et al.* (2023) conducted a study on the effect of a mobile phone-based health insurance contribution payment system on retention of coverage in Ghana's National Health Insurance Scheme (NHIS). Using descriptive statistics and propensity-score matching on a sample of 57,993 members, the study revealed that the NHIS offers comprehensive healthcare coverage for outpatient and inpatient services, including investigations and medications on the NHIS medicines list. The benefit package reportedly covers about 95% of disease conditions in Ghana, with over 4,000 public and private healthcare facilities credentialed to provide services to members of the Scheme.

2.7 Research Gap

Numerous studies have been reviewed, providing findings that influence the current research. Notable works, such as those by Nyaronga (2018), Huisman *et al.* (2022),

Raithatha *et al.* (2021), and Mtenzi (2020), focus on mobile technology in health services. These studies primarily address general health service information, revealing important insights.

For instance, Mtenzi (2020) examines the attributes and dynamics of mobile phone use from both operators' and regulators' perspectives. This discussion highlights the significance of mobile communication technology for both natural and social scientists. Many scholars, including those mentioned, have explored the role of mobile phones in health provision.

However, the current study identifies gaps in the existing literature, particularly regarding the contribution of mobile communication technologies on member's enrollment in health insurance in Tanzania's informal sector. Specifically, it aims to understand how this technology can enhance health insurance services and improve enrolment among small entrepreneurs through health insurance bundles. Previous studies have not sufficiently focused on the awareness and application of mobile communication technology strategies related to NHIF, making this research timely and relevant.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research methodologies, procedures, and techniques employed in this study. It details the study design and setting, research approaches, sampling procedures, sample size, and the methods and tools used for data collection. Additionally, the chapter covers data analysis procedures, the validity and reliability of data, and ethical considerations related to the study.

3.2 Research Design

This study utilised a descriptive case study design. According to Kothari (2004), a case study is a widely recognised method of qualitative analysis that involves thorough observation of a social unit, which may be a person, family, institution, cultural group, or even an entire community. This approach focuses on depth rather than breadth, allowing for a more nuanced understanding of the subject.

In this research, Health Insurance Bundle (HIB) members registered at the NHIF Kinondoni Regional office were the focus. Specifically, Magomeni, Kinondoni, Bunju, Makumbusho, and Mikocheni wards were randomly selected as case study locations. A case study enhances our understanding and provides clear insights into life (Kothari, 2004). Thus, this method not only examines the number of small-scale entrepreneurs enrolled in NHIF but also explores the factors that influenced their decision to join the Fund. The study aims to suggest potential reforms for the HIB enrolment process, utilising the descriptive case study design to understand how individual characteristics of HIB members respond to the design, implementation, uptake, and effects of HIB within the selected wards.

3.3 Research Approach

This study employed mixed methods approach. These approaches can play complementary roles, allowing for a richer analysis and deeper insights. Instead of being antagonistic, qualitative and quantitative methods enhance each other, providing a comprehensive understanding of the research question.

The research approach serves as a blueprint for how the researcher intends to conduct the study, encompassing data collection, measurement, and analysis strategies (Kothari, 2014).

The qualitative approach was employed to investigate the contribution of mobile communication technologies on member's enrolment to health insurance in Tanzania's informal sector. This method facilitated in-depth discussions with informants about mobile phone communication technology (MPCT). It enabled the researcher to gather insights into how HIB members perceive the product and the factors that attract them to enrol. By uncovering knowledge, opinions, and experiences related to enrolment and the application of MPCT, the qualitative approach provided a comprehensive understanding of the subject. Purposive sampling was used to select NHIF staff as respondents for the qualitative data collection.

Conversely, the quantitative approach was utilised to assess the affordability and accessibility of health insurance services for HIB members. Simple random sampling was employed to examine HIB member enrolment through MPCT at the household level within the selected wards served by the NHIF Kinondoni regional office.

3.4 Study Area

The study was conducted at the NHIF Kinondoni regional office in Dar es Salaam, where HIB members were enrolled based on their respective wards. The NHIF Kinondoni regional office has been noted for enrolling the highest number of health insurance bundle members compared to other offices in Tanzania.

The selection of this area is informed by the number of members served across the regional offices in Dar es Salaam. For example, data from 2022/2023 indicated that the Kinondoni regional office served 3,786 HIB members, while Temeke served 2,432 and Ilala served 3,091. This significant enrolment at Kinondoni motivated the researcher to choose it as the focus of the study.

Dar es Salaam, as a commercial city, exemplifies typical semi-urban and urban settings, further characterised by a large number of accredited health facilities. Within this study, Magomeni, Kinondoni, Bunju, Makumbusho, and Mikocheni wards in the Kinondoni district were randomly selected for analysis.

To ensure randomness, the names of the wards were written on separate pieces of paper, folded, and drawn at random. This method ensured an unbiased selection of the wards for this study, aligning to assess the contribution of mobile communication technologies on members' enrolment to health insurance in Tanzania's informal sector

3.5 Population of the Study

The population for this study comprised 3,786 active members of the Health Insurance Bundle (HIB) registered at the NHIF Kinondoni regional office for the 2022-2023 financial year. During the data collection period, there were 764 active members across the selected wards. The distribution of these members was as follows: Mikocheni ward had 233 members, Kinondoni ward had 348 members, Bunju ward had 145 members, Magomeni ward had 204 members, and Makumbusho ward had 182 members (NHIF Annual Reports, 2023). From this population, a quantitative formula was applied to obtain a representative sample of 111 members for the survey see paragraph 3.6.2 shows the determination of sample size and along with 12 respondents selected for in-depth interviews from 52 staff of NHIF Kinondoni regional Office and five Focus Group Discussions each has 8 members to respond qualitative findings

3.6 Sampling Procedure and Sample Size

3.6.1 Sampling Procedure

The sampling procedure involved identifying the study wards served by the NHIF regional office and selecting the respondents for the study. A mixed sampling design was employed, utilising both probability and non-probability sampling techniques. Specifically, purposive sampling was used to select key informants, Focus Group Discussion (FGD) members, and individuals for in-depth interviews. Simple random sampling was employed for the membership survey to ensure a representative sample.

3.6.1.1 Purposive Sampling

The purposive sampling technique is instrumental in ensuring that a quality sample is selected without bias, thereby enhancing the reliability and trustworthiness of the findings (Nyambili & Nyambili, 2024). This technique facilitated the collection of in-depth information from the targeted population. In this study, purposive sampling was utilised to select participants from the NHIF office, including key informants and NHIF enrolment officers. The NHIF Kinondoni regional office was specifically chosen based on the high number of enrolled HIB members.

In addition, purposive sampling was employed to select key informants, including the NHIF Kinondoni regional supervisor, information technology officers, marketing officers, and membership enrolment officers. These participants were chosen for their knowledge and experience related to HIB member enrolment through mobile

phone communication technology (MPCT). The selection aimed to gather diverse experiences and perspectives regarding the application of MPCT in the study area.

The NHIF Kinondoni regional office was purposively selected, from which five wards—Magomeni, Kinondoni, Mikocheni, Makumbusho, and Bunju—were randomly selected from a total of twenty wards. The purpose of selecting these wards was to obtain varied experiences concerning the impacts of MPCT on HIB member enrolment. The procedure was to ensure randomness, the names of the wards were written on separate pieces of paper, folded, and drawn at random. This method ensured an unbiased selection of the wards for this study, aligning with the objective of assessing the contribution of mobile communication technologies on member's enrolment to health insurance in Tanzania's informal sector

Furthermore, purposive sampling was utilised to select members for focus group discussions (FGDs) from each ward. HIB members were selected for FGDs to gather different experiences and insights about the impacts of MPCT on their enrolment.

3.6.1.2 Simple Random Sampling Technique

The study employed simple random sampling to select respondents for the membership survey. This technique ensures that every member of the population has an equal chance of being selected (Thomas, 2020). The population for this study consisted of HIB members based on their respective wards. During the field survey, membership enrolment officers provided information on the number of HIB members in their wards. The researcher obtained official records of HIB members with their assistance.

The criteria for selecting households were HIB membership. Wards meeting this criterion were randomly selected for the survey. The names of the wards were recorded on separate pieces of paper, which were then folded. A proportional sample from each ward was randomly selected for the survey. The selected members, all of whom were HIB members from the wards, were subsequently contacted to complete the questionnaire.

3.6.2 Sample Size for Membership Survey

The sample size for this study consisted of 111 members out of a total of 3,786 HIB members in the Kinondoni municipality wards. This sample size was determined with the assistance of HIB membership enrolment officers. According to Kothari (2004), the sample size refers to the number of items selected from the population to

constitute a sample. A good representative sample typically ranges between 5% and 10% (Kothari, 2014).

The total number of enrolled HIB members in each ward is as follows: Bunju (145 members), Mikocheni (233 members), Makumbusho (182 members), Kinondoni (348 members), and Magomeni (204 members) (NHIF Annual Report, 2023). This totals 1,112 HIB members. To obtain a representative sample, 10% of this total was calculated:

$$1,112 \times \frac{10}{100} = 111.2, \text{ which were approximately to } 111$$

The sample size calculated for each member in the study area was used to determine the proportional number of HIB members in each studied ward, as indicated in Table 3.1. The following formula (Kothari, 2002) was used to calculate the proportional number of members for each ward;

$$n_h = n \times \frac{N_h}{N}$$

Where;

“ N_h ”= the proportional sample of each ward

“ n ”= the total sample size of the study area.

“ N_h ”= the total number of members in each selected ward and

“ N ”= the total number of members in the study area.

Table 3.1 Sample Size Computation

S/N	Ward	No. of Members	Actual Surveyed Sample
1	Mgomoni	204	20
2	Bunju	145	15
3	Mikocheni	233	23
4	Makumbusho	182	18
5	Kinondoni	348	35
TOTAL		1112	111

Source: Field Data, 2024

3.6.3 Sample Size for Key Informants and FGDs

The sample size for key informants and focus group members is not predetermined due to the qualitative nature of this part of the study. Key informants included NHIF staff involved in supporting HIB member enrolment, specifically the Regional

Supervisor, Information Technology Officers, Marketing Officers, and Membership Enrolment Officers. In total, there were 12 key informants and 8 Focus Group Discussions (FGDs) conducted, with each FGD comprising participants from the five selected wards.

3.7 Data Collection Methods

This study utilised a combination of qualitative and quantitative methods for data collection. The qualitative instruments included in-depth interviews, Focus Group Discussions, key informant interviews, and documentary reviews, while the quantitative method primarily involved questionnaires.

3.7.1 In-depth Interviews

In-depth interviews (IDIs) are employed to collect rich qualitative data. Open-ended questions were administered across the five wards, targeting respondents based on their experiences with the application of mobile phone communication technology (MPCT) in HIB member enrolment. A total of 12 IDIs were conducted, including two Regional Supervisors, two Information Technology Officers, two Marketing Officers, and six Membership Enrolment Officers from the NHIF Kinondoni regional office.

Interviews were scheduled at the convenience of the respondents and confirmed via mobile communication. Note-taking was conducted during the interviews, which took place in the respondents' offices. An interview checklist was prepared in Swahili to ensure relevance to each group. Each interview lasted approximately 30 minutes to one hour.

3.7.2 Focus Group Discussions (FGDs)

Fewer GDs were conducted with HIB members from five wards: Magomeni, Mikocheni, Makumbusho, Bunju, and Kinondoni. These wards were selected randomly from a total of twenty in the Kinondoni district. The FGDs aimed to capture respondents' perceptions of MPCT strategies related to HIB member enrolment and accessibility of health insurance services, including benefits packages and premium rates.

Five FGDs were carried out, each consisting of 6-12 participants, allowing for in-depth discussions based on a set of guiding questions (Intract, 2017). The sessions were organised according to the availability of participants, who were small-scale entrepreneurs and members of HIB. Before the discussions, Membership Enrolment Officers assisted in gathering and informing HIB members about the FGDs.

During the discussions, the researcher introduced himself and thanked the participants for their involvement. The conversations were guided by the study's objectives, with the researcher facilitating dialogue and ensuring active participation.

3.7.3 Documentary Review

Documentary review was employed to gather relevant information about the research area. This method helped to refine the conceptualisation of the research problem, deepen the understanding of the study context, and identify research gaps. The review included textbooks, journals, legislative documents, policies, reports, and both published and unpublished research papers related to the impacts of MPCT, benefits packages, and premium rates specific to HIB members.

Table 3.2 Categories of Interviewed Informants

S/N	Category of Respondents	Number of Interviews in each Department			
		ICT	Membership	Marketing	Administration
1	IT Officers	2			
2	Marketing Officers			2	
3	Membership Officers		6		
4	Regional Supervisor				2
Total		2	6	2	2
Grand Total		12			

Source: Field Data, 2024

Table 3.3 Category of Focus Group Discussion

Category of FGDs at each level			
S/N	Ward	Number of FGD	Participants
1	Bunju	1	8
2	Mikocheni	1	8
3	Makumbusho	1	8
4	Kinondoni	1	8
5	Magomeni	1	8
Total		5	40

Source: Field Data, 2024

3.7.4 Membership Survey

The study employed a membership survey to collect quantitative data using a probability sampling method. This approach ensured that each ward within the Kinondoni municipality had an equal chance of being selected as a sample. A questionnaire guide was developed to align with the research objectives. Initially written in English, the questionnaire was translated into Swahili, the national

language spoken by the majority of respondents, to facilitate effective communication during interviews.

The membership survey aimed to complement the qualitative data gathered from interviews, enhancing the overall understanding of the research questions. Before the actual data collection, a pilot test of the questionnaire was conducted with a few small-scale entrepreneur members of HIB from the Kinondoni ward. This pilot helped ensure the validity and reliability of the instrument.

In total, 111 entrepreneurs and small-scale members of HIB were physically contacted across the selected wards. The survey captured relevant information regarding the impacts of mobile phone communication technology (MPCT) on HIB member enrollment, as well as insights into the benefits package and premium rates specific to health insurance bundles in the study area.

Table 3.4 Summary of the Population of the Study and Tools

Methods of data collection	Tools	Types of respondents	Information Collected
Key Informant Interview	Interview guide	Regional NHIF supervisors, NHIF ICT officers, NHIF membership enrolment officers and NHIF marketing officers	Information about supervising, implementation, supporting and impacts of mobile phone communication technology on NHIF member enrolment. Also information about member's acceptance of premium price rates and benefits package special for HIB
Focus Group Discussion	FGD check list	Small scale entrepreneurs members of health insurance bundles	Information about the perception of the application of Mobile phone communication technology on accessibility of health insurance services such as online member enrolment, identification of premium price rates and how is it, also to identify the benefits package and health care providers through mobile phone.
Membership Survey	Questionnaire	Small scale entrepreneurs members of health insurance bundles (HIB)	Information about accessibility, affordability and use mobile phone communication technology in health insurance bundles services
Documentary review	Document review guide	NHIF annual reports, CAG reports, NHIF journals books and implementation guidelines	Information on how implementation of HIB members enrolment through MPCT

Source: Field Data, 2024

3.8 Data Analysis

3.8.1 Qualitative Data

For qualitative data, the study employed thematic analysis, which involves reading through datasets (such as transcripts from in-depth interviews or focus groups) to identify patterns and derive themes (Delve *et al.*, 2020). The researcher followed a six-step process: familiarisation, coding, generating themes, reviewing themes, defining and naming themes, and writing up (Caulfield, 2023). The qualitative data analysed through a thematic analysis whereby data identified, analysed, and reported in patterns (themes). Data were transcribed and written as a narrative using Microsoft Excel Software. In addition, the analysis followed all the steps or process of qualitative data analysis. Data organized into main categories and sub categories according to the objectives of the study. Interview guides were formulated in Kiswahili and then translated into English to facilitate data collection.

3.8.2 Quantitative Data

Quantitative data was coded by assigning numerical values using SPSS version 23. The data was processed and edited in Microsoft Excel 2010 for summarisation and analysis through descriptive statistics, including percentages and frequencies presented in tables, graphs, and pie charts. Descriptive statistics illustrated the impacts of mobile phone communication technology (MPCT) strategies, the affordability of premium rates, and the acceptability of HIB benefits packages regarding member enrolment. The results are displayed using figures, tables, and bar charts to convey various aspects of the impacts of MPCT.

3.9 Data Reliability and Validity

To ensure the reliability and validity of the study, careful measures were taken, including formulating questions using appropriate language and rephrasing questions in different formats. This approach ensured the quality of the measured data, analysis, and findings. The researcher ensured that each respondent understood the questions asked and that responses were coded accurately to minimise uncertainty.

3.10 Ethical Considerations

As described by De Vos *et al.* (2002), ethical aspects comprise a set of moral values and principles that guide the conduct of researchers and participants. An official introduction letter from the Institute of Social Work was submitted to NHIF to obtain permission to conduct the study. The involvement of HIB members and NHIF staff based on self-determination, informed consent regarding the study's purpose, and assurance of confidentiality.

3.11 Chapter Summary

This chapter provided a comprehensive overview of the methodologies employed in this study, detailing the study area, research design, sampling procedures, sample size, data collection methods, ethical considerations, and the validity and reliability of data. By utilising both qualitative and quantitative data collection and analysis techniques, the study aimed to effectively interpret numerical data and respondents' perceptions.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter presents analyses and discusses the findings obtained in the study. The presentation, analysis and discussion of the findings and facts are done based on the research objectives. However, before the presentation, analysis and findings, the summary of questionnaire distribution and their responses were provided.

4.2 Summary of Planned Participants and Effective Questionnaire Responses.

In this study, findings are divided according to research methods. There are qualitative and quantitative findings. In qualitative findings included twelve (12%) participants from NHIF staff whereby 2(3.3%) regional supervisors, 2(3.3%) marketing Officers, 2(3.3%) were Information technology Officers, and 6(10%) membership enrolment Officers, while in Quantitative findings included 111 (100%) respondents who were small scale entrepreneurs members of NHIF through the category of health insurance bundles. Therefore, each group of respondents and participants has been summarised in chapter three in table 3.1 based on their wards and 3.2 based on their departments.

Also, the researcher imported manually transcribed data into SPSS version 23 and Microsoft Excel 2010 Software for coding and analysis. Qualitative data were analysed using a grounded approach. First, the researcher read through the transcripts to familiarise with the data. Second, the researcher conducted open coding, where key ideas were identified and labelled as the key thematic categories. Third, the researcher conducted axial coding where associated open codes and created sub categories of emerging themes and concepts. Fourth, the researcher charted the coded data and the emergent thematic categories. Interpretation of the data entailed identifying key concepts and explaining relationships between key concepts.

4.2.1 Respondents Demographic Characteristics

The demographic summary provided an understanding of the general profile of the study respondents. The study sample involved 111 respondents. 111(100%) of respondents who participated in the research as Small Scale Entrepreneurs from five wards at Kinondoni municipality. Therefore the age group outline for small entrepreneurs: 34(30.63%) of the respondents were aged between 18-35 years old, 63(56.76%) of the respondents were aged between 36-59 years old and 14(12.61%) of the respondents were age between 60 and above years old. This

indicates that those between 36-59 years old have been attracted to health insurance services. In part of marital status, 20(18.02%) of the respondents were single, 82(73.87) of the respondents were married, and 9(8.11%) of the respondents were widows.

Again, married people are more interested in health insurance services. Also, 42.34% of the respondents were male, and 57.66% of the respondents were female. These disproportionate gender statistics indicated that females are more need health insurance.

In part of education level, 43.24% of the respondents were small entrepreneurs with a university education level, 26.13% of the respondents were a small entrepreneur with a secondary education level, 18.02% of the respondents were small entrepreneurs with a vocational education Training level, and 12.61% of the respondents were a small entrepreneur with primary education level and no formal education. This implies that a person with a high education understands the importance of health insurance.

Also, the findings showed that 6.31% of the respondents worked as small-scale entrepreneurs between (1-3) years, whereas 10.81% of the respondents worked as small-scale entrepreneurs between (4-7) years, while 9.91% of the respondents working as small-scale entrepreneurs between (8-11) years. Also, 27.03% of the respondents worked as small-scale entrepreneurs between (12-15) years, and 45.95% of the respondents worked as a small entrepreneur for more than 16 years. This shows that health insurance is very important to small-scale entrepreneurs for the security of their health and their capital. In the field survey, it was found that 6(5.41%) of the respondents associated with agricultural activity. Also, 33(29.73%) of the respondents associated with technician activity. At the same time, 26(23.42%) of the respondents were associated with transportation activity. At the same time, 15(13.51%) of the respondents were associated with closing, shoes and decoration activities. Also, 11(9.91%) of the respondents were associated with local food vendor and refreshment activity, 2(1.80%) of the respondents were associated with retail shop activity, and 18(16.22%) of the respondents were agents of mobile money.

The findings underscore the importance of health insurance for all groups of small-scale entrepreneurs. To enhance enrolment in the Fund, strategies such as promoting mobile phone communication technology, offering attractive premium rates, and

providing comprehensive benefits packages are essential. Results on respondents' demographic characteristics are summarised in Table 4.2.

Table 4.1: Respondent Demographic Characteristics

Characteristic	Frequencies (n=111)	Percentage of Frequencies (%)
Age group		
18-35 years old	34	30.63
36-59 years old	63	56.76
60 and above years old	16	12.61
Total	111	100.00
Marital Status	Frequencies	Percentage of Frequencies
Single	20	18.02
Married	82	73.87
Widow	9	8.11
Divorced	0	0.00
Total	111	100.00
Gender	Frequencies	Percentage of Frequencies
Male	47	42.34
Female	64	57.66
Total	111	100.00
Education level	Frequencies	Percentage of Frequencies
University level	48	43.24
Secondary level	29	26.13
Vocation Education and Training	20	18.02
Primary level/no formal education	14	12.61
Total	111	100.00
Worked as Small Scale Entrepreneur	Frequencies	Percentage of Frequencies
Between 1-3 years	7	6.31
Between 4-7 years	12	10.81
Between 8-11 years	11	9.91
Between 12-15 years	30	27.03
Above 16 years	51	45.95
Total	111	100.00
Types of business	Frequencies	Percentage of Frequencies
Agriculture	6	5.41
Technician	33	29.73
Transportation	26	23.42
Closing, Shoes and decoration	15	13.51
Local Food vendor and refreshment	11	9.91
Retail shop	2	1.80
Mobile money agent	18	16.22
Total	111	100.00

Source: Field Data, 2024

4.3 Data analysis

4.3.1 The State of Mobile Phone Communication Strategies on Enrolment of Small-Scale Entrepreneurs through Health Insurance Bundles

The study assessed the current state of mobile phone communication strategies in enrolling small entrepreneurs in health insurance bundles at the NHIF Kinondoni regional office. To gather insights, NHIF staffs from various departments, including the regional supervisor, marketing, membership, and ICT, were interviewed. Participants emphasised that mobile communication significantly improved awareness among small scale entrepreneurs regarding health insurance options, with text messages and calls frequently used to disseminate information about available packages. The ability for two-way communication fostered engagement and trust, allowing entrepreneurs to ask questions and receive instant feedback. Many respondents noted the convenience of mobile enrollment, which reduced the need for in-person visits, alleviating barriers related to time and financial constraints. However, challenges such as network issues and varying levels of digital literacy among entrepreneurs were also highlighted, limiting some individuals' access to services.

Participants suggested enhancements, including improving the user interface of mobile applications and offering training sessions to boost digital literacy. Overall, while mobile phone communication strategies have positively impacted enrolment, addressing these challenges could further enhance their effectiveness.

“.....Currently, MPCT has not adequately met the demand for HIB member enrolment due to insufficient emphasis on its use. Many members still apply for membership by filling out physical application forms and submitting them at the NHIF office. Additionally, members often visit the NHIF office to obtain their control numbers for annual payments instead of utilising their mobile phones to request and generate these numbers.....”(NHIF Official Staff said)

Commenting on the question, another interviewee stated that;

“.....New members of the health insurance bundle can apply for membership either online or by filling out a physical application form and submitting it to the NHIF office for further processing. The responsibility of membership enrollment officers includes processing online applications and registering physical application forms for HIB members in the system. However, if there are no online application

requests in the system, enrollment officers continue to manually process the received application forms for health insurance bundles.....”(Regional Supervisor said)

Moreover, the researcher aimed to understand the impacts on member's enrolment process through mobile phone communication. The qualitative data revealed that, in assessing the current state of mobile phone communication strategies on enrolment of small-scale entrepreneurs through health insurance bundles, regional supervisors, marketing offices, ICT officers, and membership enrolment officers during the interview with open-ended questions. They responded that,

“.....Mobile phone communication can significantly increase HIB membership enrolment by providing easy access to the system, reducing paperwork, and allowing self-enrolment through smartphones. In contrast, using physical application forms for registration involves multiple steps, making the process cumbersome. This reliance on manual applications contributes to low membership coverage for the Fund....”(Enrolment Officer said).

Another interviewee commented;

”..... Through MPCT on the NHIF website, communities can gain a general understanding of NHIF's benefits package. However, not all items are fully captured in the system, which limits users' ability to see benefits specific to their chosen premium. Therefore, if a member wants detailed information about the benefits associated with their selected health insurance bundle, they should visit a nearby NHIF office for more information on the special benefits package for HIB.,,,,”(interviewees said).

Other interviewees said;

“.....The impacts of MPCT lead to the quality of insurance services, such as reducing curing at NHIF's offices .MPCT can reduce manual work to NHIF membership enrolment officers. Therefore, the MEO can concentrate on processing online member's applications rather than manual application forms, which consume more time to process the member's request. Also, the respondents reported that the results of using MPCT can reduce membership movement to NHIF offices. MPCT

can also allow people from any place to be linked with their mobile phone and be enrolled through the NHIF system....” (NHIF Information Technology officers said).

Findings from the survey revealed that while mobile phone communication technology (MPCT) was readily available to the majority of small-scale entrepreneurs in Tanzania, member enrolment could be significantly higher if these entrepreneurs were able to utilise the application effectively. Respondents indicated a lack of awareness regarding how to use or access NHIF services via their mobile phones, which contributed to the low application rates of MPCT. This aligns with Kuter (2018), who noted that acceptance of digital solutions and innovative medical technologies hinges on understanding users' anxieties and feelings of insecurity. The process of adopting these technologies takes time, as individuals accept change at different rates. Halton (2023) further explains that the diffusion of innovation theory illustrates how new ideas and technologies spread gradually through a population, beginning with innovators and early adopters before reaching the broader majority.

In the quantitative study, the researcher aimed to assess the challenges faced by small-scale entrepreneurs in using MPCT for NHIF enrolment, focusing on aspects such as premium price rates, membership renewal, and premium payment. Additionally, the study investigated the perceptions of small-scale entrepreneurs regarding the NHIF medical benefits package specifically designed for health insurance bundles.

4.3.1.1 The Challenges with the Application of Mobile Phone Communication Technology on Member Enrolment.

Table 4.2 Weak Technical Support from NHIF

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	91	82.0	82.0	82.0
Agree	12	10.8	10.8	92.8
Neutral	4	3.6	3.6	96.4
Disagree	4	3.6	3.6	100.0
Total	111	100.0	100.0	

Source: Field Data, 2024

In assessing the challenges of applying mobile phone communication technology (MPCT) that members experienced, the results indicated significant concerns regarding technical support. A substantial majority, 91 respondents (82%), strongly agreed that weak technical support is a challenge for member registration through MPCT. Additionally, 12 respondents (10.8%) agreed with this sentiment, while four respondents (3.6%) were neutral, and another four respondents (3.6%) disagreed. These findings highlight a critical gap in technical assistance for Tanzania's informal sector, suggesting that members often struggle to receive the necessary support from NHIF during the online enrolment process.

The summary findings are provided in Table 4.2

Table 4.3 Lack of Knowledge as Challenge on Using MPCT for Member Registration

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	91	82.0	82.0	82.0
Agree	10	9.0	9.0	91.0
Neutral	4	3.6	3.6	94.6
Disagree	6	5.4	5.4	100.0
Total	111	100.0	100.0	

Source: Field Data, 2024

In assessing the challenges associated with using mobile phone communication technology (MPCT) for member enrolment, the results revealed significant gaps in knowledge among respondents. A majority of respondents (82%) strongly agreed that a lack of knowledge is a barrier to member registration through MPCT. Additionally, ten respondents (9%) agreed, while 4 respondents (3.6%) remained neutral, and six respondents (5.4%) disagreed with the notion that lack of knowledge poses a challenge. These findings indicate that many small-scale entrepreneurs are unfamiliar with how to utilise MPCT for NHIF member registration. To address this challenge, NHIF should focus on providing educational resources and training to communities on effectively using MPCT. The summary findings are provided in Table 4.3

Table 4.4 Requirement of NIDA as Challenge on Using MPCT for Member Registration

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	67	60.4	60.4	60.4
Agree	44	39.6	39.6	100.0
Total	111	100.0	100.0	

Source: Field Data, 2024

A significant portion of respondents, 67 (60.4%), strongly agreed that the requirement of NIDA (National Identification Authority) during member registration through mobile phone communication technology poses a challenge. Additionally, 44 respondents (39.6%) agreed with this statement, indicating that this requirement is a major barrier preventing many small-scale entrepreneurs in the informal sector from joining the Fund. To enhance enrollment, NHIF should consider allowing alternative forms of identification for member registration. A summary of these findings can be found in Table 4.4 above.

Table 4.5 Malfunctions of Systems Challenge on using MPCT for Member Registration

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	87	78.4	78.4	78.4
Agree	18	16.2	16.2	94.6
Neutral	6	5.4	5.4	100.0
Total	111	100.0	100.0	

Source: Field Data, 2024

A majority of respondents, 87 (78.4%), strongly agreed that malfunctions of the NHIF system during member registration through mobile phone communication technology present a significant challenge. Additionally, 18 respondents (16.2%) also noted these malfunctions as an issue, while six respondents (5.4%) remained neutral. This indicates that system malfunctions are a major barrier preventing many small-scale entrepreneurs in the informal sector from enrolling in the Fund using their mobile phones. To address this issue, NHIF should ensure the system is accessible at all times. A summary of these findings can be found in Table 4.5 above.

Table 4.6 Challenge of Long Registration Procedures on using MPCT for Member Registration

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	73	65.8	65.8	65.8
Agree	26	23.4	23.4	89.2
Neutral	12	10.8	10.8	100.0
Total	111	100.0	100.0	

Source: Field Data, 2024

A significant majority of respondents, 73 (65.8%), strongly agreed that long registration procedures during member registration through mobile phone communication technology are a challenge. Additionally, 26 respondents (23.4%) agreed with this statement, while 12 respondents (10.8%) were neutral. These findings suggest that lengthy registration processes hinder many small-scale entrepreneurs in the informal sector from joining the Fund. To improve enrollment, NHIF should consider minimising the procedures involved in member registration through MPCT. A summary of these findings can be found in Table 4.6 above.

Table 4.7. Must have Smart Phone as a Challenge on using MPCT for Member Registration

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	97	87.4	87.4	87.4
Agree	5	4.5	4.5	91.9
Neutral	9	8.1	8.1	100.0
Total	111	100.0	100.0	

Source: Field Data, 2024

97(87.4%) majority of the respondents strongly agree that a smartphone during member registration through mobile phone communication technology is a challenge, 5(4.5%) of the respondents agree that must have a smartphone during member registration through mobile phone communication technology is a challenge, and 9(8.1%) of the respondents were neutral that, must have a smartphone during member registration through mobile phone communication technology is a challenge. Also, this indicated that must-have smart is a factor that hinders many

small-scale entrepreneurs in the informal sector from joining the Fund. Therefore, NHIF should make efforts to use mobile phones to allow easy member enrolment. The summary findings are provided in Table 4.7

Table 4.8 Requirement of Supportive Documents as a Challenge on using MPCT for Member Registration

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	75	67.6	67.6	67.6
Agree	27	24.3	24.3	91.9
Neutral	9	8.1	8.1	100.0
Total	111	100.0	100.0	

Source: Field Data, 2024

A majority of respondents, 75 (67.6%), strongly agreed that the requirement for supportive documents during member registration through mobile phone communication technology is a challenge. Additionally, 27 respondents (24.3%) agreed, while 9 (8.1%) were neutral on this issue. This indicates that the necessity for supportive documents significantly hinders many small-scale entrepreneurs in the informal sector from joining the Fund. To address this, NHIF should explore alternative methods for identifying principal members and their beneficiaries. A summary of these findings is provided in Table 4.8.

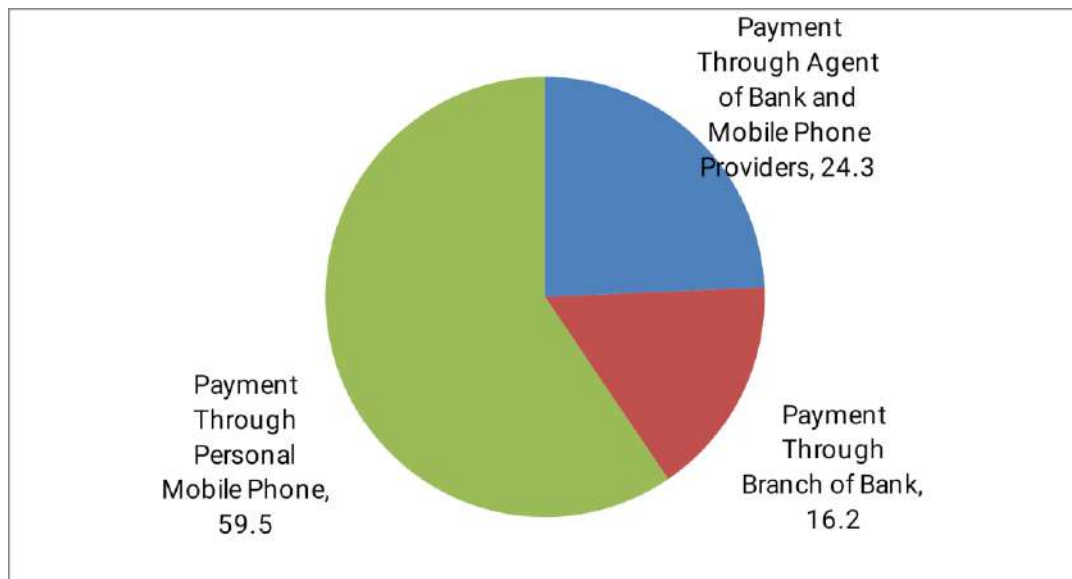
Overall, the NHIF registration requirements and processes pose obstacles for HIB members, contributing to the low coverage of health insurance in Tanzania's informal sector. Compulsory requirements like NIDA, a lack of awareness about MPCT, weak technical support from NHIF, and lengthy, complicated registration procedures all play a role in this challenge.

4.3.1.2 Payment Methods for Membership

The study highlighted the importance of diverse payment options for simplifying the enrolment process. Among the respondents, 18 (16.2%) used bank branches to pay their HIB premiums, while 27 (24.3%) opted for payment through bank agents and mobile phone providers. However, a significant majority, 66 (59.5%), preferred to make payments using their mobile phones. This preference indicates that enhancing mobile payment options could facilitate higher enrolment rates among small-scale entrepreneurs.

In summary, data analysis showed that (59%) of members' contribution payments were made through their mobile phones. This indicated that mobile phone is the most preferred method. Agents of mobile phone providers came next, followed by agents of banks and branches of banks. The findings are provided in Figure 4.1 below

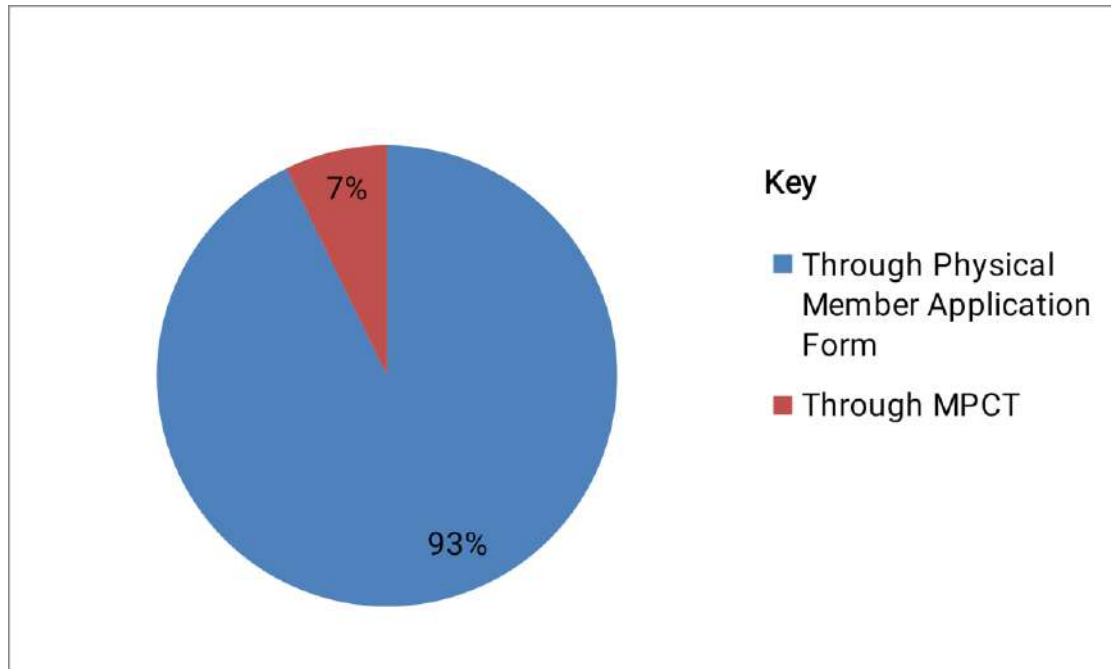
Figure 4.1 Represents Options of Payment Methods for HIB Membership



Source: Field Data, 2024

The study noted that few members had been enrolled through MPCT, and the majority used the application forms as a normal process of registration. The statistics show that, 8(7%) of the respondents have been enrolled through MPCT, while 103(93%) of the respondents have been registered through physical member application forms as a normal process. The summary of findings is provided below in Figure 4.2

Figure 4.2 Represents Respondents who have used MPCT on their Membership Registration n=111



Source: Field Data, 2024

According to Nyamperi *et al.* (2023), enhancing the reliability of mobile-based insurance access is essential for reducing barriers to enrollment in health insurance among informal sector workers. By improving the accessibility of health insurance selling points—such as offices, brokers, and agents and establishing more locations in rural areas where people live and work, enrollment rates can significantly increase. Additionally, strengthening community-based insurance schemes through technical support and awareness campaigns will facilitate greater uptake of these programs, ultimately contributing to the achievement of Universal Health Coverage (UHC).

4.3.2 Impacts of Premium Price Rates on Health Insurance Bundles Enrolment for Small-Scale Entrepreneurs

As it is shown in the previous part, NHIF applies mobile phone communication technology strategies to members' enrolment. Also, in quantitative study findings, the researcher wanted to examine the impact of premium price rates on the registration of health insurance bundle members, specifically for small-scale entrepreneurs. To get the respondent's perceptions, the question in the questionnaire

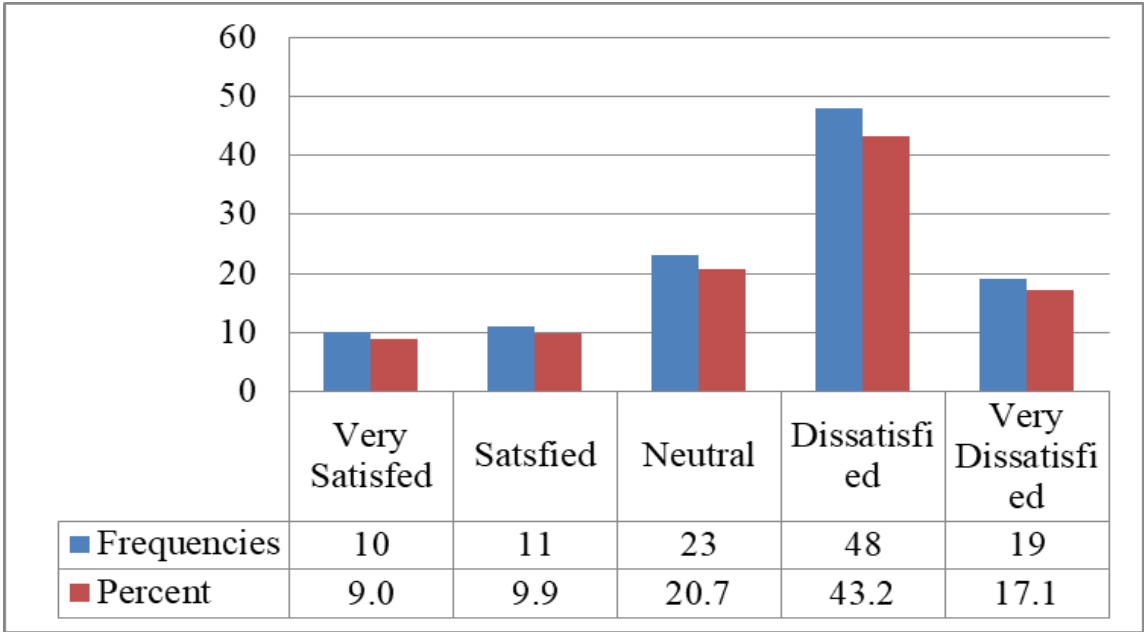
to each small-scale entrepreneur asked how satisfied they were with the access to medical services as per their premium contribution.

4.3.2.1 Satisfaction of the Premium Price Rates for HIB Membership

The study examined the impact of premium price rates on the enrollment of small-scale entrepreneurs in the informal sector, particularly those with low incomes. Respondents rated their satisfaction with the premium price rates for their health insurance membership, revealing significant dissatisfaction. Specifically, only 9% of respondents were very satisfied, while 9.9% were satisfied. In contrast, 43.2% were dissatisfied, and 17.1% were very dissatisfied, with 20.7% remaining neutral.

These findings indicate that, despite the demand for mobile phone communication technology (MPCT) in NHIF enrollment, the premium price rates present a critical barrier for many small-scale entrepreneurs. The majority expressed that the costs were not aligned with their financial capabilities, adversely affecting their ability to enroll in health insurance. This highlights the need to address premium pricing to improve enrollment rates among low-income entrepreneurs in the informal sector.

Figure 4.3 Member Satisfaction of the Premium Price Rates for HIB Membership



Source; Field Data, 2024

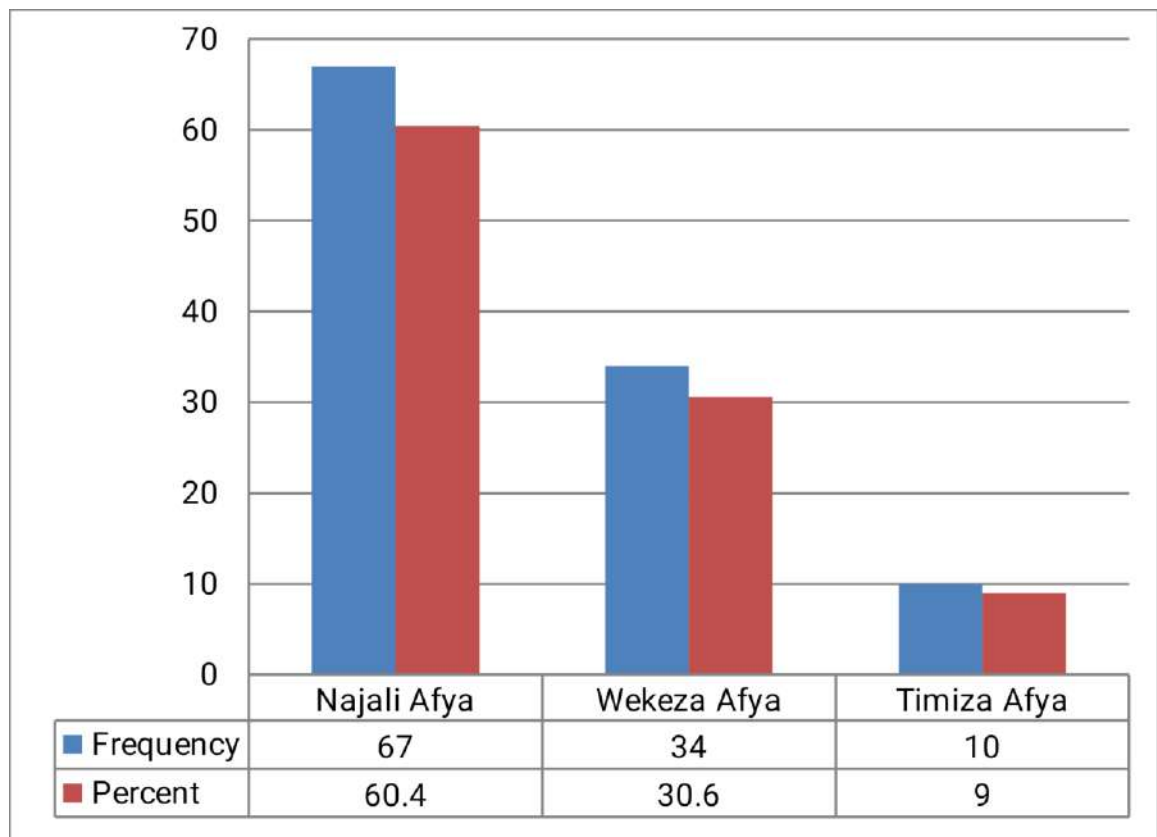
4.3.2.2 Impacts of Premium Price Rates on Member's Preference in Types of HIB

The study investigated how premium price rates impact the enrollment of small-scale entrepreneurs in health insurance bundles, particularly among low-income individuals in the informal sector. The researcher focused on three types of health insurance bundles: Najali Afya, Wekeza Afya, and Timiza Afya, noting that Najali Afya has the lowest premium rates, followed by Wekeza Afya, while Timiza Afya has the highest rates.

Findings indicated that a majority of respondents, 67 (60.4%), are members of HIB through Najali Afya, which is affordable for small-scale entrepreneurs despite offering slightly different benefits compared to other bundles. In contrast, 34 (30.6%) reported being members of Wekeza Afya, which has medium premium rates. Respondents acknowledged the higher costs associated with Wekeza Afya, citing the necessity of this choice due to coverage gaps in Najali Afya. Lastly, only 10 (9%) of respondents were members of Timiza Afya, which they described as costly but necessary to access certain medical treatments not covered by the other two bundles.

Overall, respondents expressed a strong desire for NHIF to reduce contribution amounts and implement strategies to encourage enrolment in health insurance, such as increasing community education, utilising insurance agents, and adopting modern technology. They also emphasised the need for the Tanzanian government to expedite the process of achieving universal health coverage. The preferences for different health insurance bundles are illustrated in Figure 4.4.

Figure 4.4 Member's Preference of the Health Insurance Bundles at NHIF



Source: Field Data, 2024

Furthermore, the findings showed that the majority of small scale entrepreneurs have been registered through Najali Afya, whereas its benefits package coverage is not comprehensive enough compared to Wekeza Afya and Timiza Afya. This indicated that their level of income is low. However, regardless of mobile phone communication technology as a component that can facilitate and increase member enrolment, the premium price rate is also indicated as one of the factors that can improve the best performance of enrollment at NHIF. The unaffordability of health insurance premiums is a problem to households with unstable income. The study findings revealed that small-scale entrepreneurs fail to access health insurance due to a lack of funds to pay the insurance premiums. According to (Kapologwe *et al.*, 2017) who found that there is a higher possibility of richer people in Tanzania to invest in healthcare and thus being able to afford the premiums.

4.3.3 Small Scale Entrepreneur Perceptions of NHIF Medical Benefits Package Special for Health Insurance Bundles

The researcher aimed to investigate the varying perceptions of small-scale entrepreneurs regarding the medical benefits package associated with health insurance bundles. A total of 111 questionnaires were distributed to respondents who are members of HIB, and comprehensive information was collected from all participants. The findings focus on understanding whether the benefits package contributes to the low enrollment rates in HIB.

Through the analysis, it became clear that perceptions of the medical benefits package significantly influence the decision-making of small-scale entrepreneurs. Respondents expressed concerns about the adequacy of coverage, with many indicating that certain essential medical services were either limited or excluded. This perception could deter potential members from enrolling, as individuals often seek comprehensive coverage that addresses their specific health needs.

Moreover, the findings highlighted that while some members appreciated the affordability of the packages, others felt that the limitations in benefits did not justify their contributions. This disparity in perceptions suggests that improving the benefits package and effectively communicating these offerings could enhance enrollment rates. Overall, these insights point to a critical need for NHIF to evaluate and potentially revise the medical benefits packages to better meet the expectations and needs of small-scale entrepreneurs, thereby increasing participation in the health insurance program.

4.3.3.1 Satisfaction of Benefits Package to HIB members.

The findings presented in Table 4.9 indicate that a significant majority of respondents expressed dissatisfaction with the benefits package associated with health insurance bundles (HIB). Specifically, only 15 (13.5%) of the respondents reported being satisfied, while 14 (12.6%) remained neutral regarding their satisfaction. In contrast, a substantial 57 (51.4%) of the respondents were dissatisfied, and 25 (22.5%) were strongly dissatisfied with the benefits package.

In summary, the results suggest that the benefits package for HIB does not adequately meet the needs of the members, which is a contributing factor to the low coverage of NHIF among small-scale entrepreneurs. This dissatisfaction highlights the necessity for NHIF to re-evaluate and enhance the benefits offered to better align

with the expectations and health needs of its members, potentially leading to increased enrollment in the program.

Table 4.9; Satisfaction of the Benefits Package to HIB Member=111

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Satisfied	15	13.5	13.5	13.5
Neutral	14	12.6	12.6	26.1
Dissatisfied	57	51.4	51.4	77.5
Strongly Dissatisfied	25	22.5	22.5	100.0
Total	111	100.0	100.0	

Source: Field Data, 2024

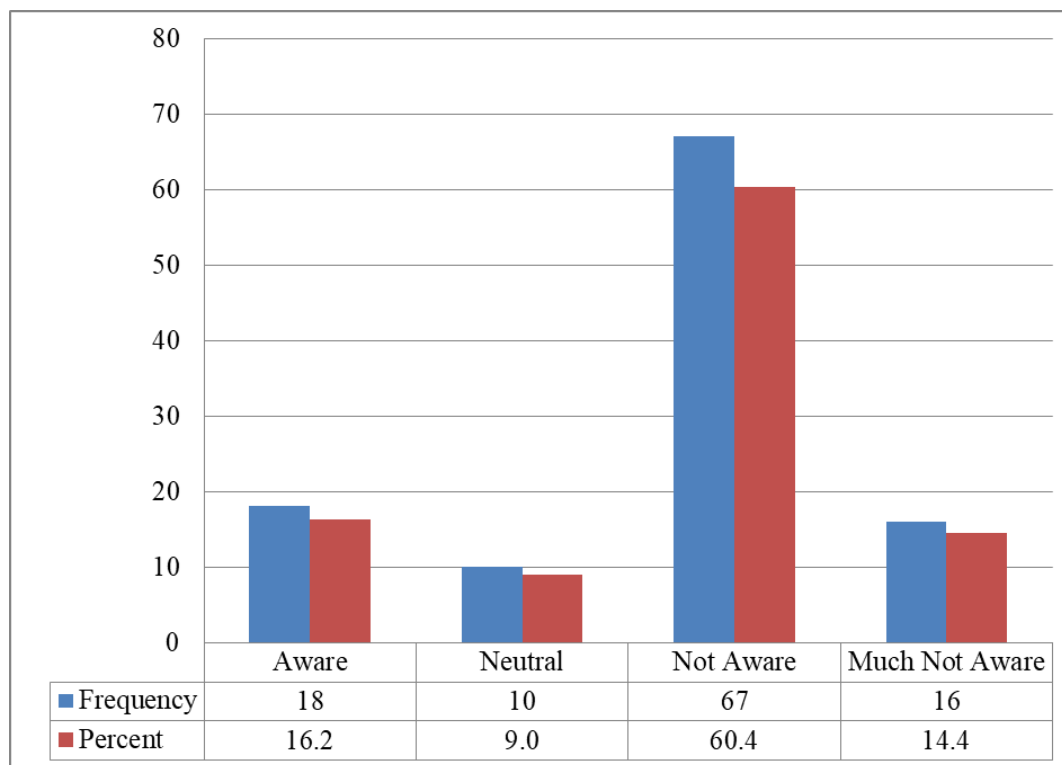
4.3.3.2 Awareness of Benefits Package to Member of HIB

The researcher aimed to investigate whether members of health insurance bundles are aware of all the medical services included in the benefits package covered by NHIF, both before joining the Fund and after enrollment. According to the study findings, 18 (16.2%) of the respondents were aware of the medical services included in the benefits package before or after joining NHIF. Additionally, 10 (9%) of the respondents were neutral regarding their awareness, while a significant majority, 67 (60.4%), reported being unaware of the included medical services at any point.

Respondents suggested that NHIF should enhance the way it shares information with members, recommending the use of a mobile app that allows users to search NHIF's data server and view the various medical services available according to their membership category.

In summary, it is challenging for many people in the informal sector to enroll in the scheme without understanding the inclusion of medical treatment services. As suggested by small-scale entrepreneurs, NHIF should provide detailed information about the benefits package online so that potential members can access it before making the decision to join the Fund. The statistics summary is provided in Figure 4.4.

Figure 4.5 Awareness of Inclusions and Inclusive of Benefits Package to HIB Member



Source: Field Data, 2024

4.3.3.3 Awareness on the Level of Accredited Health Facilities.

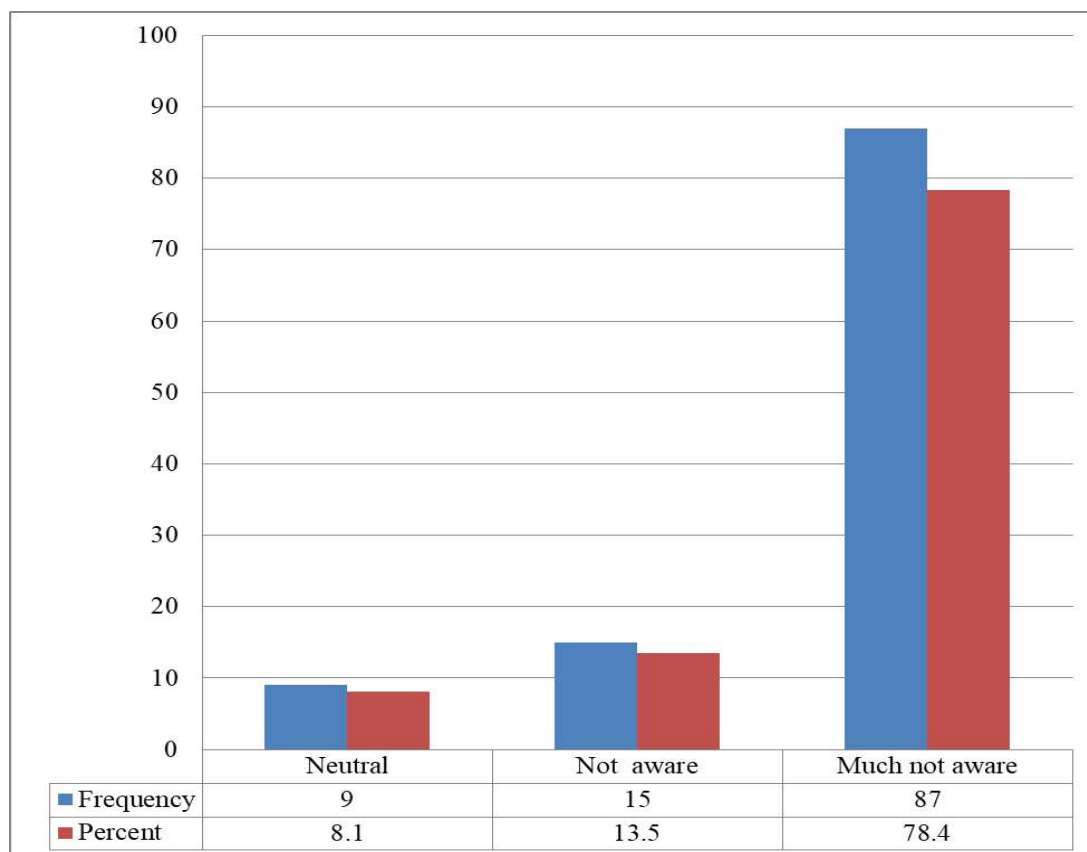
The researcher aimed to investigate whether members are aware of the accredited health facility levels that provide medical services under the health insurance bundle. The findings indicated that 9 (8.1%) of the respondents were neutral regarding their awareness of accredited health facility levels that they are not allowed to visit for medical services without a referral. Additionally, 15 (13.5%) of the respondents were not aware of these restrictions, while a significant majority, 87 (78.4%), reported that they were not aware at all.

Respondents suggested that NHIF should enhance how it shares information with members, recommending the use of a mobile app or SMS notifications that allow people to search for accredited health facilities from NHIF's data server and view various healthcare providers.

In summary, it is challenging for many people in the informal sector to join the Fund without understanding the different levels of accredited healthcare service providers.

As suggested by the respondents, NHIF should provide detailed information about these facilities. The statistics summary is provided in Figure 4.5.

Figure 4.6 Members’ Awareness on the Level of Accredited Health Facilities.



Source: Field Data, 2024

4.3.3.4 Factors that Support Member’s Enrolment of HIB

The researcher aimed to analyse various factors that facilitate member enrollment in HIB. The respondents who participated in the survey were presented with twelve (12) questions. Each respondent was required to rank their level of agreement or disagreement.

All 111 respondents (100%) who participated in the survey strongly agreed that good quality services can support enrollment. A majority of 66 respondents (59.46%) strongly agreed that the introduction of health insurance agencies might increase enrollment in HIB, while 28 respondents (25.23%) agreed, and 17 respondents (15.32%) were neutral on this point.

Furthermore, 94 respondents (84.68%) strongly agreed that affordable premium price rates may increase enrollment in HIB. Meanwhile, 13 respondents (11.71%) agreed, three respondents (2.70%) were neutral, and one respondent (0.90%) disagreed regarding the impact of premium price rates on enrollment.

In addition, 32 respondents (28.83%) strongly agreed that a comprehensive benefits package might enhance enrollment in HIB, while 48 respondents (43.24%) agreed, 22 respondents (19.82%) were neutral, and nine respondents (8.11%) disagreed.

Moreover, 53 respondents (47.75%) strongly agreed that enrollment through mobile phones may increase HIB membership, with 20 respondents (18.02%) agreeing, eight respondents (7.21%) being neutral, 20 respondents (18.02%) disagreeing, and 10 respondents (9.01%) strongly disagreeing.

Similarly, 14 respondents (12.61%) strongly agreed that eliminating the waiting period for accessing medical services after completing new registration or renewing membership may increase enrollment, while six respondents (5.41%) agreed, 32 respondents (28.83%) were neutral, 49 respondents (44.14%) disagreed, and nine respondents (8.11%) strongly disagreed.

Additionally, 47 respondents (42.44%) strongly agreed that emphasising marketing strategies through mobile communication technology may increase enrollment, with 35 respondents (31.53%) agreeing, 11 respondents (9.91%) being neutral, ten respondents (9.01%) disagreeing, and eight respondents (7.21%) strongly disagreeing.

In terms of conducting advocacy in communities, 43 respondents (38.74%) strongly agreed it may increase enrollment, while 47 respondents (42.34%) agreed, and 21 respondents (18.92%) were neutral.

Moreover, 63 respondents (56.76%) strongly agreed that providing good quality services may enhance enrollment, with 40 respondents (36.04%) agreeing, and eight of eight respondents (7.21%) decided neutral.

Additionally, 45 respondents (40.54%) strongly agreed that removing the referral system for HIB members to visit accredited health facilities may increase enrollment, while 33 respondents (36.04%) agreed, 26 respondents (23.42%) were neutrsevenl, and seven respondents (6.31%) disagreed.

Lastly, 69 respondents (62.16%) strongly agreed that having no age limit for beneficiary enrollment may increase participation, with 38 respondents (34.23%) agreeing and three respondents (2.70%) remaining neutral.

The majority of respondents indicated a need for improvements in the provision of good quality services, the introduction of insurance agencies to assist NHIF with the enrollment process, enrollment through mobile phones, a review of the beneficiary age limit policy, and marketing through mobile communication technology (MPC). The statistical findings are provided in Table 4.10 below.

Table 4.10 Factors that Support Member's Enrolment of HIB

Response.	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	Freq	(%)	Freq	(%)	Freq	(%)	Freq	(%)	Freq	(%)
Introduce insurance agencies	66	59.46	28	25.23	17	15.32	0	0	0	0
Affordability	94	84.68	13	11.71	3	2.70	1	0.90	0	0
Comprehensive Benefits package	32	28.83	48	43.24	22	19.82	9	8.11	0	0
Enrolment through mobile phone	53	47.75	20	18.02	8	7.21	20	18.02	0	0
No waiting period to access services	14	12.61	6	4.41	32	28.83	49	44.19	9	8.11
Marketing through MPCT	47	42.34	35	31.53	11	9.91	10	9.01	8	7.21
Advocacy to communities	43	38.74	47	42.34	21	18.92	0	0	0	0
Good Quality of services	63	56.76	40	36.04	8	7.21	0	0	0	0
No referral system	45	40.54	33	29.73	26	23.42	7	6.31	0	0
No Age Limit	69	62.1	38	34.23	3	2.70	0	0	0	0

Source: Field Data, 2024

Summary of Small-Scale Entrepreneurs' Perceptions of NHIF Medical Benefits Package for Health Insurance Bundles

The study findings revealed that the unavailability of certain services leads to mistrust in the scheme, resulting in low renewal and enrolment rates among members. Limited transparency about the benefits package and a lack of trust in the commitment of community-based health insurance administrators further contribute to this mistrust, leading to low enrolment in health insurance (Orgera *et al.*, 2019). Increasing transparency and improving information dissemination about health insurance using mobile communication technology strategies could help reduce these barriers, potentially increasing enrolment among small-scale entrepreneurs (SSE) in the NHIF.

4.4 Qualitative Findings from Interviews and Focus Group Discussions (FGDs)

Apart from the survey that generated quantitative findings, insights from interviews and FGDs revealed additional perspectives. FGDs facilitated discussions among small groups of individuals with specialised knowledge or interest in the topic. Typically comprising 6 to 12 participants, FGDs are guided by a short list of questions designed to elicit in-depth information. Discussions usually last between one and two hours (Intract, 2017). The purpose of these discussions was to gather in-depth information on concepts, perceptions, and ideas from the groups.

In this study, the researcher aimed to assess different aspects of mobile communication technology strategies regarding the enrolment of health insurance bundles, as well as the premium price rates and benefits package provided to small-scale entrepreneur members of HIB.

A total of five Focus Group Discussions were conducted across five wards, with each group consisting of eight participants. All five groups included small-scale entrepreneur members of health insurance bundles, resulting in a total of forty participants. A convenience sampling method was employed to select FGD members.

The findings were obtained from all forty participants. The results are detailed in the following sub-section.

4.4.1 Perceptions on Member Enrollment and Access to Health Insurance Services through Mobile Phone Communication Technology

The researcher aimed to gather various perceptions from FGD members on how mobile phone communication technology (MPCT) facilitates access to health insurance services, including new member enrolment, requesting information about NHIF via mobile phones, and obtaining control numbers for membership renewal payments. Many participants in the focus group discussions expressed that...

Members reported that they have little awareness and lack the skills necessary for online member registration via mobile phone. This includes making contribution payments and accessing various services offered through mobile phones. Travelling long distances to seek health insurance services at NHIF offices, which are far from where they live or work, is costly for them. (FGD interviewees said).

Commenting on the question, other interviewees stated that;

“.....members have limited awareness of using mobile applications for member enrollment. However, they often encounter difficulties due to a lack of technical support from NHIF. As a result, many members prefer to visit the office in person to request a control number for their membership payment.....” (Other interviewees said)

Another SSE member from the FGD stated that;

Sometimes, I make contribution payments for renewing my membership through my mobile phone, but the transactions fail to be acknowledged by NHIF, even though my mobile service provider shows that the transaction has been completed. This creates frustration and discourages me from using the mobile payment system. For this reason, I decide to make my membership contribution payment through a bank branch. (FGD, SSE interviewee, aged 34).

The researcher wanted to know from the participants about the quality of services provided at the NHIF offices. From the Focus Group Discussion, the findings showed that SSE members face several challenges, including travelling long distances to seek insurance services to NHIF offices, and staffing who serve members is not enough to meet the demands of people. *This was justified by several small-scale entrepreneurs;*

NHIF offices and official staff are insufficient to accommodate many people. This leads individuals to travel long distances to access health insurance services. Once I reach the NHIF office, it takes a long time to receive services due to the limited number of offices available. For example, in Dar es Salaam, NHIF has only six offices, which are not able to meet the needs of the population. Therefore, many respondents suggested that NHIF should increase the number of offices and staff. Alternatively, they should provide education on the use of mobile phone applications to facilitate self-service options, such as generating control numbers for membership payments. (FGD interviewee aged 36).

Also, the majority of the participants said that;

NHIF should introduce health insurance agencies across the country to support the process of member enrollment through the MPCT application, similar to mobile phone subscriber practices. This could help alleviate the problem of office and staff shortages.” They also noted, “There is a significant relationship between mobile phone communication and NHIF member enrollment. NHIF should provide awareness and support to the public regarding the application of mobile phone communication technology (Other interviewees said).

Furthermore, the findings of this study revealed that a lack of awareness and limited support regarding the application of mobile phone communication technology, along with the inaccessibility of health insurance selling points and services such as insurance organisation offices, were reported as barriers to accessing health insurance for small-scale entrepreneurs. Most insurance offices are located in town centre areas, and their limited number relative to the high demand makes it difficult for many people who live in remote areas to access health insurance services. Additionally, not all small-scale entrepreneurs live in towns where NHIF offices are situated; thus, those living far from urban centres or in rural areas face significant challenges in accessibility, contributing to low membership enrollment among small-scale entrepreneurs. This aligns with the findings of Hurtig *et al.* (2017), which also noted that staff shortages in various sectors hinder service accessibility.

4.4.2 Perceptions on Premium Price Rates for Health Insurance Bundles

The study also aimed to gather diverse views from Focus Group Discussion members regarding how premium price rates attract or hinder the enrollment of small-scale entrepreneurs in health insurance bundles. This assessment focused on the affordability of small-scale entrepreneurs to manage the annual premium payments for their health insurance bundle memberships.

This question asked to determine whether all family members have health insurance and, if not, why some do not. From the Focus Group Discussions, the findings indicate that small-scale entrepreneurs (SSEs) faced economic crises, leading families to enrol only those members who have health challenges or the head of the family.

In each Focus Group Discussion across five wards, one SSE member stated:

The premium price rates, especially for health insurance bundles, are high compared to my actual economic status because I have a low income. It is difficult for all members of my family to join the health insurance bundles. In my family, only the person who has health challenges or the head of the family can be enrolled. (FGD, SSE interviewee, aged 43).

The majority of members from each Focus Group Discussions supported that,

Members have stated the truth about enrolling only family members who face health problems because we have a low income and cannot afford the annual contribution premium payment for all family members. We suggested that the government introduce a monthly contribution option for health insurance bundles and expedite universal health coverage, allowing assistance for people with low incomes. (Other SSE interviewees said).

The study also wanted to know if the premium price rate is an obstacle to the enrolment of HIB members.

I stated that there is a direct relationship between premium price rates and NHIF membership enrollment. Last year, I wanted to join NHIF but could not because I had insufficient funds for the membership payment. Other members supported the idea that the fund should review the premium rates of health insurance bundles (HIB) to make it

affordable for many small-scale entrepreneurs with low incomes. Additionally, there are other costs associated with completing the enrollment process, such as travel, accommodation, and meals, as not everyone lives in Dar es Salaam. For example, I come from Kisarawe District, where there is no NHIF office. (FGD SSE interviewee said).

Again, the majority of the participants said that;

The National Health Insurance Fund should use mobile phone messaging to communicate with all members and non-members to help everyone interested in enrollment understand the premium price rates both before and after joining the Fund. Additionally, they suggested that NHIF implement a payment modality that allows members to contribute in instalments, preferably every month, rather than as a lump sum. This approach would help address the challenges many face in gathering the necessary funds all at once when renewing their membership. (Other FGD interviewees said).

The study also aimed to gather members' perceptions of premium price rates based on age limits. NHIF offers three health insurance bundles in the HIB package: Najali Afya, Wekeza Afya, and Timiza Afya. Each package is divided into three age groups: the first group includes individuals aged 18 to 35 years, the second group includes those aged 36 to 59 years, and the last group includes individuals aged 60 years and older. Each age group differs in premium price rates, with the lowest rates for the youngest group and higher rates for the oldest group. When asked about the age limits as a standard for setting premium price rates, members shared their views.

The majority of members from different wards expressed that setting premium price rates for health insurance based on age is a significant obstacle to joining the Fund or maintaining their membership, as their income does not correlate with age. They advised that NHIF should not set premium price rates based on members' ages, as higher age results in increased rates. One member stated, "I cannot afford to enrol my two parents because I am required to contribute a total amount of TZS 720,000 per year for registering a couple aged 60 and above, and my capital is low, which means my monthly income is also low" (FGD, SSE interviewee, aged 49). They urged NHIF to review the premium price rates for health insurance bundles, advocating against using age limits as a standard.

In summary, the study findings indicated that small-scale entrepreneurs believe the premium price rates for health insurance bundles are unrealistic given their income, a sentiment supported by other research. Lack of affordability is one of the primary reasons for low membership in health insurance schemes in Tanzania (Kapologwe *et al.*, 2017). Financing for health services is essential for sustaining universal health coverage, where affordability and equitable access to services is based on individuals' ability to pay and their need for services, regardless of their background characteristics (WHO and World Bank, 2021). Furthermore, to ensure high enrollment in health insurance, ease of accessibility is crucial. Accessibility should encompass physical, economic (affordability), and informational aspects (Lutinah, 2020).

4.4.3 Perceptions on Quality of Benefits Package Special for Health Insurance Bundles.

The study also aimed to gather diverse views from the Focus Group Discussion regarding the quality of service delivery to small-scale entrepreneurs (SSEs) enrolled in the health insurance bundle (HIB). The researcher inquired whether members had attended healthcare facilities as HIB members to understand the quality of medical services they accessed. The findings from the Focus Group Discussions revealed that SSE members faced several limitations in accessing medical services, including medicines, diagnostic tests, and the referral system.

Thirty-four respondents stated:

When we receive medical services at various healthcare facilities, many of the healthcare providers inform us that certain medicines and diagnostic tests are not covered under the NHIF benefits package. Additionally, service providers often ask us to pay cash for some medical services. This situation frustrates us and erodes our trust in NHIF. As a result, it sometimes becomes difficult to renew our membership or promote NHIF services to others because the quality of services is unappealing.” (FGD interviewees said)

The respondents from different wards revealed that;

They advised that to avoid member frustration when visiting healthcare facilities, NHIF should implement an alternative system that allows both members and non-members of the health insurance bundle to understand which medical services are accessible before and after joining the scheme. Since many members travel long distances to reach healthcare facilities and

sometimes do not have money available, they face difficulties in managing these situations. They suggested enhancing the use of mobile phone communication so that members can access information about services provided by NHIF. By utilising mobile phone communication technology (MPCT), members can better understand excluded treatments and plan their budgets for any uncovered medical services. (FGD interviewees said).

The study findings also aimed to understand the level of awareness among small-scale entrepreneurs who are members of HIB regarding the healthcare facilities they are entitled to access for medical services before going to zonal referral or national hospitals, such as Muhimbili Hospital. This is important because members of health insurance bundles are not permitted to go directly to higher-level health facilities without a referral. HIB members are entitled to access medical services directly from dispensaries up to the level of regional hospitals. If a lower-level healthcare facility determines that a patient needs further treatment at a higher-level facility, they will provide a referral. The study findings revealed that:

The majority of respondents stated that they do not understand where they are entitled to start accessing medical services. Many times, they encounter difficulties when visiting Muhimbili National Hospital, Kitengule Hospital, Rabininsia, and Regency Hospital for medical treatment. The NHIF system often rejects their access to services at these hospitals, directing them instead to healthcare facilities at the regional hospital level. They noted that, at such times, they are very sick and unsure of where to go. Therefore, NHIF should provide a comprehensive list of all levels of health facilities categorised as National, Zonal, District, Health Center, and Polyclinic. This information should be made available online so that any member or non-member can easily access it via mobile phone or other devices. (FGD interviewees said).

In summary, regarding perceptions of the accessibility of the benefits package, particularly for health insurance bundles, the study, supported by findings from Evangelina C. Chihoma and Mughwira Mwangi (2024), revealed that more effort is needed to enhance communication processes with beneficiaries and improve relationships with healthcare providers for better performance of health insurance packages. NHIF does not effectively communicate with its clients during enrolment or at any other time during their membership. Additionally, NHIF fails to properly

inform beneficiaries about changes to the benefits package, communicating only with healthcare providers. This lack of communication fosters mistrust among small-scale entrepreneurs (SSEs) and contributes to low enrolment rates within this group.

4.5 Suggestions of Improvement on Member's Enrolment and Health Insurance Services

Suggestions given by the majority of the respondents about the application of mobile phone communication technology strategy as shown below;

NHIF should invest in educational campaigns to build capacity within communities by utilising modern mobile phone communication technology to facilitate the enrollment process and access other services. To implement these educational campaigns effectively, NHIF should engage insurance agents who can assist in enrolling members in health insurance bundles via mobile phone technology. This approach could significantly increase enrollment coverage among small-scale entrepreneurs (SSEs) in Tanzania's informal sector. Additionally, NHIF should enhance mobile phone communication capabilities to allow members to generate control numbers and make payments, as well as to understand the services offered by NHIF through their mobile devices, such as the benefits package. (FGD interviewees said).

Also, the majority of the respondents suggested that the premium price rates are special for health insurance bundles, whereas small-scale entrepreneurs are members through HIB.

NHIF should review the premium price rates for health insurance bundles to ensure they are realistic for individuals with low incomes. Additionally, if possible, NHIF should implement a system that allows members to make payments in instalments rather than in a lump sum. It would also be beneficial for NHIF to allow members of the Health Insurance Bundle (HIB) to make monthly contributions, similar to members in the formal sector. These changes could encourage more self-employed individuals in Tanzania's informal sector to enrol in NHIF (FGD interviewees said).

Also, the majority of the respondents suggested that the benefits package is special for health insurance bundles, whereas small-scale entrepreneurs are member of this program.

It has been suggested that NHIF review the benefits package for health insurance bundles. Improving this package could increase coverage, especially for small scale entrepreneurs in Tanzania's informal sector with low incomes. Members should clearly understand the benefits available to them before and after enrolling in NHIF. Utilising mobile phone communication technology could effectively disseminate this information to both members and non-members through short messages or internet platforms. (FGD interviewees said).

The findings from the Focus Group Discussions indicate that to meet the demands of Tanzania's informal sector and achieve Universal Health Coverage, as endorsed by the President's 2023 Act, NHIF plays a crucial role for low-income, small-scale entrepreneurs. However, the contribution of mobile communication technologies to member enrollment in health insurance in Tanzania's informal sector is needed to improve member enrollment in the informal sector through MPCT. Additionally, there should be enhancements in premium rates and the benefits package specifically for the Health Insurance Bundle, as suggested by self-employed individuals.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter summarises the study, draws conclusions, and makes recommendations for further research.

5.2 Summary of Major Findings

This study conducted to assess the contribution of mobile communication technologies on member's enrolment to health insurance in Tanzania's informal sector in NHIF Kinondoni regional Office. Additionally, researcher interested in assess the current state of mobile phone communication strategy on enrolment of small-scale entrepreneurs through health insurance bundles, examine the impacts of premium price rates on health insurance bundle enrolment for small-scale entrepreneurs and investigate small-scale entrepreneur perceptions on NHIF medical benefits package special for health insurance bundles. The respondents being the NHIF Official Staff and Small Scale Entrepreneurs member of HIB. They were asked to provide suggestions on the contribution of MPCT on NHIF member enrolment.

The findings from this study have shown that, contribution of mobile communication on member enrolment processes is low at NHIF. However, small scale entrepreneur are not satisfy with premium price rate and medical benefits package special for HIB.

In order to overcome the challenges on application of MPCT identified by this study, NHIF should conduct campaign education to the community on how to use mobile phone in membership registration. Due to unrealistic of price and benefits package, NHIF should review premium price rates and medical benefits package special for HIB.

5.3 Conclusion

The need for mobile phone communication technology (MPCT) in NHIF enrolment for Tanzania's informal sector has been validated, although manual operations remain prevalent. MPCT is currently applied in activities such as student registration, health insurance bundle recruitment, and employee recruitment.

This study assessed the impact of MPCT strategies on NHIF enrolment and concluded that MPCT is effectively used for member enrolment, sending SMS

notifications after accessing health services and processing contributions. However, manual enrolment processes dominate the membership services department at NHIF.

Furthermore, the study recognised the positive impacts of MPCT strategies, including simplifying the enrolment process, increasing membership coverage, reducing manual workloads, decreasing wait times for health insurance services, streamlining payment processes, and enhancing awareness of NHIF offerings.

Additionally, the findings align with other research indicating that manual operations lead to challenges such as delayed member enrolment, late delivery of medical identity cards, and difficulty in disseminating education to large groups within a short period. These delays can erode members' confidence in the Fund, create inefficiencies in document management, and result in inaccuracies in information.

Moreover, the study highlighted that low member coverage in Tanzania's informal sector is largely due to the inadequate skills of small-scale entrepreneurs in using mobile applications for the registration process. Other contributing factors include unrealistic premium rates for health insurance bundles to the incomes of small-scale entrepreneurs, as well as a benefits package for the Health Insurance Bundle (HIB) that fails to attract informal sector participants. Many respondents reported that essential medical services require out-of-pocket payments, which are not covered by NHIF.

5.4 Recommendations

Based on the findings of this research, the following recommendations should be considered:

Awareness of Mobile Communication Technology

The study found that low enrolment coverage is significantly affected by small-scale entrepreneurs' limited skills in using mobile communication technology for HIB enrolment. To enhance MPCT utilisation, NHIF should train staff to educate the community on modern technology for registration. NHIF needs to adopt paperless processes and introduce health insurance agencies to assist with member registration via MPCT. Such agencies will be crucial as the Tanzanian government strives for universal health insurance coverage.

Cost of Health Insurance Bundles

Also, the study indicates that the premium rates for health insurance bundles negatively impact enrolment, as they are not aligned with the economic realities of

small-scale entrepreneurs. To address this issue, NHIF should review the premium pricing for HIB and consider allowing members to pay in instalments rather than a lump sum.

Awareness of Benefits Package Special for HIB

Findings revealed that the benefits package for health insurance bundles contributes to low coverage among small-scale entrepreneurs, as it does not comprehensively meet their needs. NHIF should review and enhance the current benefits package to include essential medical services, even if this requires increasing member contributions. It's vital to educate communities about the importance of health insurance and how it operates. Improved information and education campaigns, leveraging mobile communication technology, will help increase enrolment in health insurance bundles among Tanzania's informal sector. Ultimately, the government should continue to prioritise universal health coverage (UHC), as mandatory enrolment may be necessary to expand coverage for the informal sector.

Policy Implications

The government of Tanzania should emphasize many Tanzania's informal sector to join the Fund even through universal health coverage (UHI). The government need to review NHIF premium price rates and medical benefits package special for HIB. Application of MPCT on NHIF member enrolment should be improved by provide awareness to the community.

5.5 Suggestions for Further Research

Further research is needed to compare and assess the consistency of these findings. Additional studies should examine premium pricing and the quality of services for members of health insurance bundles in Tanzania's informal sector NHIF. Moreover, research should investigate how social, political, and economic factors influence the coverage of small-scale entrepreneurs.

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APPENDIX I

Questions for NHIF Staff

This tool is for a study titled “**The Contribution of Mobile Communication Technologies on Members Enrollment to Health Insurance in Tanzania’s Informal Sector**”. It is for academic purposes only.

1 What is the department you are working with?

.....

2 What is your designation?

.....

3 Do you use mobile phone communication technology in your department to assist online member’s enrolment and why?

.....
.....
.....
.....

5 Does NHIF educate members on the use of mobile phone communication technology on members’ enrolment?

.....
.....
.....
.....

6 What are the impacts of the use of mobile phone communication strategies in the provision of health insurance bundles to Tanzania’s informal sector?

.....
.....
.....
.....

7 Which methods have been used to enrol more health insurance bundle members?

.....
.....
.....
.....

9 What are the member's perceptions of health insurance bundles concerning the MPCT?

- i)
- ii)
- iii)
- iv)
- v)

10 What are the members' perceptions of health insurance bundles concerning the premium price rates special for HIB?

- i)
- ii)
- iii)
- iv)

11 What are the member's perceptions of health insurance bundles concerning the benefits package special for HIB?

- i)
- ii)
- iii)
- iv)
- v)

- 12 How satisfied are you with the current mobile phone communication strategies in the enrolment of health insurance bundles?
- 13 Which type of health insurance bundles are mostly preferable by members?
- 14 Which group of age are mostly members have been registered through health insurance bundles more than others?.....
- 15 What are the factors mostly affecting Small-scale Entrepreneur on registration of insurance bundles?
- 16 Which advantages do you see if mobile phone Apps and short messages will be fully used in your provision of services?
17. What do you think can be done to increase the rate of mobile phone communication application in member enrolment at NHIF?.....
18. What can be done to eliminate the challenges of MPCT on member enrolment?

Thank you for your good cooperation.

Questionnaires to Small Scale Entrepreneur members of health insurance bundles

Dear Respondent,

This questionnaire is for a study titled “***Contribution of Mobile Communication Technologies on Members Enrollment to Health Insurance in Tanzania’s Informal Sector***” It is for academic purposes only. You are requested to fill them with clarity, and the answers you offer will be treated as confidential.

PART I: PERSONAL PARTICULARS

1 What is your age group? (Tick where appropriate)

- i) 18-35 years old ()
- ii) 36-59 years old ()
- iii) 60 and above years old ()

2 What is your Marital Status?

- i) Single ()
- ii) Married ()
- iii) Widow ()
- iv) Divorced ()

3 What is your gender?

- i) Male ()
- ii) Female ()

4 What is your education level? (Tick where appropriate)

- i) University level ()
- ii) Secondary level ()
- iii) Vocation Education and Training ()
- iv) Primary level ()

5 How long period worked as a Small, small-scale entrepreneur? (Tick where appropriate)

- i) Between 1-3 years ()
- ii) Between 4-7 years ()
- iii) Between 8-11 years ()
- iv) Between 12-15 years ()
- v) Above 15 years ()

6 How long is the distance of the NHIF office from your place of living/working?

- i) Very far away ()
- ii) Faraway ()
- iii) Normal ()
- iv) Near ()
- v) Very near ()

PART II: ASSESSING THE CURRENT STATE OF MOBILE PHONE COMMUNICATION STRATEGIES ON ENROLMENT OF SMALL-SCALE ENTREPRENEUR THROUGH HIB.

1 Which method you have used to register your membership of HIB? (Tick where is appropriate)

- i) By filling out the physical member application form ()
- ii) Through MPCT ()

2 How do you make payment for your health insurance bundle membership? (Tick your options)

- i) Payment through a branch of bank ()
- ii) Payment through agents of mobile phone ()
- iii) Payment through agents of the bank ()
- iv) Payment through your mobile phone ()

3 Do you have an awareness of using mobile phone communication to access NHIF services? (Tick where appropriate)

- i) Yes ()
- ii) No ()

4 How satisfied are you with the current mobile phone communication strategies in enrolment of health insurance bundles? (Tick where appropriate)

- i) Very satisfied ()
- ii) Satisfied ()
- iii) Neutral ()
- iv) Dissatisfied ()
- v) Very dissatisfied ()

5 Do you agree that lack of education to members on using mobile phone App has impact on member's enrolment in insurance bundles? (Tick where appropriate)

- i) Strongly agree ()
- ii) Agree ()
- iii) Neutral ()
- iv) Disagree ()
- v) Strongly disagree ()

6 If any additional, in question number 5, what other factors or negative impacts do you think are reasons behind the low member's coverage of health insurance bundles specific Small Scale Entrepreneur.....
.....
.....
.....

7 Please rank each of the following factors that are the experience challenges you get with the application of mobile phone communication technology on member enrolment. Use tick (✓) to indicate your position once in the rows provided

Key: 1 = strongly agree, 2 = agree, 3 = Neutral, 4 = disagree, 5 = strongly disagree

- | | 1 | 2 | 3 | 4 | 5 |
|--------------------------------------|-----|-----|-----|-----|-----|
| i) Weak technical support from NHIF | () | () | () | () | () |
| ii) Lack of knowledge | () | () | () | () | () |
| iii) Malfunction of system | () | () | () | () | () |
| iv) Long registration procedures | () | () | () | () | () |
| v) Requirements of NIDA | () | () | () | () | () |
| vi) Network failure | () | () | () | () | () |
| vii) Must have smartphone | () | () | () | () | () |
| viii) Needs of supportive documents | () | () | () | () | () |
| ix) Age limit not below 18 years old | () | () | () | () | () |
| x) Cost of Bandwidth | () | () | () | () | () |
- 8 Which advantages do you think you will use effectively mobile phone communication technology in the member enrolment process?
-
-
- 9 Do you satisfy with the availability of NHIF's offices and employed staffs in provision of health insurance services to members who are Tanzania's informal sector? (Tick were appropriate)
- | | |
|----------------------|-----|
| i) Very satisfied | () |
| ii) Satisfied | () |
| iii) Neutral | () |
| iv) Dissatisfied | () |
| v) Very dissatisfied | () |
- 10 How are you satisfied with the mobile phones communication technology strategies in reducing the challenges on access services of health insurance bundles? (Tick where appropriate)
- | | |
|---|-----|
| i) Very dissatisfied | () |
| ii) Somewhat satisfied | () |
| iii) Neither satisfied nor dissatisfied | () |
| iv) Somewhat satisfied | () |
| v) Very dissatisfied | () |

PART III: EXAMINE THE IMPACTS OF PREMIUM PRICE RATES ON HIB ENROLMENT FOR SMALL SCALE ENTREPRENEURS IN THE INFORMAL SECTOR

1 Do you agree that, the premium price rates of health insurance bundles have impact of all process of membership enrolment? (Tick where appropriate)

- i) Strongly agree ()
- ii) Agree ()
- iii) Neutral ()
- iv) Disagree ()
- v) Strongly disagree ()

2 If any additional, in questions number 1 what others negative impacts you think are reasons behind the small member's coverage of health insurance bundles specific Small Scale Entrepreneur.....
.....
.....
.....

3 Do you satisfy with premium price rates related with quality and quantity of medical services? Please rank each of the following medical services. Use tick (✓) to indicate your position once in the rows provided Key: 1 = strongly dissatisfied, 2 = dissatisfied, 3 = Neutral, 4 = Satisfied, 5 = strongly satisfied

- | | 1 | 2 | 3 | 4 | 5 |
|-----------------------------|-----|-----|-----|-----|-----|
| i) Consultation services | () | () | () | () | () |
| ii) Inpatient services | () | () | () | () | () |
| iii) Specialized services | () | () | () | () | () |
| iv) Vaccination services | () | () | () | () | () |
| v) Medicines services | () | () | () | () | () |
| vi) Minor and Major surgery | () | () | () | () | () |

4. Do you satisfy with the premium price rates on enrolment of health insurance bundles? (Tick where appropriate)

- i) Very satisfied ()
- ii) Satisfied ()
- iii) Neutral ()
- iv) Dissatisfied ()
- v) Very dissatisfied ()

5 What your perceptions over premium price rates special for HIB?

.....
.....

**PART IV: INVESTIGATE SMALL SCALE ENTREPRENEUR
PERCEPTIONS ON NHIF MEDICAL BENEFITS PACKAGE
SPECIAL FOR HIB**

1. Which kind of health insurance bundle you have been registered? (Tick where appropriate)

i) Najali Afya ()

ii) Wekeza Afya ()

iii) Timiza Afya ()

2. After join NHIF have you been visited at the health facility for medical treatment?

i) Yes ()

ii) No ()

3 If the answer is yes in question No (2), what about the medical services you have been access based on HIB benefits package (Tick where is appropriate)

i)

ii)

iii)

4 Why you have decided to join NHIF and not other private health insurance scheme?

i) Their premium price rates is too high ()

ii) Low coverage of accredited health facilities ()

iii) Their benefits package is not comprehensive ()

iv) Others (Mention).....

.....
.....

5 Please rank each of the following factors that will support to increase member's enrolment. Use tick (✓) to indicate your position once in the rows provided

Key: 1 = Strongly agree, 2 = Agree, 3 = Neutral, 4 = Disagree,

5 = Strongly Disagree

- | | 1 | 2 | 3 | 4 | 5 |
|--|-----|-----|-----|-----|-----|
| i) Introduce Insurance agencies | () | () | () | () | () |
| ii) Attractive premium rates | () | () | () | () | () |
| iii) Comprehensive benefits package | () | () | () | () | () |
| iv) Enrolment through mobile phone | () | () | () | () | () |
| v) No waiting period to access services | () | () | () | () | () |
| vi) Sensitization through mobile phone | () | () | () | () | () |
| vii) Payment through mobile phone | () | () | () | () | () |
| viii) Accessibility of health facilities | () | () | () | () | () |
| ix) Advocacy to the communities | () | () | () | () | () |
| x) Quality of services | () | () | () | () | () |
| xi) No referral system | () | () | () | () | () |
| xii) No age Limit | () | () | () | () | () |
- 6 Do you agree that, the benefits package special for health insurance bundles are the ones causes low HIB members enrolment (tick were appropriate)
- | | |
|----------------------|-----|
| i) Strongly agree | () |
| ii) Agree | () |
| iii) Neutral | () |
| iv) Disagree | () |
| v) Strongly disagree | () |
- 7 If any additional, in questions number 6 what other negative impacts you think are reasons behind the small member's coverage of health insurance bundles specific Small Scale Entrepreneur.....
.....
.....
8. How are you satisfied with the current benefits package of health insurance bundles? (Tick where appropriate)
- | | |
|----------------------|-----|
| i) Very satisfied | () |
| ii) Satisfied | () |
| iii) Neutral | () |
| iv) Dissatisfied | () |
| v) Very dissatisfied | () |

9 Are you aware with benefits package for HIB members which covered and not covered by NHIF before and after join the Fund?

- i) Much aware ()
- ii) Aware ()
- iii) Neutral ()
- iv) Not aware ()
- v) Much Not aware ()

10. Is it, member of HIB understand the all level of accredited health facilities which provide medical services, before and after join NHIF? (Tick where appropriate)

- i) Yes ()
- ii) No ()

11 If the answer in question number 11 is No, please provide your suggestions to NHIF.....
.....

Thank you for your good answers

Kiswahili Version Questionnaire to Members of Health Insurance Bundles

Habari

Mimi ni mwanafunzi katika Taasisi ya Ustawi wa Jamii, nasomea shahada ya uzamili katika kazi ya kijamii. Ninakuomba unisaidie kushiriki katika maswali ya mahojiano ambayo yanatafuta majibu kuhusu matokeo ya mbinu itumikayo ya mawasiliano ya Teknolojia ya Simu ya Mkononi katika kusaidia Kusajili miongoni mwa Wajasiliriamali wadogo wasio katika sekta rasmi kupitia vifurushi vya bima ya afya Tanzania. Majibu yako yatatumika tu katika kuandika ripoti yangu ya utafiti. Ninakuhakikishia kuwa maoni yako yatashughulikiwa kwa usiri wa hali ya juu.

1 Una miaka mingapi?(Weka alama ya vema kwenye jibu)

- i) Kati ya Miaka 18-35 ()
- ii) Kati ya Miaka 36-59 ()

- iii) Zaidi ya miaka 60 ()
2. Ipi ni hali yako ya ndoa?
- i) Sijaowa/sijaolewa ()
- ii) Nimeowa/nimeolewa ()
- iii) Mjane/Mgane ()
- 3 Aina ya Jinsia yako? (Weka alama ya vema kwenye jibu)
- i) Mwanaume ()
- ii) Mwanamke ()
- 4 Je, Kiwango chako cha elimu ni kipi? (Weka alama ya vema kwenye jibu)
- i) Elimu ya chuo kikuu ()
- ii) Elimu ya sekondari ()
- iii) Elimu ya ufundi ()
- iv) Elimu ya msingi ()
- 5 Je, unajishughulisha na ujasiriamali gani? (Weka alama ya vema kwenye jibu)
- i) Kilimo ()
- ii) Ufundi ()
- iii) Usafirishaji ()
- iv) Nguo, viatu na mapambo ()
- v) Duka dogo ()
6. Una muda gani unafanya kazi ya Ujasiriamali mdogo ?(Weka alama ya vema kwenye jibu)
- i) Kati ya Miaka 1-3 ()
- ii) Kati ya Miaka 4-7 ()
- iii) Kati ya Miaka 8-11 ()
- iv) Kati ya Miaka 12-15 ()
- v) Zaidi ya miaka 16 ()

**SEHEMU YA II; MATOKEO YA MATUMIZI YA MWAWASILIANO YA
TEKNOLOJIA YA SIMU YA MKONONI KATIKA USAJILI
WANACHAMA WA VIFURUSHI VYA BIMA YA AFYA**

- 1 Je,uwanachama wako wa bima ya afya ulijisajili kupitia mfumo wa simu ya mkononi? (Weka alama ya vema kwenye jibu)
 - i) Ndiyo ()
 - ii) Hapana ()
2. Je,unalipaje uanachma wako wa bima ya afya? (Weka alama ya vema kwenye jibu)
 - i) Unalipia katika tawi la benki ()
 - ii) Unalipia kwa wakala wa kampuni ya simu benki ()
 - iii) Unalipia kupitia simu yako ya mkononi ()
- 3 Je, uanakubali elimu ya uelewa ambayo NHIF inatoa kwa wanachama wake juu ya matumizi ya teknolojia ya mawasiliano ya simu ya mkononi kwa ajili ya kupata huduma kidigitali?(Weka alama ya vema kwenye jibu)
 - i) Nakubali kabisa ()
 - ii) Nakubali ()
 - iii) Kawaida ()
 - iv) Sikubali ()
 - v) Sikubali kabisa ()
- 4 Je, kwa sasa unaridhika kiasi gani na huduma ya usajili wa uwanachma wa vifurushi vya bima kupitia simu ya mkononi?(Weka alama ya vema kwenye jibu)
 - i) Naridhika kabisa ()
 - ii) Naridhika kiasi ()
 - iii) Nipo pande zote ()
 - iv) Siridhiki kiasi ()
 - v) Siridhiki kabisa ()
- 5 Je, unakubali uelewa kwa wanachama kuhusu matumizi ya mawasiliano ya simu ya mkononi ni changamoto ya usajili wa wanachama wa vifurushi?(Weka alama ya vema kwenye jibu)
 - i) Nakubali kabisa ()
 - ii) Nakubali ()
 - iii) Kawaida ()
 - iv) Sikubali ()
 - v) Sikubali kabisa ()

- 6 Tadhali weka kiwango cha kukubali au kutokubali kwa jambo ambalo ni changamoto unayopata katika matumizi ya mawasiliano ya teknolojia ya simu ya mkononi katika usajili wa bima ya afya. Weka alama ya vema ($\sqrt{\quad}$) kuonyesha kiwango cha kukubali au kukataa kwako kwa kila safu unazoziona hapo chini. Muongozo: 1 = Nakubali sana, 2 = Nakubali, 3 = Kawaida, 4 = Sikubali, 5 = Sikubali kabisa

	1	2	3	4	5
i) Msaada mdogo kutoka kwa NHIF	()	()	()	()	()
ii) Ukosefu wa Ujuzi wa simu janja	()	()	()	()	()
iii) Mfumo kuwa na tatizo	()	()	()	()	()
iv) Hatua nyingi za usajili	()	()	()	()	()
v) Uhitaji wa lazima wa NIDA	()	()	()	()	()
vi) Kushindwa kwa mtandao	()	()	()	()	()
vii) Lazima kuwa na simu janja	()	()	()	()	()
viii) Lazima kuwa na viambatishi vya utambuzi	()	()	()	()	()
ix) Ili usajiliwe uwe na miaka 18	()	()	()	()	()
x) Gharama za bando	()	()	()	()	()

- 7 Je, nini faida unayodhani kama mawasiliano ya teknolojia ya simu za mkononi ikitumika ipasavyo katika zoezi zima la usajili wa wanachama wa vifurushi vya bima ya afya?.

.....

- 8 Je, unaridhika na idadi ya ofisi za bima ya afya pamoja na watumishi wake wanatosha kukidhi mahitaji ya wananchi wasio katika sekta rasmi?(Weka alama ya vema kwenye jibu)

i) Naridhika kabisa	()
ii) Naridhika	()
iii) Kawaida	()
iv) Siridhiki	()
v) Siridhiki kabisa	()

- 9 Kama jibu katika swali na. 9 ni hapana, tafadhali naomba toa maoni yako ni nini NHIF wafanye ili wakidhi mahitaji ya wananchi ambao wapo njie ya mfumo rasmi?

.....

- 10 Tafadhali weka kiwango katika mambo yafuatayo ambayo unaona yanawezesha kuongezeka kwa wigo wa wanachama wa vifurushi vya bima ya afya. Tumia alama ya vema (✓) kuonyesha kiwango ulichoona mara moja kila jambo kweye mabano. Muongozo:1= Nakubali sana, 2=Nakubali, 3=Kawaida, 4=Sikubali, 5 = sikubali sana

	1	2	3	4	5
i) Kuwepo na wakala wa usajili	()	()	()	()	()
ii) Bei za vifurushi zivutie	()	()	()	()	()
iii) Kitita cha mafao ya matibabu kivutie	()	()	()	()	()
iv) Usajili kwa njia ya simu ya mkononi	()	()	()	()	()
v) Pasiwe na kipindi cha kusubiri huduma	()	()	()	()	()
vi) Uhamasishaji kwa njia ya simu	()	()	()	()	()
vii) Malipo kwa njia ya simu ya mkononi	()	()	()	()	()
viii) Wigo mpana wa watoa huduma za afya	()	()	()	()	()
ix) Elimu kwa jamii kuhusu bima ya afya	()	()	()	()	()
x) Pawe na huduma bora kwa wanachama	()	()	()	()	()
xi) Matibabu popote bila refero	()	()	()	()	()
xii) Pasiwe na kigezo cha umri	()	()	()	()	()

11 Je, ni umbali gani upo kutoka unapoishi mpaka ofisi za bima ya afya? (Weka alama ya vema kwenye jibu)

- i) Mbali sana ()
- ii) Mbali ()
- iii) Sio mbali sio karibu ()
- iv) Karibu ()
- v) Karibu sana ()

12 Je, unaridhika kiasi gani na teknolojia ya mawasiliano ya simu ya mkononi katika kupunguza changamoto ya hupatikanaji wa huduma za bima ya afya? (Weka alama ya vema kwenye jibu)

- i) Naridhika kabisa ()
- ii) Naridhika kiasi ()
- iii) Nipo pande zote ()
- iv) Siridhiki kiasi ()
- v) Siridhiki kabisa ()

SEHEMU YA III: KUTATHIMINI MATOKEO YA BEI YA VIFURUSHI VYA BIMA AFYA KATIKA USAJILI WA WATU WASIO KATIKA SEKTA RASMI WENYE KIPATO KIDOGO.

1 Je, unaridhika na kiwango cha bei ya vifurushi vya bima ya afya husababisha matokeo hasi katika shughuli nzima ya usajili wanachama?(Weka alama ya vema kwenye jibu)

- i) Naridhika kabisa ()
- ii) Naridhika ()
- iii) Kawaida ()
- iv) Siridhiki ()
- v) Siridhiki kabisa ()

2 Je unaridhika kiasi gani na kiwango cha bei ya vifurushi vya bima ya afya kuwa ni kikwazo cha usajili? (Weka alama ya vema kwenye jibu)

- i) Naridhika kabisa ()
- ii) Naridhika ()
- iii) Kawaida ()
- iv) Siridhiki ()
- v) Siridhiki kabisa ()

3 Je, kiwango cha bei za vifurushi vya bima ya afya zinaendana na ubora wa huduma za afya itolewayo? Weka alama ya vema (✓) kwenye kiwango ulichoridhika nacho Muongozo: 1 = Siridhiki kabisa, 2 = Siridhiki , 3 = Kawaida , 4 = Naridhika, 5 = Naridhika kabisa

- | | 1 | 2 | 3 | 4 | 5 |
|--------------------------------------|-----|-----|-----|-----|-----|
| i) Kujiandikisaha na kumuona daktari | () | () | () | () | () |
| ii) Huduma za kulazwa | () | () | () | () | () |
| iii) Huduma za kibingwa | () | () | () | () | () |
| iv) Huduma za chanjo | () | () | () | () | () |
| v) Huduma za dawa | () | () | () | () | () |
| vi) Huduma za upasuaji | () | () | () | () | () |

SEHEMU YA IV: UCHUNGUZI JUU YA KITITA CHA HUDUMA ZA MATIBABU KWA WAJASIRIAMALI WADOGO WANACHAMA WA VIFURUSHI VYA BIMA YA AFYA.

1 Je, una aina gani ya bima ya afya ya vifurushi? (Weka alama moja ya vema katika jibu sahihi kwenye mabano)

- i) Najali Afya ()
- ii) Wekeza Afya ()
- iii) Timiza Afya ()

2 Je, tokea ujiunge na bima ya afya uliishawahi kutumia kadi yako ya bima?

i) Ndiyo ()

ii) Hapana ()

3 Kama jibu katika swali na. 2 ni ndiyo, je ulionaje huduma za matibabu kwa kuzingatia kitita cha huduma za matibabu cha vifurushi?

.....
.....
.....

4 Je, kwa nini umeamua kujiunga na NHIF na sio kampuni nyingine za bima ya afya?

i)

ii)

iii)

iv)

5 Je, ukubwa wa kitita cha mafao kwa ajili ya wanachama wa vifurushi vya bima ya afya ni chanzo hasi cha wigo mdogo wa usajili wao? (Weka alama ya vema kwenye jibu (i) Ndiyo () (ii) Hapana ()

6 Kama jibu ni ndiyo kwenye swali namba 5, nini sasa kifanyike kuondokana na hiyo changamoto ya kitita cha mafao ya matibabu kwa wanachama wa vifurushi vya bima afya

.....
.....
.....

- 7 Je, kwa sasa unaridhika kiasi gani na kitita cha matibabu kwa ajili ya wanachama wa vifurushi vya bima ya afya?(Weka alama ya vema kwenye jibu)
- | | |
|---------------------|-----|
| i) Naridhika kabisa | () |
| ii) Naridhika | () |
| iii) Kawaida | () |
| iv) Siridhiki | () |
| v) Siridhiki kabisa | () |
- 8 Je, kabla na baada ya kujiunga na NHIF unajua huduma zote za matibabu ambazo hazilipiwi na bima ya afya? (Weka alama ya vema kwenye jibu)
- | | |
|--------------|-----------------|
| i) Ndiyo () | (ii) Hapana () |
|--------------|-----------------|
- 9 Kama jibu ni hapana katika swali na. 8. Tafadhali toa mapendekezo yako kwa NHIF nini kifanyike ili mwananchi ajue huduma zote ambazo hazilipiwi na bima ya afya kabla na baada ya kujiunga
-
-
-
- 10 Je, kabla na baada ya kujiunga na bima ya afya, unajua vituo vyote vya afya ambavyo vimesajiliwa na NHIF ili kutoa huduma kwa wanachama wake pamoja na viwango vyao vya usajili wao?(Weka alama ya vema kwenye jibu)
- | | |
|--------------|-----------------|
| i) Ndiyo () | (ii) Hapana () |
|--------------|-----------------|
- 11 Kama jibu ni hapana katika swali na. 10. Tafadhali toa mapendekezo yako kwa NHIF nini kifanyike ili mwananchi ajue vituo vyote vya afya ambavyo vimesajiliwa na NHIF ili kutoa huduma kwa wanachama wake pamoja na viwango vyao vya usajili?
-
-

Asante sana kwa majibu yako mazuri

Focus Group Discussion (FGD) Guide

Part I

Greetings!

I am a student at the Institute of Social Work pursuing a Master's degree in social work. I kindly request you, Small Scale Entrepreneur members of health Insurance bundles at NHIF, to discuss the “***Contribution of Mobile Communication Technologies on Members Enrolment to Health Insurance in Tanzania's Informal Sector***” The answers to this discussion will be used only in writing my research report.

I promise you that the information received in this discussion will be treated with the utmost confidence.

Introduction

This guide outlines the procedures that will be followed and general issues that will be included in the Focus Group Discussion. First, introductions will be made, and the purpose of the research will be re-explained. Then, the researcher starts the discussion with the question:

Part II.

General particulars:

- i) What about the impacts of mobile phone communication on access to health insurance services such as new member's enrolment, request information about NHIF and control number for payment of renewal membership?
- ii) How long time you spend to arrive at NHIF offices for membership services?
- iii) How long time you spend accessing services at NHIF offices?
- iv) What is your perception of premium price rates for health insurance bundles?
- v) What is your perception about the quality of the benefits package, especially for health insurance bundles?
- vi) What is your suggestion on which can improve the situation?

Thanks for your corporation

APPENDIX II

The Premium Price Rates Special for HIB

HEALTH INSURANCE BUNDLES PREMIUMS AMOUNT									
Size of the Family	Principal Aged 18- 35			Principal Aged 36 - 59			Principal Aged 60+		
	Najali Afya Premium	Wekeza Afya Premium	Timiza Afya Premium	Najali Afya Premium	Wekeza Afya Premium	Timiza Afya Premium	Najali Afya Premium	Wekeza Afya Premium	Timiza Afya Premium
Individual Person	192,000	384,000	516,000	240,000	444,000	612,000	360,000	660,000	984,000
Couple	384,000	732,000	996,000	456,000	864,000	1,188,000	684,000	1,284,000	1,908,000
Couple + 1 Child	504,000	924,000	1,272,000	576,000	1,068,000	1,464,000			
Couple + 2 Children	612,000	1,116,000	1,536,000	696,000	1,248,000	1,728,000			
Couple + 3 Children	720,000	1,284,000	1,788,000	804,000	1,416,000	1,980,000			
Couple + 4 Children	816,000	1,452,000	2,028,000	900,000	1,584,000	2,220,000			
Individual + 1 Child	312,000	576,000	792,000	360,000	648,000	888,000			
Individual + 2 Children	432,000	756,000	1,056,000	468,000	828,000	1,152,000			
Individual + 3 Children	540,000	924,000	1,308,000	576,000	996,000	1,404,000			
Individual + 4 Children	636,000	1,092,000	1,548,000	672,000	1,164,000	1,644,000			

APPENDIX III

The NHIF Benefits Package Special for HIB

MAFAO KWA WANUFAIKA WA NHIF KUPITIA VIFURUSHI VYA BIMA YA AFYA				
NA	MAFAO	Huduma Zinazopatikana Katika Vifurushi Vya Bima ya Afya		
		NAJALI AFYA	WEKEZA AFYA	TIMIZA AFYA
1.	Ada ya kujiandikisha na kumwona daktari	Inalipiwa katika ngazi zote za vituo.	Inalipiwa katika ngazi zote za vituo.	Inalipiwa katika ngazi zote za vituo
2.	Huduma za kulazwa	Inapatikana kwa jumla ya siku zisizozidi 30 kwa mwaka kwa kila mnufaika mmoja.	Inapatikana kwa jumla ya siku zisizozidi 45 kwa mwaka kwa kila mnufaika mmoja.	Inapatikana kwa jumla ya siku zisizozidi 60 kwa mwaka kwa kila mnufaika mmoja.
3.	Huduma za dawa	Dawa zote zilizoainishwa katika Kitita cha Mafao cha NHIF Daraja A, B, C, D na S	Dawa zote zilizoainishwa katika Kitita cha Mafao cha NHIF Daraja A, B, C, D na S	Dawa zote zilizoainishwa katika Kitita cha Mafao cha NHIF Daraja A, B, C, D na S
4.	VIIMO VYA MAABARA NA UCHUNGUZI			
	Aina za Vipimo	162	197	223
	X-RAY	Inapatikana	Inapatikana	Inapatikana
	ECHO & EEG	Inapatikana	Inapatikana	Inapatikana
	Ultrasound	Inapatikana	Inapatikana	Inapatikana
5.	HUDUMA ZA KINYWA NA MENO			
	Kung'oa na kuziba meno	Inapatikana	Inapatikana	Inapatikana
6.	HUDUMA ZA UZAZI			
	Kujifungua kawaida	Inapatikana baada ya kuchangia mfululizo katika kipindi cha miaka miwili.	Inapatikana kuanzia mwaka wa pili wa kuchangia mfululizo.	Inapatikana kuanzia mwaka wa pili wa kuchangia mfululizo.
	Kujifungua kwa upasuaji	Inapatikana baada ya kuchangia mfululizo katika kipindi cha miaka miwili.	Inapatikana kuanzia mwaka wa pili wa kuchangia mfululizo.	Inapatikana kuanzia mwaka wa pili wa kuchangia mfululizo.
7.	HUDUMA ZA MATIBABU YA KIBINGWA			
	Huduma za kibingwa	Zinapatikana mpaka ngazi ya Hospitali za Mkoa na kwa rufaa hadi Hospitali za Rufaa za Kanda na Taifa.	Zinapatikana mpaka ngazi ya Hospitali za Mkoa na kwa rufaa hadi Hospitali za Rufaa za Kanda na Taifa.	Zinapatikana mpaka ngazi ya Hospitali za Mkoa na kwa rufaa hadi Hospitali za Rufaa za Kanda na Taifa.
8.	HUDUMA ZA UPASUAJI			
	Aina za upasuaji mdogo	27	30	50
	Aina za upasuaji mkubwa	14	36	80
Vigezo na Masharti Kuzingatiwa				

APPENDIX IV

Application Letter for Data Collection at NHIF

Fridolin Edward
S.L.P 7195,
DAR ES SALAAM
22/02/2024

Mkurugenzi Mkuu,
Mfuko wa Taifa wa Bima ya Afya,
S.L.P 1434,
DODOMA.

Kk

Meneja wa Mkoa Ilala,
Mfuko wa Taifa wa Bima ya Afya,
S.L.P 7195
DAR ES SALAAM.

*Nashamini uridhie maombi
haya.*
Fridolin Edward, 22/02/2024.

YAH: MAOMBI YA KUKUSANYA TAARIFA KWA AJILI YA UTAFITI WA MASOMO.

Husika na somo hapo juu.

Mimi Fridolin Edward Afisa Uanachama Ofisi ya Mkoa wa Ilala, naomba kupewa ruhusa ya kukusanya taarifa kwa ajili ya utafiti wa masomo ya shahada ya uzamili katika chuo cha Ustawi wa Jamii Kilichopo Mkoa wa Dar es Salaam kama barua iliyoambatishwa inavyoeleza.

Naomba kukusanya taarifa katika Mkoa wa Kinondoni na Ilala kwa baadhi ya wanachama wa vifurushi na Mafisa wa Mfuko wanaohusika na usajili wa wanachama kupitia utaratibu wa mitandao ya simu ya mkononi (Online registration).

Moja ya mwaswali ambayo nitauliza ni

1. Kujua hali ya utumiaji wa simu ya mkononi katika kuwezesha usajili wa wanachama wa vifurushi tokea ianzishwe mpaka sasa
2. Kujua matokeo ya matumizi ya simu ya mkononi katika kutoa huduma bora
3. Kujua mtazamo na uridhikaji wa wanachama wa vifurushi katika matumizi ya simu ya mkononi katika kuboresha huduma

Umuhimu wa utafiti huu ni kujua mkwamo na uboreshaji katika utumiaji wa simu ya mkononi kwa wanachama wa Mfuko ili kuokoa muda, kuondokana na msongamano ofisini na kusaidia ujio wa bima ya afya kwa wote.

Natanguliza shukrani zangu.

Wako Katika Ujenzi wa Taifa
Fridolin Edward
Fridolin Edward

APPENDIX V

Research Clearance

INSTITUTE OF SOCIAL WORK

Phone: +255 (22)2700918/2774443
Fax: 2701375
Email: info@isw.ac.tz
Website: www.isw.ac.tz



210 Shikilango Road
P.O. Box 3375
14113 Kijitonyama
Dar es Salaam.

MSW/T.2022/014

22nd February, 2024

DIRECTOR GENERAL,
NATIONAL HEALTH INSURANCE FUND,
P.O BOX 1437,
DODOMA.

Dear Sir/Ma'am

RE: RESEARCH CLEARANCE

The Institute of Social Work was established by the National Social Welfare Training Institute Act No. 26 of 1973 (as amended by the Miscellaneous Act No. 13 of 2002). The aim of its establishment is to prepare human resource for strengthening the social service delivery structure in Tanzania. The mission of the Institute is to continuously transform individuals' and communities' life by conducting high quality training programmes, research and consultancy that lead to socio-economic development of the country.

The purpose of this letter is to introduce to you **Fridolin Edward**: REG. NO. **MSW/T.2022/012**, a student pursuing a Master's Degree in Social Work. His research title is "**EFFICIENCY OF GLOBAL SYSTEM FOR MOBILE COMMUNICATION ON MEMBERS ENROLMENT TO HEALTH INSURANCE IN TANZANIA INFORMAL SECTOR**". The Institute requests on behalf of the student to grant him permit to collect data at **National Health Insurance Fund**.

The period which this permission has been granted is from **1st March, 2024 to 30th June, 2024**. In case of any further clarification required, please contact: Deputy Rector Academics Research and Consultancy; Institute of Social Work, P.O BOX 3375; Dar es Salaam. Telephone number: 022-2700918/274443

Thanking you in advance for your cooperation.

Yours sincerely,

For **Prof. SOTCO KOMBA**

Deputy Rector Academics, Research and Consultancy.

APPENDIX VI

Acceptance Letter for Data Collection at NHIF Kinondoni Office



UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH
NATIONAL HEALTH INSURANCE FUND



In reply, please quote:

Ref. No. NHIF/PF.546/01/21

Date: 07.05.2024

RECTOR,
INSTITUTE OF SOCIAL WORK
P.O. BOX 3375
DAR ES SALAAM

Re: REQUEST FOR RESEARCH CLEARANCE

Please refer to your letter with Ref. MSWF/T2022/014, dated 22 February, 2024 regarding the above-captioned heading.

2. The Fund is pleased to inform you that it has granted permission to Fridolin Edward to collect data on his academic project titled *"Efficiency of Global Systems for Mobile Communication on Members Enrollment to National Health Insurance in Tanzania Informal Sector."*
3. The student is required to carry this letter with him to the Ilala and Kinondoni NHIF offices during the data collection exercise, and the timeframe for data collection should be between March and June 2024, as stated in the introduction letter.
4. The collected data from NHIF during this research should be used for the aforementioned purpose and treated with strict confidentiality.
5. Sincerely yours.

Baraka J. Maduhu
For: DIRECTOR GENERAL

NHIF House Tambukarelli, Jakaya Kikwete Road, P.O. Box 1437, Dodoma, Tel: +255282963888, Email: info@nhif.or.tz, Website: www.nhif.or.tz