FACTORS AFFECTING ENROLLMENT IN SOCIAL HEALTH INSURANCE BENEFIT: A CASE OF EMPLOYEES' PERSPECTIVE IN DAR ES SALAAM

Zakia Mohamed

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By

Zakia Mohamed

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Public Health of
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CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled: **Factors Affecting Enrollment in Social Health Insurance Benefits: A case of Employees' Perspectives in Dar es Salaam** in partial fulfillment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

_____

Prof. P G M Mujinja, BA (Hons), CIH, MPH, MA (Econ) PhD

(Supervisor)

_____

Date

DECLARATION

AND

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I **Zakia Mohamed,** declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature…….. **Date……**

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DEDICATION

I dedicate this dissertation to my wonderful family. Particularyl to my lovely, patient and supportive husband, Juma T. Mgori who encouraged me until the time I complited this work, and to our beloved son Baraka, who is the joy of our lives.

LIST OF ABBREVIATIONS

AIDS	-	Acquired Immuno Deficiency Syndrome
CBHI	-	Community Based Health Insurance
CBI	-	Community Based Insurance
CFMS	-	Core Fund Management System
CHF	-	Community Health Fund
DRC	-	Democratic Republic of Congo
DMHIS	-	District-wide Mutual Health Insurance Scheme
DNA	-	Deoxyribo Nucleic Acid
GOT	-	Government of Tanzania
HBM	-	Health Belief Model
HIV	-	Human Immuno-deficiency Virus
IEC	-	Information, Education and Communication
ILO	-	International Labour Organization
LMIC	-	Low and Middle Income Countries
MRI	-	Magnetic Resonance Imaging
MOHSW	-	Ministry of Health and Social Welfare
TB	-	Tuberculosis
NHIF	-	National Health Insurance Fund
NHIS	-	National Health Insurance Scheme
NSSF	-	National Social Security Fund
SHI	-	Social Health Insurance
SHIB	-	Social Health Insurance Benefit
SSNIT	-	Social Security and National Insurance Trust

ABSTRACT

Background; In 2001 the government of Tanzania initiated health care financing reforms, one of it was the Social Health Insurance schemes targeting to improve access to health care services, quality of health services and protect people against financial catastrophic expenditures. Since SHIB inception there were scanty specific studies that explored why the enrolment to the scheme has not been substantially rising.

Objectives; The aim of this study was therefore to explore factors affecting enrollment in the Social Health Insurance Benefit among National Social Security Fund members in Dar es Salaam through assessment of their risk profile, risks perceptions regarding enrolment, awareness level of health insurance and the quality of health care services.

Methodology; This study was conducted in Dar-es-Salaam region involving employees from both public and private organizations who are NSSF members. The study employed random and multistage sampling technique to obtain a required sample. Primary data for the study were collected by using closed and open ended semi-structured self-administered questionnaire to elicit information corresponding to study specific. Data were analysed using Statistical Package for Social Science -SPSS Version 21**.**

Findings; A total of 327 NSSF membres participated in the study, 241 (73.70%) were males and 86 were females (26.30%). Non SHIB members were 225 (68.8%) and SHIB members were 102 (31.2%). The level of awareness on SHIB decreases with the decrease level of education among non SHIB members. Furthermore 27 (79.4%) of males and 7(20.6%) of females participants strongly disagree that the accredited health care facilities provide adequate supply of medicines. The results shows high percentages of participants 31.85% those who heard about health insurance and 41.11% those not heard about health insurance feared that their contributions will be deducted to cover SHIB medical bills.
Other reasons were, no enough time to accomplish registration procedures, difficult procedures of enrollment, associated registration cost during registration were almost having average of (20%) amongst partcipants.

Conclusion Since NSSF registration and SHIB enrollment are separately done and SHIB enrollment is voluntary, a careful review of SHIB code is required to address the enrollment gap. However, well designed SHIB demand creation of community campaigns , sensitations and educations initiatives are worth investing to promote SHIB enrollment which largely contributes not only to promote health of the NSSF members but also reducing income povety.

Recommendations The study recommends to the NSSF governing body to review its SHIB code, so that enrollment procedures are not separated with the NSSF registration. Extensive community sensitization should done focusing to inform the mass that their monthly contribution will not be deducted in case they become SHIB members. Work place registration is a good strategy to increase enrollment because most employees have no enough time to go for the SHIB registraion.

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OPERATIONAL DEFINITIONS

Accreditation of health care facilities in this study context means a process of providing a certification of competence to provide health care services after meeting the set of standards as set by the Ministry of Health and Social Welfare.

Accesibility of health care facilities in the context of this study means delivering health care that is timely, geographically reasonable and provided in a setting where skills and resources ara appropriate to medical need.

Aversion meant a strong feeling of dislike, opposition towards something with a desire to avoid or turn from it.

Health care workers: Individuals providing health care services at health facilities.

Health facility: in the context of this study, health facility means all accredited health care facilities registered as public, private and faith based organizations.

Non-SHIB members: National Social Security Fund members who are not enrolled into Social Health Insurance Benefit.

Quality of health care services in context of this study means the extent to which health services provided to individuals and patient populations meet their expectations and archieve desired outcome(s).

Risk perceptions meant a belief (whether rational or irrational) held by an individual, group or society about a chance of occurance of a risk or about the extent, magnitude and timing of its effect(s).

A risk profile is a quantitative analysis of the types of threats an individual faces.

SHIB members: National Social Security members who enrolled into Social Health Insurance Benefit.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

The government was the major provider of health services in for more than thirty years after independence. The government chose to be the sole provider of social services under the Ujamaa political ideology. Following the Arusha Declaration 1967, private organizations, individuals and firms were restricted to own major means of production of goods or provision of social services including health care services. However due to poor economic indicators in the 1990s and the growing poverty, the government could not afford to provide free health services to the Tanzanian population.[1]

To address the emerging challenges in the health care services in 1990's the government embarked in the health sector reforms to improve the quality of health care services. Through these reforms, cost sharing for health services was introduced. Cost sharing included drug revolving fund, out of pocket payment, Community Health Fund (CHF) in the rural areas and health insurance for employed people.[1] In early 2000 health insurance schemes started to operate in the country both as private and public insurance schemes. [1]

Tanzania implemented a cost sharing by introducing CHF and NHIF in 1995 and 2001 respectively. After introduction of cost sharing, the third provider of social health insurance in Tanzania became National Social Security Fund (NSSF) in 2005 under its Social Health Insurance Benefit (SHIB). SHIB scheme is financed through NSSF investments profit generated from member's contributions, which are currently 20 percent deduction of employee gross salary, of which the employee contributes 10 percent of the gross salary and the 10 percent of the same from employer.

The coverage includes the insured person, spouse and up to four children. The NSSF pensioner is also entitled to membership of the SHIB provided he or she is willing to accept a 6 percent monthly deduction from the pension after retirement.

The SHIB benefit package covers both inpatient and outpatient services. These services include accommodation, consultation with clinical/medical officer/specialist or consultant,

basic and specialized investigations, minor and major surgeries, drugs on the Essential Medicines List, and referral to higher-level hospitals. Exclusions include services received free of charge from other government schemes, such as maternity, immunization, TB and leprosy, cancer, HIV/AIDS, epidemics, mental illness, injuries where a third party with insurance is involved, cosmetic surgery, services/ treatments for self-inflicted diseases, physiotherapy at home, medical examination for employment, therapeutic trials, and expensive specialized investigative procedures like DNA typing.

SHIB uses capitation to reimburse service providers. The method has built-in incentives for providers to keep costs down by maximizing efficiency in the services provided to SHIB members. [36] It was found that most of the private providers prefer SHIB to NHIF. [36] The main objectives of SHIB are to provide free medical services to NSSF members and their dependants which include spouse and four biological, step or adopted children less than 18 years of age, to reduce the burden of financing health care services from employers for their employees. In addition the fund target helps the government to extend accessibility and coverage of health care services to the community. It also intend to fight against poverty by transferring some of the costs of health services from the members to the fund hence contributing to a health community and to fulfill the law requirement as stipulated by NSSF act NO. 28 of 1997 adopted from ILO.

This benefit is being provided to members and their dependants free without any other additional cost as all finances being incurred by the fund. Despite free provision of the benefit, the enrolment of members into SHIB is stil low across the country. Therefore this study sought to explore factors affecting enrolment in SHIB.

1.2 Statement of the Problem

In recent years, social health insurance was introduced in parts of the developing world as an alternative to tax financing and out-of pocket payments. Vietnam introduced Social Health Insurance SHI in 1993, Nigeria in 1997, Tanzania in 2001 and Ghana in 2005.

To reduce the burden of health care financing, few years after introduction of SHI in Tanzania, National Social Security Fund (NSSF) introduced Social Health Insurance Benefit to its members in 2005. Besides free provision of health care to NSSF members, the enrollment of Social health insurance benefit is low, though National Social Security Fund members are increasing. Currently there are more than 567,109 members, only 11,618 are enrolled in Social Health Insurance Benefit which is only 2.0% of all members.[9] Non enrollment of members affect more workers who are not covered by any other health insurances and their families at large.

Social Health Insurance Benefit has been confronted with many challenges, one of them being low enrolment of members into the scheme. Reasons for low enrollment include insufficient public information, employer-provided health care for some private sector employees, and limited or no access to accredited facilities in some areas[36]. For SHIB, during its inception the amount paid per beneficiary per year was not sufficient to cover health care costs incurred by the facilities. Others includes of patient mistreatment, shortages of medicines, poor ability of accredited medical providers in providing quality services, and long waiting time before well accessing services point to the fact that employees may have dissimilar and undesirable risk perceptions and negative attitudes regarding social health insurance benefit which contribute to low enrolment among other factors.

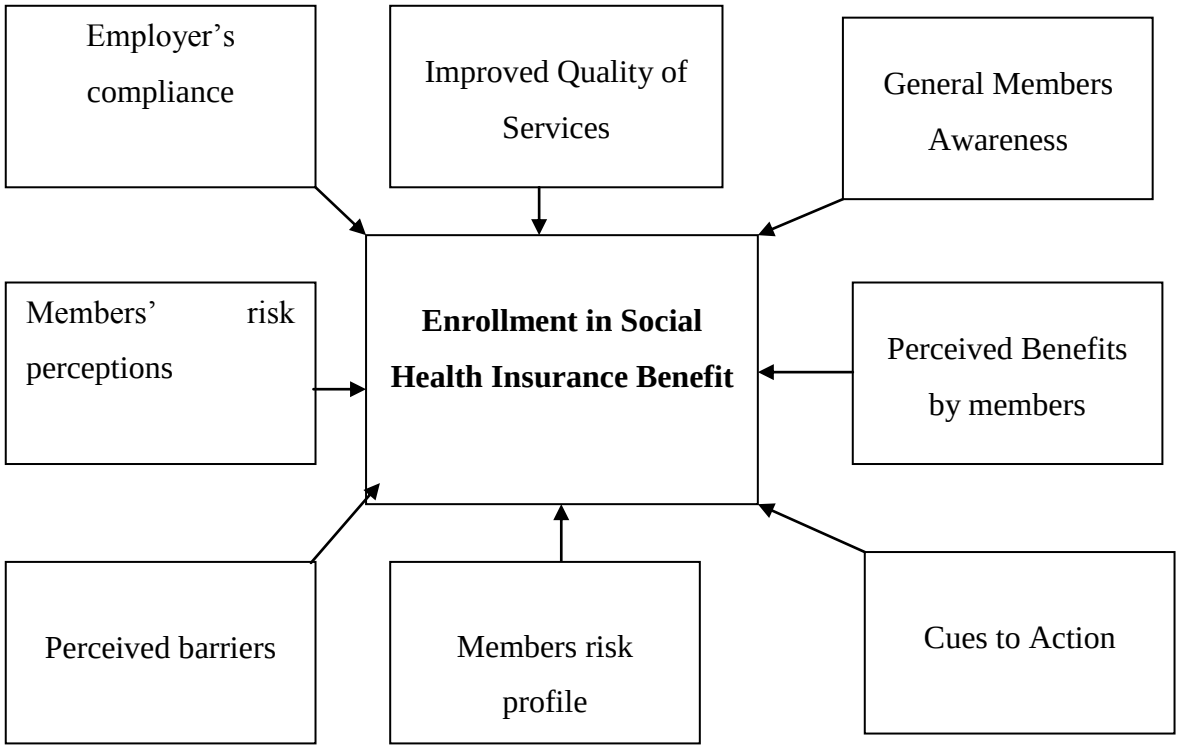
To minimize some of these problems some measures have been taken by various stakeholders, such as awareness creation, review of capitation payments after every two financial years, implementing safe care to some accredited medical providers so as to improve quality of health care services by applying health care international standards that suites an African environment and increase number of accredited health facilities to ensure accessibility yet low enrolment rate is still observed.

Given that SHI is only available to those in formal employment, where the contributions are collected from the employer and employee, often but not necessarily, as part of the payroll; there have also been some attempts to expand coverage to the informal sector or the whole population.[10] In expanding the coverage NSSF have recently introduced two new schemes named in swahili and english acronomy Wakulima scheme and Madini scheme. These two new schemes focus in informal sector that have no monthly salary as a wage but are earning in either daily basis or periodically.

Studies on social health insurance in Tanzania have been conducted, focusing on the health care providers and users of the services from the general community mainly from National Health Insurance Fund (NHIF) and Community Health Fund (CHF) beneficiaries. There are scanty literatures on social health insurance schemes, especially SHIB and those focusing on utilization of services provided by the scheme. More specifically, beneficiaries' perspective concerning factors affecting enrolment, awareness, the quality and accessibility of health services under social health insurance benefit have not been widely explored to give valuable insights and understanding the issues leading to the challenges being facing enrolment in SHIB.

1.3 Theoretical Framework

Figure 1: Theoretical Framework



Source: Adopted from Health Belief Model HBM) and modified by the researcher.

Health Belief Model is based on the understanding that a person will take a health related action when he/she perceives that there is benefit from that action. Contrary, in HBM there is perceived susceptibility whereby people will not change their health behaviors unless they believe that they are at risk. Therefore those who do not think that they are at risk of getting sick they are unlikely to join SHIB unless they are confronted with the disease which require specialized investigations or is very costly. Perceived barriers also contribute to low enrolment, for instance some employees belief that joining SHIB will result in the deductions of their monthly contributions, these barriers escalate the condition.

1.4 Rationale of the Study

The prospective study results which aim to explore the factors affecting enrolment of NSSF members into SHIB will help to inform decision makers and policy makers on the actions to improve enrollment of NSSF members in SHIB. From SHIB member's point of view, it's an opportunity to find out their experince about the services and whether the expected quality, efficiency and effectiveness are being met. From non-SHIB member's point of view, it's an opportunity to probe on the reasons for not being enrolling into SHIB services besides being provided freely without any other additional costs. The study also expected to generate new knowledge to help the Social Security Scheme on how to increase enrollment. The recommendations will also contribute towards further research on the area to explore SHIB and its enrollment trends.

1.5 Research Questions

This study aimed at exploring factors affecting enrollment in Social Health Insurance Benefit among employees in Dar es Salaam region. Specifically this study will answer the following questions:

(i.) What is the level of awareness among study participants on the services provided under Social Health Insurance Benefit?

(ii.) What are the perceptions of SHIB members on the quality of health services provided under the Social Health Insurance Benefit?

(iii.) What are the risk perceptions of non-SHIB members regarding enrollment in Social Health Insurance Benefit?

(iv.) What are the risk profiles of the study participants registered by National Social Security Fund?

1.6 Study Objectives

1.6.1 Broad Objective

To explore factors affecting enrollment in the Social Health Insurance Benefit scheme among National Social Security Fund members in Dar es Salaam.

1.6.2 Specific Objectives

(i.) To identify the level of awareness among study partcipants on the services provided under Social Health Insurance Benefit.

(ii.) To find out the perceptions of SHIB members on the quality of health services provided by Social Health Insurance Benefit.

(iii.) To explore the risk perceptions/aversions of non-SHIB members regarding enrollment in Social Health Insurance Benefit.

(iv.) To identify risk aversions profiles of study participants registered by National Social Security Fund.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Global Health Care Financing Mechanism

Globally, social health insurance started at work places and coverage gradually expanded to non-working parts of the population in all Social Health Insurance countries.[23]

Health financing in many Low and Middle Income Countries (LMIC) is characterized by high levels of out-of-pocket expenditure for serious illnesses leading to potentially catastrophic payment for health care among its citizens. [21] Financial constraints is one of the major barriers for access to healthcare in these countries for marginalized sections of society where health care expenditure is a major cause of impoverishment [22]

Apart from financial constraints, several low- and middle-income countries are interested in extending their existing health insurance for specific groups to eventually cover the bigger percentage of their populations. [6] This is the reason why this study was appealing to understand the factors negatively affecting enrollment in SHIB so as to improve the coverage to working parts that are not yet covered. Health financing systems through general taxation or through the development of social health insurance are generally recognized to be powerful methods to achieve universal coverage with adequate financial protection for all against healthcare costs. [41]

There are different insurance financing mechanism for health care, the most common ones includes: Tax funding, where the money to pay for health services comes from the general revenue of the government (sales taxes, income taxes, and import and export taxes). The second health financing mechanism is Social Health Insurance (SHI), where members pay a contribution based on their income to a health insurance agency, which purchases health services from either public or private facilities. The contribution is proportional to income, so that within the pool of Social Health Insurance members, the better-off subsidies lower income groups. Also, the healthy and young subsidize the sick and elderly. To avoid a high-risk pool, SHI is usually compulsory.[2]

The third mechanism is the Private health insurance, where people buy health insurance for themselves from private, for-profit insurance companies. These companies pay providers of health services for their members and charge their members' premiums according to their health risk status. As a consequence, the poor usually cannot afford private health insurance.[2]

Fourthly is the Community-based health insurance which entails local schemes that raise money from their members to pay for their health services.[2]

2.2 Health care financing in Tanzania

Tanzanian population receive health care services from government, Parastatal organizations, religious organizations, private practitioners, voluntary organizations and traditional medicine practitioners.[4] Tanzania Ministry of Health and Social Welfare oversees the administration of medical services throughout the country. Like in other LMIC the Tanzanian population which comprises of 17.8 million labour forces, of whom 2.5 per cent are employed by government and parastatal institutions faces the financial constraints potentially for financing health care services.[8]

Achieving better health care financing is still a challenge in most of developing countries, including Tanzania because of limited resources available to support the health systems. These demands result from growth in the communicable and non-communicable diseases burden as well as emerging and re-emerging diseases. Furthermore, the costs for health interventions are increasing. Over time, the health sector has registered an increase in public health per capita spending, from US$5.80 in 2008 to US$11.00 in 2009.[4]

To overcome the existing problems related to health care financing, the Government of Tanzania developed a number of strategies, including cost sharing and pre-payment schemes such as National Health Insurance Fund (NHIF), the Community Health Fund and Social Health Insurance Benefit (SHIB). These strategies enhanced complementary financing without increasing direct funding from the government.[4]

In the view of that, the government of Tanzania is emphasizes to improve coverage of health insurance schemes while minimizing the use of out-of-pocket expenditure among communities and it would like to increase social health insurance coverage as a strategy to achieve universal coverage. To this end, the government of Tanzania set a target of enrolling 45 percent of the population in pre-payment schemes by 2015 [40]. This is still far reached target, because the current coverage stands at 10 percent of the whole Tanzanian population. [36]

2.3 Voluntary Membership versus Compulsory Membership

Enrollment of SHI among social security schemes members in some countries such as Democratic Republic of Congo (DRC) is compulsory for all formal workers,[2] this is different from NSSF SHIB in Tanzania where registration is still voluntary, thus the question of enrollment becomes an interesting area for investigation. The expected results of this study will diversify insights for influencing policy environment to promote voluntary membership or total shift towards compulsory SHI membership.

Studies regarding social health insurance in Tanzania have been done mainly on CHF; hence there is minimum field experience gathered particularly on SHIB enrollment. This call for more scientific methods to examine the issues associated with barriers towards universal health coverage.

2.4 Concept of Health Insurance

The available literature conclude that, the concept of health insurance is poorly understood amongst community members in Tanzania [28] and therefore requires sound evaluation of the underlying causes, since low level of knowledge has been found to directly impact SHI enrollment.

A recent study conducted in DRC on Employees' perceptions regarding social health insurance strongly recommended educating employees about the introduction of SHI across the workforce spectrum[2] could address low SHI enrollment issue. In the same study, they found out that many of the employees were less knowledgeable despite many having

high academic qualifications. This fact will not be taken for granted since this study has been designed to assess socio demographics characteristics of NSSF members.

2.5 SHIB and Enrolment in Tanzania

Signing up for SHIB under NSSF – Tanzania is a separate and voluntary procedure regardless whether an individual is a NSSF registered member.[36] This is not user friendly procedure instead acts as barriers to enrolment in SHIB because registering new NSSF members doesn't go together with registering new SHIB members. This is due to two main reasons, one being the fact that a new member has to wait for three months before joining SHIB as one of the present qualifying condition to join SHIB and the other reason being voluntarily membership.

The Tanzania Health System Assessment Report (2010) appreciated several other reasons why NSSF has registered fewer members in SHIB. Such reasons included: insufficient public information, limited access to accredited facilities and same members are entitled by private health insurance. However, this assessment directly interviewed the NSSF members who are SHIB enrolled and it was also designed to collect data from non SHIB members, document review and consultations to gather some of these facts.

Furthermore accredited health facilities are increasing annually and NSSF members are also increasing, but SHIB members are increasing in low pace, these are operational gaps which need to be addressed by doing researches such as this. The researchers identified and provided the facts which will help to fill the gaps and provide new knowledge for other researchers to perform in the future.

2.7 Selection of Providers and Quality of Service.

In DRC, majority of employees indicated that when they were sick they preferred to go to private hospitals rather than public hospital[2]. This is a result of better services provided by the private health sector. There is a similar situation Tanzania.

NSSF Tanzania has accredited many private health facilities than public health facilities, yet members are not encouraged to make use of the private accredited facilities.

In a qualitative study done in Dar- es- Salaam to examine service provider's perceptions of the quality and accessibility of health services under National Health Insurance Fund (NHIF), [42] the study results recognized long waiting time and lack of drugs and fewer accredited health facilities negatively affect the quality of services. This hinders enrollment in SHI because members are not receiving the quality of service to their expectation. However, this study also realizes the importance of examining perception of quality on the side of the social health insurance beneficiaries.

2.8 SHIB Enrolment and Contribution

There is wide spread of anecdotal information among NSSF members that enrolling in SHIB will results into deduction of their contributions hence reducing their pension benefit. This anecdotal information is considered to be reliably explaining the perceived barrier towards SHIB enrollment.

Among other objectives this study seeks to explore how employees perceive their health risks that inhibit their willingness to enroll in SHIB voluntarily. In support to this fact, a famous health belief model which emphasizes that a person may hesitate to undertake a certain action if more risks are perceived than benefits.[39] Likewise in SHIB, members perceive that utilizing SHIB services while they are still working may result in reduction of their pension savings. This is possibly attributed by low awareness on the facts related to SHIB caused by insufficient public information.[36]It has also been found that both private and public sector employees have same trend of enrolment in SHI, this was reported in the study done in DRC[2]

Apparently, many countries in East Africa region are offering SHI either through their NHIF or substantially independent social insurance organs, but the case of NSSF Tanzania, this benefit is directly offered by the scheme and it has remained voluntary. Thus carrying study out will contribute to the available literature claimed to be least and more focusing on other models of health care financing such as CHF and leave out SHIB particularly provided by social security funds.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter presents the study area and setting, study design, study population, sample size, sampling procedure, data collection tool and pre testing, recruitment and training of research assistant, variables, data collection procedure, data management and analysis, ethical considerations and limitations of the study.

3.2 Study Design

This study was an explorative cross sectional study using quantitative data collection methods. The design was selected for this study as it was intended to explore factors affecting enrolment in Social Health Insurance Benefit. It involved two sub-sets of the respondents namely SHIB and non-SHIB members. Basically, the study type was chosen to reduce costs and time because data were collected once.

3.3 Study Area and Setting

The study was conducted in Dar-es-Salaam city which is administratively divided in three municipal authorities; Temeke, Ilala and Kinondoni. Dar es Salaam is the largest economic and capital city of Tanzania. [25] Dar es Salaam was selected as the study area due to the fact that the city provides large number of formal and informal employment opportunities, and over 40 % of the NSSF members are found in Dar es Salaam.

3.4 Study Population

This study involved respondents from public and private sector organizations. From the selected organizations participants aged between 18 and 60 years who are the registered members of NSSF were involved in the study.

3.5 Sample Size

The sample size in this study was obtained from the single proportion formula. The formula was chosen so as to be able to adjust the sample size to the affordable level. Also

there was little information available collected through cross sectional survey conducted on outcome variable. The estimated proportion (p) is 15%, the margin of error on p estimated as 4% and considered at 95% confidence level.

$$n = \frac{z^2 p(100-p)}{\varepsilon^2}$$

$$\frac{1.96^2\ 15(100-15)}{4^2} = 306$$

n= the maximum of number of subjects required in the sample

P= proportional of employees not enrolled in Social Health Insurance Benefit

Z= the standard normal deviate that corresponds to 5% level of statistical significant is 1.96

E= maximum error of the study assigned a value of 4% to achive the desired level of precision

(i.) Non response rate 7%

(ii.) Setting the margin of error on p as 4% and considering a 95% confidence level in the estimate of the proportion of NSSF member who are not enrolled, and adding 7% of non response rate, the above formula yields a minimum required sample size of 327 employees who were members of NSSF.

3.6 Sampling Procedure

This study employed probability sampling and multistage to select the organization and to select study respondents.

(a.) Multi Stage Sampling

(i.) Three lists of NSSF members were drawn from NSSF registered organizations with more than 50 members from each region Temeke, Ilala and Kinondoni.

(ii.) From each of the three lists, five organizations were randomly selected to make a total of 15 organisations.

(b.) Random Sampling

Simple random sampling was performed in each sampled organizations, lotary method was used to obtain 7 SHIB members and 15 Non SHIB members to participate in the study. Both sub samples add to make total of 327 interviewees.

Non SHIB members were oversampled compared to SHIB members. This was done so as to take into consideration the fact that Non SHIB members were many in number in each organization.

3.7 Data Collection Tool and Pre Testing

Structured self administered questionnaire was designed to elicit information from respondents. The study had two questionnaires; the questionnaire for SHIB members which comprises of 31 questions and the one for non-SHIB members which had a total of 43 questions.

All questionnaires were divided into two main sections. Section one for both questionnaires collected the respondents' socio demographic informations such as age, sex, marital status, district of residence and education level. Section two for SHIB members' questionnaire had set of questions specifically enquiring about quality and egibility of SHIB services, behavioral risks profiles and risk perceptions/aversions of respondents on their monthly contributions. Section two for non-SHIB was purposely desgined to probe on why members hesitate to join SHIB.

All questions were translated from English to Kiswahili and re-translated to ensure consistency was maintained.

The questionnaires were pre tested in Kibaha town of Pwani region. This step helped to improve the tool. The responses were evaluated and used to modify the questions to suit the objectives of the study.

3.8 Recruitment and Training of Research Assistants

Two research assistants were recruited to assist in data collection. Research assistants were trained for two days prior to the exercise of data collection. They were trained on objectives of the study, confidentiality, how to administer verbal consent, and how to conduct interviews and recording responses. The emphasis was made on completeness of the questionnaires and approapriate recording of the responses based on the codes.

3.9 Study Variables

Dependent Variable;

Enrollment of NSSF members in Social Health Insurance Benefit

Independent Variables

(i.) Study participants' level of awareness regarding SHIB

(ii.) Quality of health care services perceptions among SHIB members

(iii.) Non-SHIB members' risk perceptions/aversions regarding enrollment into SHIB

(iv.) Socio demographic characteristics (age, sex ,marital status and education level)

(v.) Risk aversions profiles of the study participants.

3.10 Data Collection Procedure

The Management in each of the sampled organisation was officially informed of the research activities prior to the data collection. The researcher and team of assistants in collaboration with respective employers developed a schedule for each organization.

In each organization, respondendents and the researchers sat in a room to fill in the questionnaires. The respondents filled in the questionnaires in the presence of the researchers.

Every respondent who consented to participate in the study was assured of confidentiality and privacy of the information filled in the questionnaire. The actual data collection was done by the researcher with the assistance of two research assistants. The principal Researcher was also responsible to ensure responses were correctly filled in questionnaires and accurately coded.

The Researcher reviewed all the questionnaires collected by research Assistant in each day before the team left the field. Completed questionnaires were collected on the same day after the researcher and the team have reviewed again all the questions for accuracy and consistency.

Study participants were approached by the study team for one to one interaction. The Information about the study was provided to the respondents prior to filling of the self admistred questionnaire. It was estimated that filling of the questionnaire took 10-20 minutes, depending on the ability of the respondent to comprehend questions. However, all the filled questionnaires were submitted by the research assistants to the principal researcher on the daily basis.

The Research Assistants made sure that every participant signed the consent form. They were also there to oversee the filling of the questionnaires to make clarifications to the issues or questions that participants encountered some difficulties, including the notes of the open ended questions or any extra information provided by the participant. Data collection was done for six weeks December 2012 and January 2013.

3.11 Data Management and Analysis

All questionnaires were read to sort out the information collected. Then the data were entered in the computerized Microsoft excel data master sheet and then cross-checked for errors and coding before being analyzed by using Statistical Package for Social Scientists, SPSS version 21 which present quantitative descriptions of data in manageable form. Data was presented using frequency tables and cross tabulations. The significance level of 0.05 (that is $p< 0.05$) was used to determine the significance of association being examined. All raw data were kept under researcher custodian untill the end of the research.

Frequency tables were developed to check for completeness of the responses. Thereafter key variable were identified and cross- tabs were made. The dependent variable was cross-tabbed with different variables. Statistical test were perfomed on the required cross-tabs.

3.11.1 Ethical Considerations

Ethical issues such as informed consent, anonymity, confidentiality, actions and competence of researchers, release of findings and accountability [12, 43, 44] were adhered to. Informed consent was obtained when all possible or adequate information on the goal of the study, the procedures that was followed, the possible advantages and the disadvantages and dangers to which the respondent may be exposed have been explained to the participants [44]. Informed consent were sought by explaining the purpose of the study, the expected value of the study and the importance of the participants' contribution by taking part in the study, before asking them to fill in a consent form (see Appendix I). It is worth noting that certain prospective participants may wary of signing a consent form for fear of implications regarding whatever they choose to disclose in their interview. We assured them that anonymity was maintained.

Respondents were allowed to ask questions regarding SHIB enrollment procedures and regulations of which the researcher considers that to be one of the benefits to the respondents.

The information obtained during data gathering was only be seen by the researcher, supervisors and the independent coder. Full permission and ethical clearance was obtained from MUHAS. Permission was also obtained from the heads or directors of private and pubic organizations involved in this study.

3.11.2 Limitations of the Study

Sample size was randomly selected in organisations found in Dar es Salaam. Basing on one region selection, not random to all organisations available in Tanzania, thus the results can not be genaralised in all organmisations found in Tanzania.

CHAPTER FOUR

4.0 STUDY FINDINGS

4.1 Socio Demographic Characteristics of the Study Participants

A total of 327 participants were interviewed. Out of the total participants 241 (73.70%) were males and 86 (26.30%) were females. Non-SHIB members were 225 (68.8%) and SHIB members were 102 (31.2%). Over 60% (199) of them had secondary education and more. The age of respondents ranged between 18 to 51+ years of age. The number of participants ranged between 29 and 39 years of age was not significantly different among non-SHIB members (47.0%) compared to SHIB members (46.1%). (Table1).

Table 1: Socio-Demographic Characteristics of Study Participants

Variable	Non- SHIB N (225)		SHIB N (102)	
	N	(%)	N	(%)
SEX				
Male	174	(77.3)	67	(65.7)
Female	51	(22.7)	35	(34.3)
AGE				
18-28	64	(28.4)	19	(18.6)
29-39	106	(47.1)	47	(46.1)
40-50	42	(18.7)	32	(31.4)
51+	13	(5.8)	4	(3.9)
EDUCATION				
Primary school	88	(39.1)	40	(39.2)
Secondary school	75	(33.3)	25	(24.5)
Secondary and above	62	(27.6)	37	(36.3)

4.2 Non-SHIB employees awareness on Benefit Package provided by SHIB scheme

Table 2 shows the relationship between Non-SHIB members' socio demographic characteristics and awareness on services provided by SHIB among those who had heard about health insurance. The result shows a significant number of men 83(81.4%) were not aware of the Benefit Package provided by SHIB as compared with women 19(18.6%). Among all age groups, those who had 29-39 years of age were more aware 63(51.4) compared to all other age groups. Furthermore as the level of education decreases, awareness on SHIB services also decreases among participants reported not had heard about health insurance.This was shown by participants having primary education 40(39.2%), secondary education 39(38.2%) and above secondary education 29(22.5%). (Table 2)

Table 2: Non-SHIB respondents' awareness on services provided by SHIB scheme

Variable	Yes		No		p-value
	N	(%)	N	(%)	
SEX					
Male	91	(74.0)	83	(81.4)	
Female	32	(26.0)	19	(18.6)	0.204
AGE					
18-28	32	(26.0)	32	(31.4)	
29-39	63	(51.4)	43	(42.2)	
40-50	21	(17.1)	21	(20.6)	0.592
51+	7	(5.7)	6	(5.9)	
EDUCATION					
Primary school	48	(39.0)	40	(39.2)	
Secondary school	36	(29.3)	39	(38.2)	0.218
Secondary and above	39	(31.7)	29	(22.5)	

The level of awareness was further explored to understand participants' awareness of services provided by SHIB. More than a half 121 (53.8 %) of the Non-SHIB members were not know who pays for the medical bills for SHIB services. The results shows one third 68 (30.2%) of the Non-SHIB members thought that, joining SHIB required permission from their employers, which is not the case. (Table 3)

Table 3: Study Participants' awareness on Services provided by SHIB

Variable	Non- SHIB		SHIB		p-value
	N	(%)	N	(%)	
Who pays medical bill for SHIB?					
Employer	8	(3.6)	7	(6.9)	
Government	1	(0.4)	1	(1.0)	
Employee	17	(7.6)	13	(12.7)	
NSSF	78	(34.7)	78	(76.5)	
I don't know	121	(53.8)	3	(2.9)	
What are requirement in joining SHIB?					
Being NSSF member for at least three months	95	(42.2)	76	(74.5)	
Money to pay for the services	19	(8.4)	7	(6.9)	
Employers permission	68	(30.2)	-		
Its NSSF who select the members	9	(4.0)	4	(3.9)	
Being a member for one year	34	(15.1)	15	(14.7)	**0.000**

4.3 Perceptions of SHIB members on the quality of health services provided by SHIB

Participants were asked to provide opinions on their levels of satisfaction of health services; accessibility to health services provided by SHIBs' accredited health facilities; availability and adequancy supply of medicines and medical supplies provided by SHIB accredited health facilities of their choices.

About 39 (38.2%) of the participants reported that they were not satisified with the health services provided by accredited SHIB health care facilities.This was pronounced more among males 19 (73.1%) while only 7 (26.9%) among females reported that they were not satisfied with services provided by SHIB accredited health care facilities.

Study participants both male 35 (62.5%) and female 21 (37.5%) reported that; they easily accessed the SHIB accredited health care providers. Regarding drugs and medical supplies, 27 (79.2%) of males and 7(20.6%) of females participants strongly disagreed that the accredited health care facilities provide adequate supply of medicines. (Table 4)

Table 4: Opinion on satisfaction, accessibility, and supplies of medicines among SHIB members by Sex

Are you satisified with health services offered by accredited health care facilities	**Male**	**Female**	**p-value**
	N (%)	**N (%)**	
1.Strongly disagree	8 (11.9)	5(3.9)	
2.Disagree	19 (28.4)	7(19.4)	
3.Don't know	10(14.9)	8(22.2)	
4.Agree	29(43.3)	15(41.7)	
5.Strongly agree	1(1.5)	1(2.8)	0.722
Does your current SHIB accredited health facility easily accessible?			
1.Strongly disagree	1 (1.5)	1(2.9)	
2.Disagree	20(29.9)	5 (14.3)	
3.Don't know	9(13.4)	8(22.9)	
4.Agree	35(52.2)	21(60.0)	
5.Strongly agree	2 (3.0)	0 (0.0)	0.286
Does your current SHIB accredited health facility provide adequate supply of medicine?			
1.Strongly disagree	27(40.3)	7(20.0)	
2.Disagree	8(11.9)	11(31.4)	
3.Don't know	12(17.9)	5(14.3)	
4.Agree	19(28.4)	12(34.3)	
5.Strongly agree	1(1.5)	0(0.0)	

Table 5: Perceptions on the quality of health services provided by SHIB Accredited health care facilities among SHIB members

Do SHIB providers meet your expectations - N (%)		**Mean**	**SD**
1.Strong disagree	13 (12.7)	2.4	1.56
2.Disagree	26(25.5)		
3.Don't know	18 (17.6)		
4.Agree	44(43.1)		
5.Strongly agree	1(1.1)		
Do you get required drugs in those facilities - N (%)		**Mean**	**SD**
1.Strong disagree	34 (33.1)	2.87	1.55
2.Disagree	19 (18.6)		
3.Don't know	17 (16.7)		
4.Agree	31 (30.4)		
5.Strongly agree	1(1.0)		

4.4 Employees' risk perceptions/aversions regarding enrollment in SHIB among Non – SHIB members

About 58(43.0%) of the participants who had heard about health insurance reported that they feared the deductions of their monthly contributions to cover SHIB medical bills if they had joined SHIB. Furthermore, about 34(37.8%) of the respondents who had not heard about health insurance expressed the same fear.

Table 4 shows that 43(31.95%) of respondents who had heard about health insurance were of the understanding that joining SHIB takes long.Furthermore, about 36(40.0%) of the participants who had not heard about health insurance expressed similar understandings.(Table 6)

Table 6: Risk perception among Non-SHIB members regarding enrollment in SHIB

Risk perception	Heard health insurance	Not heard health insurance	p-value
My NSSF contribution will be deducted if I become a SHIB member?			
	N (%)	**N (%)**	
1.Strongly disagree	17 (12.6)	16 (17.8)	
2.Dis-agree	41 (30.4)	26 (28.9)	
3.Don't know	1 (0.7)	2 (2.2)	0.705
4.Agree	58 (43.0)	34 (37.8)	
5.Strongly agree	18 (13.3)	12 (13.3)	
Dou you think joining SHIB takes long?			
	N (%)	**N (%)**	
1.Strongly disagree	13 (9.6)	8 (8.9)	
2.Dis-agree	41 (30.4)	15 (16.7)	
3.Don't know	11 (8.1)	11 (12.3)	0.221
4.Agree	43 (31.9)	36 (40.0)	
5.Strongly agree	27 (20.0)	20 (22.2)	

4.4.1 Risk perception/Aversion for joining SHIB among Non-SHIB members

Non-SHIB respondents were asked as to why they had not joined the SHIB scheme.

Fear of paying medical bills from their NSSF monthly contributions was expressed among males 60 (75%) which was three times higher than that of females 20(25%). Such fear was more reported among Non-SHIB partipants aged 29-39 [40(50.0%)]. Results also show that as the age increases the fear decreases. Also fear of paying medical bills from their NSSF monthly contributions increased with decresed level of education; above secondary education were 18(22.5%), secondary education were 24(30.0%) and primary education were 38(47.5%). (Table 7)

Table 7 also shows that male 37(71.2%) participants who reported to have no time to undergo registration processes was three times higher than that of female respondents [15(28.8%)].The table further shows that male 38(82.6%) Non-SHIB participants who reported that they are not joining SHIB due to associated registration costs were four times higher than of female respondents 8(17.4) participants. The results also show that there was statistical significant association between participants education level (p=0.002) and reasons for not joining SHIB.These reasons include fear of paying medical bills from their NSSF monthly contributions,no time to accomplish registration processes, associated registration cost, difficult to get registration requirement and use of other health insurance. (Table 7)

Table 7: Reasons for not joining SHIB by Socio-demographic characteristics

	Reasons for not joining					
	Fear of paying medical bills from their monthly contributions.	**No time to accomplish registration.**	**Associated registration cost**	**Difficult to get registration requirement**	**Use other health insurance**	**P-value**
SEX						
Male	60(75.0)	37(71.2)	38(82.6)	36(87.8)	3(50.0)	
Female	20(25.0)	15(28.8)	8(17.4)	5(12.2)	3(50.0)	0.124
AGE						
18-28	22 (27.5)	16 (30.8)	10 (21.7)	14(34.1)	2(33.3)	
29-39	40 (50.0)	20 (38.5)	28(60.9)	15(36.6)	3(50.0)	
40-50	13 (16.3)	12 (23.0)	6(13.1)	10 (24.4)	1(16.7)	
51+	5(6.2)	4 (7.7)	2(4.3)	2(4.9)	0 (0.0)	0.754
EDUCATION						
Primary school	38(47.5)	15(28.8)	15(32.6)	20(48.8)	0(0.0)	
Secondary school	24(30.0)	15(28.8)	22(47.8)	13(31.7)	1(16.7)	0.002**
Secondary and above	18(22.5)	22(42.3)	9(19.6)	8(19.5)	5(83.3)	

*Note' ** means statistically significant at p<0.002*

Figure 2: Risk Aversion Profiles Of Non SHIB Members Who Have Heard or Not Heard About Health Insurance

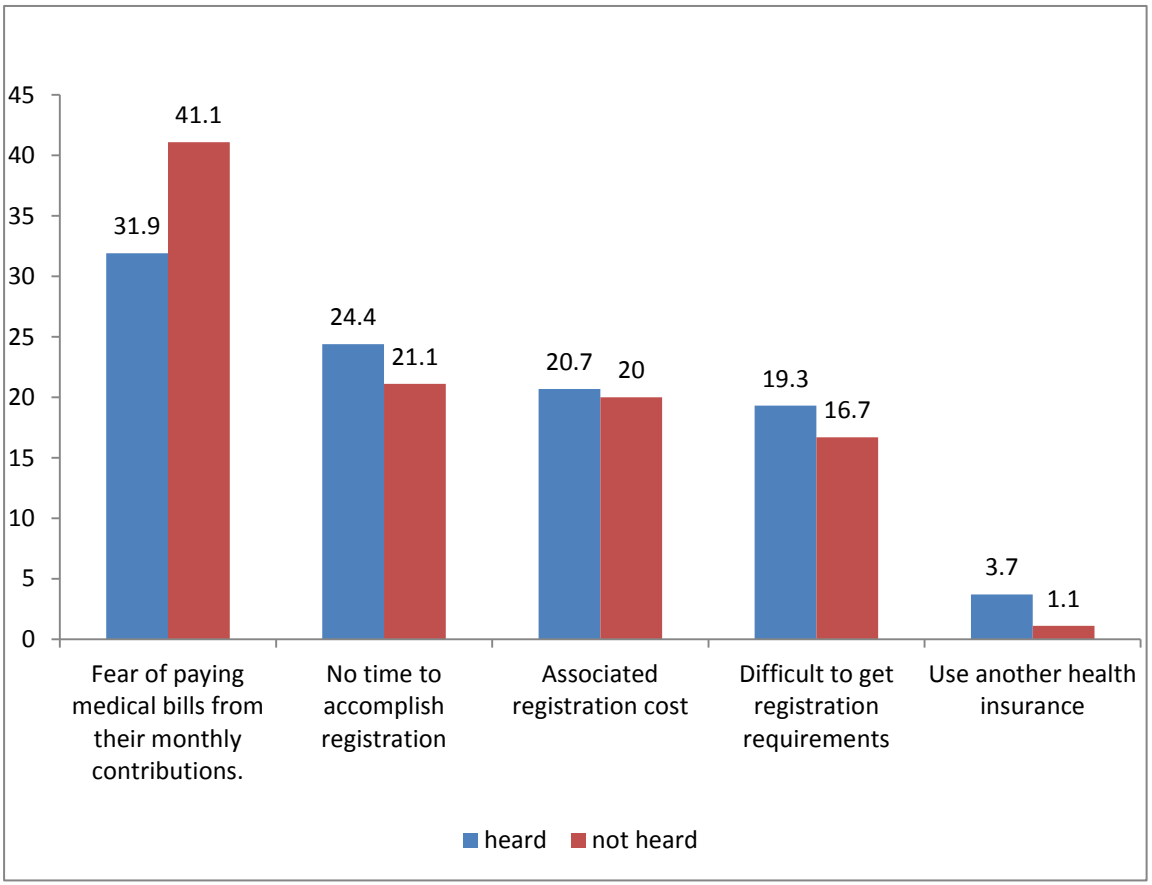
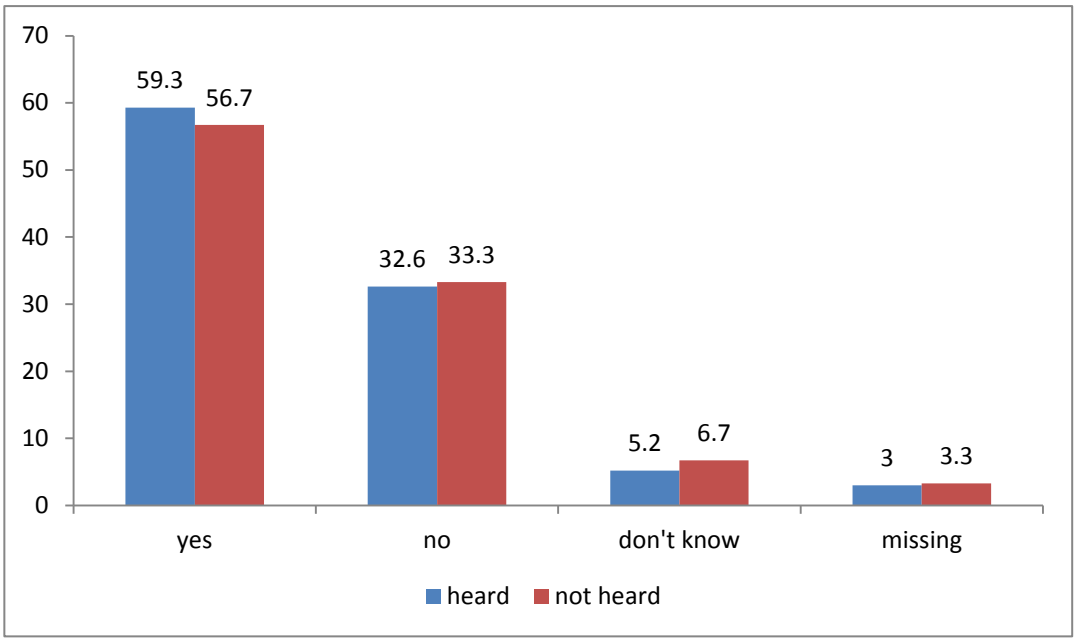


Figure 2 summarises the reasons contributing to poor enrollment into SHIB scheme among Non-SHIB members. The results shows that majority of participants (31.85%) among those who had heard of health insurance and 41.1% of those who had not heard about health insurance had a misconception of how the SHIB medical bills are paid and wrongly reported of their contributions to be deducted to cover SHIB medical bills, since they thought medical bills were to be paid from deductions of their monthly NSSF contributions.

Other reasons mentioned by respondents were; they did not have enough time to accomplish registration procedures; difficult procedures of enrollment; associated registration cost during registration. These were equally mentioned by all Non SHIB members (about 33%). (Figure 3)

Figure 3: Non-SHIB responses on whether NSSF contribution deducted to cover SHIB services



Furthermore, figure 3 also shows that 59.3% of those who had heard about health insurance and 56.7% of those who had never heard about health insurance feared NSSF monthly contributions would be deducted to cover SHIB medical bills.

4.5 Risk aversions profiles among Non-SHIB employees who are members of NSSF

Non-SHIB participant were asked if they knew who would pay their medical bills if they were to join SHIB.

Table 8 shows a total 81 (60.0%) of those who had heard about health insurance and 64(71.1%) of those who had never heard about health insurance reported that SHIB medical bills were paid by the Government which is not the case.

Frequency of falling sick in the last three months prior the interview as a risk factor for one to be willing to join SHIB was reported by those who had heard about health insurance 84 (62.2%) and those had never heard about health insurance 54(60%) reported to had felt sick within three months prior the interview. However, 87(64.4 %) of those who had heard about health insurance and 62 (68.9%) who had never heard about health insurance were

paying their medical bills from out of their pockets. Over 20% of the partcipants reported to have lost their relatives because they once failed to pay for the medical bills.

Suprisingly, many of the participants 106(78.5%) who are aware of health insurance and 81(90.0%) who had never heard about health insurance reported to have no any extra source of income, still couldn't see the reason for joining SHIB to reduce the burden of health care costs.

Moreover, many of the participants 79 (58.5%) who are aware of health insurance and 51(56.7) who had never head about health insurance reported to not doing physical exercises. Majority of the respondents, 87(64.4%) those who had heard about health insurance and 62(68.9) who had never heard about health insurance were paying medical bill through out pocket but still couldn't see the reasons for enrolment. Table 8

Table 8: Risk profiles of study participants who are members of NSSF among Non-SHIB members.

	Heard health insurance		Not heard health insurance		p-value
	N	**(%)**	**N**	**(%)**	
Who pays medical bills for SHIB?					
Employer	30	(22.2)	22	(24.4)	0.024
Government	81	(60)	64	(71.1)	
Member itself	13	(9.6)	1	(1.1)	
NSSF	11	(8.2)	3	(3.3)	
Times attended medical service in the last 3 months					
1 - 2 times	84	(62.2)	54	(60)	0.932
3 times or more	26	(19.3)	19	(21.1)	
Not attended	25	(18.5)	17	(18.9)	
How do you pay for medical bill					
Cash	87	(64.4)	62	(68.9)	0.007
NHIF	16	(11.9)	2	(2.2)	
Contribute to the cost	17	(12.6)	21	(23.3)	
Free	15	(11.1)	5	(5.6)	
Is any relative died because failed to pay medical bill					
No	70	(77.8)	103	(76.3)	0.796
Yes	20	(22.2)	32	(23.7)	
Do you have extra source of income					
No	106	(78.5)	81	(90)	0.024
Yes	29	(21.5)	9	(10)	
Do you do physical exercise?					
No	79	(58.5)	51	(56.7)	0.783
Yes	56	(41.5)	39	(43.3)	
History of chronic disease in the family					
No	104	(77)	73	(81.1)	0.465
Yes	31	(23)	17	(18.9)	

4.6 Risk factors regarding enrollment among SHIB members and Non-SHIB members

SHIB members and Non-SHIB respondents were asked to report what they perceived to be their personal health risks which affect their enrollment. About 93.3% of Non-SHIB members were not smoking thus risk originated from cigarrete smoking was very low. Among SHIB members, the results shows 85.3% did not smoke cigarrates. A few participants were taking alcohol 42 (18.7%) among Non-SHIB respondents and 33 (32.4%) SHIB members. More than a half of the study participants were not performing physical exercise were 131 (58.2%) among SHIB members, for the Non-SHIB respondents were 53 (52.2%). The risk of chronic disease in the families was low in both SHIB members 48 (21.3%) and Non-SHIB members 25 (24.5%). (Table 9)

Table 9: Risk factors regarding enrollment among SHIB members and Non-SHIB members

	Non-SHIB			**SHIB**		
Risk factors	Yes	No	p-value	Yes	No	p-value
	N (%)	N (%)		N (%)	N (%)	
Do you smoke ciggarrates?	15 (6.7)	210(93.3)		15(14.7)	87(85.3)	
Do you drink alcohol?	42(18.7)	183(81.3)		33(32.4)	69(67.6)	
Do you perform physical exercise regularly?	94 (41.8)	131(58.2)		49 (48.0)	53(52.0)	

This study conducted in Dar es Salaam explored factors affecting enrollment in SHIB among employees who are NSSF members. The results shows that majority of the respondents not only were not aware of the benefit package provided by SHIB, but also hesitate to join SHIB scheme fearing their Social Security monthly contributions would be deducted to cover SHIB medical bills.

CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

In this chapter, key study findings are elaborated to create meangiful insight of the knowledge which is genarated by this study. The discussion also interprates the study results to respond to the study questions which broadly wanted to explore factors affecting enrollent of NSSF members into SHIB scheme.

5.2 Employees, awareness on the benefit package provided by Health Insurance among Non-SHIB respondents

The GOT has made health a prority sector and demonstrates its commitment by annually increasing the amount of funding provided to the MOHSW. A move toward universal coverage and social health insurance is a core element of the government's health financing policy. Besides all the efforts done by the MOHSW to increase the fund annually still the issue of attaining 45% of Tanzanian population to be covered by Health Insurance by 2015 is far reaching goal.

Currently, Dar es Salaam has nearly 242,624 of NSSF members but only 3962 (1.6%) are enrolled in SHIB scheme, this characteristic comforms to the study results which observed only 2 % of NSSF members were registered into SHIB countrywide.

The result shows that majority of the participants were not aware of the benefit package and SHIB services entitled to NSSF members. Awareness on SHIB benefit package decreases with the decrease in education level of the respondents. This finding forms strong convictions that the more people become educated the more likely to understand SHIB benefit package hence increases enrolment. In health economic perspectives where the question of equity and making access to better health care services are universal agenda, thus the health insurance schemes should concern of the people with least education who are basically constitute large part of the population. A study conducted in DRC (2010) on Employees' perceptions regarding social health insurance strongly

recommended educating employees about the introduction of SHI across the workforce spectrum2 could address low SHI enrollment. In the same study, they found many of the employees were less knowledgeable despite many having high academic qualifications.

Reaching out more women in the sensitization of SHIB seems to be a promising investment since the results shows, 35 (34.3%) women were registered members of SHIB. The findings suggest that, new initiatives for reaching women are an opportunity need to be creatively taped.

More than a half of Non-SHIB respondents' don not knew who pays for the medical bills for SHIB services. This strongly suggests a need of introducing and implementing new marketing strategies. Also the development of EIC materials and the use of media and social networks including door to door campaigns should be a priority when marketing SHIB benefit package and other benefits provided by NSSF to its members. Suprisingly one third of the Non–SHIB members were of opinion that, they require permission from their employers to enroll into SHIB; this implies that, members are least informed about the benefit. These calls for the well designed cascade education session to ensure employers are also well informed to help their employees to rapidly enroll into SHIB. Educating employers about SHIB does not only speed up members to enroll into SHIB but also will reduce the cost of health care financing to employers.

5.3 Perception of SHIB members on the quality of health services provided by SHIB

This study speculated quality of health care services offered by SHIB accredited health care facilities. Level of satisfaction on services provided by accredited health care providers among members of SHIB was gauged and was found to be low for both males and females.

Although SHIB re emburse its medical bills through a pre payment method know as capitation, it was unfortunately found that SHIB members reported inadequace supply of medicines. The issues of frequently stocks out of medications have also been reported in Mara region. Interviewees suggest that the drug stock could be managed more effectively, if staff were well trained. For example, according to interviewees, over-prescribing to

NHIF patient occurs. Additionally, the staff dispensing drugs often are unqualified to do so, and thus do not know how to use generic medication in place of brand–name versions.36

Access to health care service was enquired among SHIB members; the results showed members were enjoying easy access to SHIB accredited health facilities. The present level of accesibility in terms of geographical coverage should be regarded as potential opportunity for the NSSF to improve other key components of quality of services.

5.4 Risk perception of partipants regarding enrollment in SHIB among Non – SHIB members

This study came out with number of reasons which were perceived as risk aversion for the NSSF members attributing them to refrain from recruiting into SHIB scheme. Study participants 58 (43.0%) who had heard about health insurance and 34 (37.8%) never heard about health insurance feared about deduction of their monthly contributions to re emburse for SHIB medical bills.

Others participants reported that, SHIB joining process takes long, thus many of them are often occupied at their work stations so they can not afford to go out to the NSSF offices to accomplish the registration processes. The finding calls for an altenative ways for the NSSF to take closer the registration process to where the members are spending most of their day time.

Fear of deduction of their NSSF monthly contributions to re emburse SHIB medical bills increased with decreased level of education. The results showed that, 59.26 % who had heard about health insurance and 56.67% those never heard about health insurance feared NSSF monthly contributions would be deducted to cover SHIB medical bills.

Despite being aware or not regarding the health insurance benefits, higher numbers of the participants were carrying a misconception about deduction of their NSSF monthly contribution to re emburse for SHIB medical bills. This risk aversion contributes much in low enrollment into SHIB among NSSF members.

Other reasons were; no enough time to accomplish registration procedures, difficult procedures of enrollment, associated registration cost were almost having the same percentange among the partcipants.

5.5 Risk Aversion profile of employees versus Health Insurance Enrollment

Despite having health risks members of NSSF have continued be reluctant to join SHIB as a way to minimize helath care costs. Reasons such as frequency of falling sick in the last three months was also observed to be risk factor as 84 (62.2%) felt sick 1-2 times within three months prior the interview. Similar observation 54 (60%) was noted in those who never heard about health insurance. However, 87 (64.4 %) for those who heard about health insurance and 62 (68.9%) those who have not heard about health insurance reported paying their medical bills through out of pocket.

Over 20% of the partcipants reported to have lost their relatives because they once failed to pay for the medical bills. Majority of the participants reported not doing physical exercise. This sedentary life increases their risks of acquiring non communicable diseases which are currently increasing in Sub Saharan Africa.

Majority of the respondents reported to have no extra source of income. This implies that they depend on monthly salaries. Despite not having an extra source of income; majority of the respondents reported to pay medical bills out pocket, but still couldn't see the reasons for enrollment.

Generally the study looked on factors affecting enrolment in SHIB. The fear of being deducted their NSSF monthly contributions and un awareness on the benefits was the main gaps identified. Respondent's bias was observed since the self administered questionnaires were given only participants found in Dar es Salaam. The biases were minimized by selecting study participants randomly.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

This chapter present conclusion and recomandations of the study.

6.1 Conclusion

Conclusion of this study is as follows;

Currently NSSF-SHIB has been in place for more than 8 years. The issue of low enrollment have been reported since SHIB conception. This low enrollment have been caused by two major reasons among other factors; Firstly, fear of NSSF members to be deducted their NSSF monthly contributions to re emburse for SHIB medical bills have been reported by majority of the participants. Secondly the respondents reported not to be aware of the benefit package and services provided by SHIB.

Other factors include; in adequate supply of medicines, difficulty registration processes, no time to accomplish registration processes, and associated registration costs.

Besides all hinderances contributing to low enrollment, SHIB members reported easy accesible of accredited medical providers.

Secondly, the key factors attributing to the low enrollment of NSSF members need to be continously evaluated as "supply" as NSSF and the "demand" side as NSSF members to build knowledge that would sustain the quality of the SHIB services.

6.2 Recommendations

6.2.1 Recommendations to the National Social Security Fund of Tanzania

(i.) Because respondents were unaware of the benefits of SHIB, then NSSF should take the liberty, educating their members on SHIB benefits in all working places that NSSF has members.

(ii.) More studies should be conducted to find a way of increasing awareness on the benefit.

REFERENCES

1. Report on Medicines Coverage and Health Insurance Programs Survey in Tanzania, 2008.

2. Kayiba T. and Rankhumise E.M. "Employees' perceptions regarding social health insurance: A case of Kinshasa, Democratic Republic of Congo," 2010.

3. Carrin G, "Social health insurance in developing countries: a continuing challenge." Int. Soc. Sec. Rev., 55(2):57-69, 2002.

4. National Bureau of Statistics, Dar es salaam, Tanzania, "Tanzania Demographic and Health Survey," 2010.

5. National Social Security Fund Tanzania, "NSSF Operations Guide," Issue No 3, 2011.

6. Carrin G, and James C, "Social health insurance: key factor affecting the transition toward universal coverage," International Soc. Sec. Review, 58(1) 2005.

7. Gine X, and Yang D, "Insurance, Credit, and Technology Adoption: Field Experimental Evidence from Malawi, Policy Research Working Paper 4425" The World Bank, Washington DC. 2007.

8. Humba E, "Implementing social security health care," ISSA Regional Conference for Africa, 2005.

9. National Social Security Fund in Tanzania, "Performance Annual Report 2013/2014," 2014.

10. Goudge J, Khumalo N, and Gilson L, "Policy options to improve the economic access of low income households to state provided," 2003.

11. Carrin G & James C, “Reaching universal coverage via social health insurance: key design features in the transition period. Health Financing Policy Issue Paper” Geneva: WHO health care. 2004.

12. Babbie E, &Mouton J, “The Practice of Social Research (South African Edition),” Oxford University Press. 2001.

13. Busse R, Schreyogg J & Gericle C, “Analyzing changes in Health Financing Arrangements in High Income Countries,” A comprehensive Framework Approach. 2007.

14. Bärnighausen, T. and Sauerborn, R, “One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries?” Social Science and Medicine 54: 1559-1587. 2002

15. European Observatory on Health Systems and Policies. Country profiles. Also available at http://who.int/observatory/CtryInfo/CtryInfo (visited on 18 May 2012). Copenhagen, World Health Organization. 2002.

16. www-israel-mfa.gov.it/mfa/.

17. Miranda, G. “La seguridad social y el desarratio en Costa Rica. San Jose, Editorial Nacional de Salud y Seguridad Social (EDNASSS),” 1994.

18. Carrin G. and James C, “Social health insurance: Key factors affecting the transition towards universal coverage,” World Health Organization, Geneva, 2005.

19. Ogawa, S.; Hasegawa, T.; Carrin, G.; Kawabata, K. “Scaling up community health insurance: Japan’s experience with the 19th century Jyorei scheme”, in Health Policy and Planning, Vol.18, No. 3. 2003.

20. Henke, K. and Schreyögg, J. "Toward sustainable health care systems strategies in health insurance schemes in France, Germany, Japan and the Netherlands," Geneva: International Social Security Association, 2004.

21. WHO 2000 2005 and 2007 WHO (World Health Organization) World Health Report 1999: Health Systems-Improving Performance. Geneva: WHO. Available from: http://www.who.int/whr/2000/en/whr00_en. Accessed 19 July 2012.

22. Xu K, Evans D, Kawabata K, Zeramdini R, Klavus J, Murray C. Household catastrophic health expenditure: a multi-country analysis..;Vol 362, 2003.

23. Saltman, Richard S, Busse R, Figuares J (eds): "Social health insurance system in Western Europe," World Health organization, 2004.
24. www.africa-union.org

25. United Republic of Tanzania; Regional Administration and Local Government; Prime Minister's Office. "Strategic Plan for 2010/2011 – 2012/2013," Dar es salaam Regional Commissioner's Office, 2013.

26. Carrin, G. "Community Based Health Insurance Schemes in Developing Countries: facts, problems and perspectives," Discussion Paper No. 1-2003. Geneva, WHO 2003.

27. Agyemang-Gyau, P. "The Ability and Willingness of People to Pay for their Health Care: The Case of Lushoto District, Tanzania," Department of Tropical Hygiene and Public Health. Germany, University of Heidelberg. Postgraduate Master of Science Course: Community Health and Health Management in Developing Countries. 1998.

28. Beraldes, C. and L. Carreras "Willingness to pay for community health fund card in Mtwara Rural District, Tanzania," 2003.

29. Steinwachs, L. “the Potential of Social Structures in Regard to Health Financing and the Perspectives of the Local Populations” – A Qualitative Empirical Study, GTZ, 2001.

30. Shaw, R. P. “Tanzania's Community Health Fund: Prepayment as an Alternative to User Fees,” 2002.

31. Sheuya, S. A. “Assessment of the Rungwe Smallholder Tea Growers Association and wakulima Health Fund Programme,” Draft Report. Dar es Salaam, University College of Lands and Architectural Studies (UCLAS), 2006.

32. Kelley, A. G., F. Diop, et al. “Approaches to Scalling up Community-Based Health Financing Schemes,” USA, PHRplus, 2006.

33. Japan. Ministry of Health, Labour and Welfare. “The social security system in the prewar days”. Also available at http://www.mhlw.go.jp/english/index.html 2003

34. Ensor, T. “Developing health insurance in transitional Asia”, in Social Science and Medicine, Vol. 48, No. 7. 1999.

35. Saltman, R. B.; Busse, R.; Figueras, J. (eds.) (forthcoming). Understanding social health insurance systems: A comparative review of Western Europe. Copenhagen, World Health Organization, European Observatory on Health Systems and Policies.

36. Massau S. et all Tanzania Health System Assessment Report. 2010.

37. Capacity Building for effective Health – Health Financing 2009 – 2010. Title: Towards Health Insurance Regulations in Tanzania. 2010.

38. Tanzania Health Sector Strategy Plan 2009 – 2015.

39. Health Belief Model (HBM), University of Twente 2012.

40. Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note Human Development Department; Africa Region; The World Bank 2011.

41. Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems Guy Carrin1, Maria-Pia Waelkens2 and Bart Criel. 2008

42. Chomi E. service provider's perceptions of the quality and accessibility of health services under social health insurance in Dar-es-Salaam. 2007.

43. The Social Sciences and Human Service Professions. 2nd Edition. Pretoria: JL van S De vos, A.S; Strydom, H; Fouche, C.B & Delport, CSL Research at Grass Roots for chaik Publishers. 2002.

44. Laws, S; Harper, C & Marcus, R Research for Development: A Practical Guide. London: Sage Publications. 2003.

45. Amanda E; Mark B; Jozefina C; Fiona MacC; Holger S; Gender and Economic Growth in Tanzania - Creating Opportunieties for Women. 2007.

46. Women and Employment in Africa: A Framework for Action, Marty Chen, Havard University WIEGO Network, 2008.

APPENDICES

Appendix 1(a): Directorate of Research and Publications- MUHAS

CONSENT FORM (English version)

Form no: ☐☐☐☐

Greetings,

My name is ……., Working for School of Public Health and Social Sciences at Muhimbili University of Health and Allied Sciences in Dar es Salaam.

Purpose of the Study

Dear respondent I would like to inform you that this is a research study titled "Factors affecting enrolment on Social Health Insurance Benefit. A case of employees perspective in Dar es Salaam. " I would like to give you information about your participation in the study which seek explore factors affecting enrollment in the Social Health Insurance Benefit scheme among National Social Security Fund members in Dar es salaam , this study will help to inform decision makers and policy planners on the actions to improve enrollment of NSSF members in SHIB. The study will generate new knowledge to help this social security scheme on how to increase enrollment.

Confidentiality

We will protect and treat the information you will be providing with high confidentiality to the best of our knowledge. We will not write your name on the questionnaire or in any report/documents that might let someone identifies you. Your name will not be linked with the research information in any way. The investigators will take care of the data. And information collected. However, the final results after the analysis will be shared with national stakeholders and I will submit the manuscript for publication in scientific journals.

Right and withdrawal alternatives

Your participation is voluntary. You may decline from participation to the study at any time during interview even if you have consented to participate. Your decision to participate or not will not be associated with your right to work in the facility. There is no penalty for refusing to participate on the study. You will not experience any loss if you refuse to participate in this study.

Benefits

The information you provide will help to find out the factors contributing to low enrolment in SHIB. Also will help policy and decision makers to understand the areas that need to be improved hence increasing enrolment trend of employees and even non employees into SHIB. The information also will provide feedback to NSSF management and health care providers on the areas that need empowerment so as to increase number of employees accessing health care services through Social Health Insurance in Tanzania.

If any damage that might occur

It is not expected that there will be any damage for your participation as the respondent to this study.

Risks

There is no harm for participating in the study. However, you are free to stop participation at any time during this discussion in the event you feel uncomfortable.

Who to Contact

If you ever have questions about this study, you should contact the **Principal Investigator Zakia Mohamed (+255 715 134 210)** of Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam.

If you ever have questions about your rights as a participant, you may call **Prof. M. Mush**i, **Chairman (Research and Publications Committee, MUHAS. P. O. Box 65001,** Dar es Salaam – Tanzania, Tel **+2552150302-6**); and **Prof. P.G.M. Mujinja** who is the supervisor of this study (Tel. +**225 754 271 171**)

I ……. have read the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of participant ……

Signature of Research Assistant ……..

Date of signed consent ……

DECLARATION

The above document describing the benefits, risks and procedures for the research titled "**Factors affecting enrolment in Social Health Insurance Benefit. A case of employees' perspective in Dar es salaam."** has been read and explained to me and I have agreed to participate. I certify that the nature and purpose, the potential benefits and possible risks associated with participating in this study have been explained to me.

Signature or Right Thumb stamp of the respondent..... Date.....

Signature of Research Assistant.....…… Date.....

Appendix 1(b): Directorate of Research and Publications MUHAS

FOMU YA IDHINI (Swahili version)

Fomu nambari ☐☐☐☐

Salaam,

Mimi ni ……., nafanya kazi pamoja na Chuo Kikuu Cha Afya na Sayansi Shirikishi Muhimbili, Dar es Salaam.

Lengo la utafiti:

Ndugu mshiriki napenda kukufahamisha huu ni utafiti ujulikanao kama sababu zinazoathiri usajili wa wanachama wa Mfuko wa Taifa wa Hifadhi ya Jamii katika mafao ya matibabu kwa mkoa wa Dar es salaam.

Usiri

Taarifa zote kuhusu utafiti huu zitakuwa siri. Majina yako hayataandikwa popote au sehemu yeyote wakati wa utafiti. Tutahakikisha majina yako hayatohusishwa na taarifa zako kuhusu utafiti. Mtafiti mkuu atakuwa msimizi wa taarifa na takwimu zitakazo tolewa wakati wa utafiti. Hata hivyo wadau mbalimbali watapewa matokeo ya mwisho ya utafiti huu na pia matokeo hayo yatawasilishwa sehemu mbalimbali kwa ajili ya machapisho au majarida ya kisayansi.

Haki za mshiriki

Ushiriki wako ni wa hiari. Unaweza kusitisha ushiriki wako wakati wowote hata kama ulisha wahi kukubali kushiriki awali. Ikiwa utaamua kusitisha ushiriki wako, hali hiyo hautaathiri jambo lolote au huduma nyingine za kijamii unazostahili.

Faida za kushiriki utafiti huu:

Taarifa utakazo tupatia zitasaidia kuelewa zaidi juu ya sababu zinazochangia wanachama wa Mfuko wa taifa wa hifadhi ya jamii kutojisajili katika mafao ya matibabu yatolewayo na mfuko.Taarifa utakayotoa itawasaidia watunga sera na watendaji kuelewa maeneo yanayohitaji kuboreshwa ili kuongeza usajili wa wanachama waajiriwa na wasio waajiriwa kwenye mafao ya matibabu. Taarifa hizo pia zitasaidia kuwapa mrejesho uongozi wa

Mfuko waTaifa wa Hifadhi ya Jamii na watoa huduma za afya kwenye maeneo yote yanayohitaji uboreshwaji ili kuongeza kiasi cha usajili wa wafanyakazi katika kupatiwa matibabu kwa njia ya bima ya afya nchini. Faida za utafiti huu hazitakuwa za moja kwa moja kwa mshiriki, isipokuwa utafiti huu unalenga kuwanufaisha wanajamii kwa ujumla wao. Hata hivyo mshiriki atapatiwa elimu sahihi juu ya mafao ya matibabu yatolewayo na mfuko. Faida nyingine utakayopata ni ufafanuzi wa maswali ambayo utakuwa hujayaelewa.

Madhara yanayoweza kutokea

Hakutakuwa na madhara ya kihisia au kisaikolojia hasa kutokana na maswali utakayo ulizwa. Hakutakuwa na madhara kimwili kutokana na ushiriki wako.

Ikiwa utakuwa na tatizo au maswali:

Ikiwa utakuwa na maswali au maoni kuhusu utafiti huu unaweza kuwasiliana na watu wafuatao: Mtafiti Mkuu **Zakia Mohamed (+255 715 134 210**) wa Chuo Kikuu cha Afya na Sayansi Shirikishi cha Muhimbili.

Iwapo utakuwa maswali au maoni juu ya haki zako kama mshiriki wa utafiti huu unaweza kuwasiliana na **Prof. M. Mushi,** ambaye ni Mwenyekiti wa Kamati ya Maadili ya Tafiti **MUHAS. P.O.Box 65001,** Dar es Salaam – Tanzania, Simu **+2552150302-6**; au and **Prof. P.G.M. Mujinja** ambaye ni msimamizi wa utafiti huu kwa simu nambari **(Tel. +225 754 271 171**)

Mimi ……. Nimesoma na kuelewa yote yaliyomo katika fomu hii, na pia maswali yangu yamejibiwa. Kwa hiari yangu mwenyewe nimekubali kushiriki katika utafiti huu.

Sahihi ya mshiriki ……

Sahihi ya mtafiti msaidizi…. ……..

Tarehe ya siku mshiriki aliposaini fomu hii. ……

AZIMIO

Fomu hii imetoa maelezo kuhusu lengo,faida, taratibu na madhara ya Utafiti juu ya sababu zinazoathiri usajili wa wanachama wa Mfuko wa Taifa wa Hifadhi ya Jamii katika mafao ya matibabu kwa mkoa wa Dar es salaam. Nakiri kuwa nimesomewa na kuelezwa mambo yote na kisha nimekubali kushiriki utafiti.

Sahihi au alama ya dole gumba ya mshiriki.....Tarehe.....

Sahihi ya mtafiti msaidizi .....……Tarehe.....

Appendix 2 (A): Questionnaire for Social Health Insurance Benefit (SHIB) Members

Questionnaire Code Number _____

Section One: Demographic information

1. Name of your Organisation _____
2. Age _____
3. Sex _____
4. District of residence._____
5. Marital Status
   (a.) Married ☐
   (b.) Single
   (c.) Divorced/widowed

6. What is the highest level of education you have attained?
   (a.) Never been to school ☐
   (b.) Primary education
   (c.) Secondary and above

7. Type of organisation you are currently working with?
   (a.) Public ☐
   (b.) Private (including faith based)

Section Two: Study variablequestions

8. Are you aware of any health insurance scheme/benefits?
   (a.) Yes ☐
   (b.) No

9. If yes what is the name(s) of that insurance? Mention it/ them.

   _____

10. Is your organisation a client of any medical insurance?

(a.) Yes

(b.) No

11. Which dependents are covered as members' beneficiaries in SHIB?

(a.) Parents and children

(b.) Parents, children and any other dependents not exceeding 4 people

(c.) Children, spouse and parents

(d.) Spouse and maximum of 4 children up to 18 years of age.

12. 12. Where do you usually go for health care services when you or your familyfalls sick?

(a.) Private facility

(b.) Public facility

(c.) Traditional healers

(d.) Self-medication practices

(e.) Faith based facilities

(f.) Others specify _____

13. What influences your choice of health facility?

(a.) Cost of services

(b.) Good quality of services

(c.) Distanceto the health facility

(d.) Reputation of the service provider(quality gives reputation)

(e.) Others

14. How long have you been a member of SHIB? Please state number of years

_____

15. Have you ever changed health facility?

(a.) Yes

(b.) No

16. If yes, what were the reasons for changing health facility?
    (a.) Long waiting time before accessing services
    (b.) Insufficient medicines
    (c.) Distance from home to a health facility
    (d.) Poor customer care from health care provider.
    (e.) Others (state)

17. Are you satisfied with the health services provided under Social Health Insurance Benefit?
    (a.) Yes
    (b.) No

18. Are you satisfied by the health services offered at the current SHIB accredited health facility?
    (a.) Agreed
    (b.) Disagreed
    (c.) Strongly agreed
    (d.) Strongly disagreed

19. Does your current SHIB accredited health facility easily accessible?
    (a.) Agreed
    (b.) Disagreed
    (c.) Strongly agreed
    (d.) Strongly disagreed

20. Does your current SHIB accredited health facility provide adequate supply of medicines?
    (a.) Agreed
    (b.) Disagreed
    (c.) Strongly agreed
    (d.) Strongly disagreed

21. Who pays your medical bills for SHIB?

(a.) Employer

(b.) Government

(c.) Employee (member)

(d.) National Social Security Fund

(e.) I don't know

22. What are the requirements in joining SHIB?

(a.) Being NSSF member for at least three months

(b.) Money to pay for the services

(c.) Employers permission

(d.) It's the NSSF who select the member.

(e.) Being a member for more than 1 year

23. Does enrolment in SHIB affects the monthly contribution?

(a.) Yes

(b.) No

24. Do you do physical exercise?

(a.) Yes

(b.) No

25. If YES how many times do you perform physical exercises per week?

(a.) 1 day per week

(b.) 2days per week

(c.) 3days per week

(d.) Others (Mention)

26. Do you currently suffer from any chronic condition?

(a.) Yes

(b.) No

27. Is your spouse or children suffering from chronic condition?

(a.) Yes

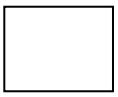
(b.) No



28. Do you drink alcohol?

(a.) Yes

(b.) No

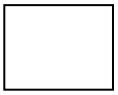


29. How much alcohol do you consume per week? _____ litres.

30. Do you smoke cigarettes?

(a.) Yes

(b.) No



31. How many cigarettes do you smoke per day?

(a.) 2-5

(b.) 5-10

(c.) 10 above



Appendix 2 (B): Questionnaire for Non- Social Health Insurance Benefits Members

Questionnaire code number……..

Section One: Demographic information

1. Name of your Organisation _____
2. Age _____
3. Sex _____
4. District of residence _____

5. Marital Status
   (a.) Married
   (b.) Single
   (c.) Divorced/widowed

6. What is the highest level of education you have attained?
   (a.) Primary education
   (b.) Secondary education
   (c.) Secondary and above

7. Type of organisation you are currently working with?
   (a.) Public
   (b.) Private (including faith based)

8. Are you aware of any health insurance scheme/benefits?
   (a.) Yes
   (b.) No

9. If yes what is the name(s) of that insurance? Mention it/ them.
   _____

10. Is your organisation a client of any medical insurance?
    (a.) Yes
    (b.) No

11. How do you pay your medical bills?

(a.) The company or organisation pays.

(b.) Out of pocket

(c.) Medical insurance pays

(d.) Shared costs between employer and employee

(e.) Others (state)

12. If the answer above is C, (medical insurance) which medical insurance are you registered to?

(a.) Yes

(b.) No

13. In your own opinion what makes you not register for SHIB?

_____

_____

_____

14. Have you ever heard about SHIB?

(a.) Yes

(b.) No

15. If the answer is YES, mention health care services provided under SHIB.

_____

_____

_____

16. Mention two qualifying conditions which NSSF members must have before joining SHIB

_____

_____

_____

17. Where do you prefer to go for health care services when you or your dependents fallsick?

(a.) Private facility
(b.) Public facility
(c.) Traditional healers
(d.) Self-medication practices
(e.) Church/ Missionary facilities

18. Do you seek health care from more than one health facility?

(a.) Yes
(b.) No

If YES why? _____

19. What influences you is your choice of health facility?

(a.) Cost of services
(b.) Good quality of services
(c.) Nearby health facility
(d.) Reputation of the service provider(quality gives reputation)
(e.) Others

20. Who pays medical bills for SHIB?

(a.) Employer
(b.) Government
(c.) Employee (member)
(d.) National Social Security Fund
(e.) I don’t know

21. What are the requirements in joining SHIB?

(a.) Being a member for at least three months

(b.) Money to pay for the services

(c.) Employers permission

(d.) NSSF select the member.

(e.) Being a member for more than 1 year

22. Who are employees dependent's in Social Health Insurance Benefit?

(a.) Spouse and parents

(b.) Parents and children

(c.) Children and spouse

(d.) Children, spouse and parents

(e.) Spouse and any other four dependents

23. Does National Social Security Fund deduct monthly contributions from employees to cover Social Health Insurance Benefit medical bills?

(a.) No

(b.) Yes

24. If you ever not sought or received care because you have failed to pay for the health services?

(a.) Yes

(b.) No

25. If YES how much were you supposed to pay?

_____

_____

26. In the last three months how many times did you go to seek for health care services?

_____

_____

27. When you fall sick, how do you pay for medical services bills?

(a.) Out of pocket payment
(b.) Health insurance
(c.) Cost sharing using public facilities
(d.) Free medical services

28. What is the distance from home to the health facility you visited last time?

(a.) Less than 500m
(b.) 500m to 1kilometer
(c.) 1kilometer to 5 kilometer
(d.) More than 5 kilometer

29. Is there any of your nuclear family member ever died because you failed to pay for his /her medical bills for medical services for the past three years?

(a.) Yes
(b.) No

30. If the answer is yes,

(a.) What is your relationship with the deceased?

_____

(b.) How much was needed to take care of the patient?

_____

(c.) What is/ are some other sources of income do you have beside the job?
State them _____

31. Does enrolment in SHIB affects your monthly contribution?

(a.) Agreed
(b.) Disagreed
(c.) Strongly agreed
(d.) Strongly disagreed
(e.) Don’t know

32. Do enrolment in SHIB has a long process before accessing the services

(a.) Agreed
(b.) Disagreed
(c.) Strongly agreed
(d.) Strongly disagreed
(e.) Don't know



33. When were you sick for the last time? _____

34. Where did you go to seek for health care services?

_____

_____

35. How much did you pay for health care services?

_____

_____

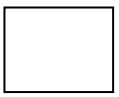
36. Do you perform physical exercise regularly?

(a.) Yes
(b.) No



37. How many times do you perform physical exercises per week?

(a.) 1 day per week
(b.) 2days per week
(c.) 3days per week
(d.) Others (Mention)



38. Do you have a history of any chronic disease in your family?

(a.) Yes
(b.) No



39. If yes, who had been suffering from chronic disease?

(a.) Mother/ Father

(b.) Brother/ Sister

(c.) Grandmother/ Grandfather

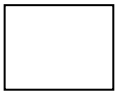
(d.) Others (Mention)



40. Do you drink alcohol?

(a.) Yes

(b.) No



41. How much alcohol do you consume per day? _____ litres.

42. Do you smoke cigarettes?

(a.) Yes

(b.) No

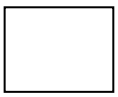


43. How many cigarettes do you smoke per day?

(a.) 2-5

(b.) 5-10

(c.) 10 above



CHUO KIKUU CHA SAYANSI NA TIBA MUHIMBILI

Appendix 3A:Maswali kwa Watakaoshiriki Kujibu DodosoKwa wanachama waliojiunga na Mafao ya matibabu *(zungushia jibu utakaloona ni sahihi)*

Dodoso namba _____

Sehemu ya kwanza

1. Jina la mwajiri ……..
2. Umri ……..
3. Jinsia ……..
4. Wilaya unayoishi ……
5. Hali ya ndoa
   (a.) Nimeoa/Nimeolewa
   (b.) Sijaoa/ Sijaolewa
   (c.) Nimeacha/Nimeachika
   (d.) Mjane/Mgane

6. Elimu
   (a.) Elimu ya Msingi
   (b.) Elimu ya Secondari
   (c.) Zaidi ya Elimu ya Secondari

7. Aina ya kampuni/taasisi unayofanyia kazi ni ya
   (a.) Serikali
   (b.) Binafsi

Sehemu ya pili

8. Ulishawahi kusikia kuhusu bima ya afya?
   (a.) Ndiyo
   (b.) Hapana

9. Kama jibu ni ndiyo, taja jina la bima hiyo au bima hizo.
   (a.) _____
   (b.) _____
   (c.) _____

10. Je mwajiri wako anatoa/kulipia matibabu yako kupitia bima yoyote?
   (a.) Ndiyo
   (b.) Hapana

11. Kwenye mafao ya matibabu hutibiwa mwanachama pamoja na wategemezi wake, ni wapi wategemezi wa mwanachama?
   (a.) Wazazi na watoto wa mwanachama
   (b.) Wazazi, watoto na wategemezi wengine wasiozidi wanne
   (c.) Mwenza na watoto wa mwanachama wasiozidi wanne chini ya miaka 18
   (d.) Mwenza, wazazi, na watoto wane chini ya miaka 18.

12. Unatibiwa wapi pindi uuguapo?
   (a.) Watoa huduma za afya binafsi
   (b.) Hospitali za Serikali
   (c.) Tiba asilia
   (d.) Nanunua kwenye duka la dawa
   (e.) Hospitali za kidini

13. Ni sababu zipi zinakufanya uchague kutibiwa kwa mtoa huduma maalum
   (a.) Unafuu wa bei
   (b.) Ubora wa huduma
   (c.) Ukaribu wa hospitali kutoka mahali niishipo
   (d.) Umaarufu wa daktari katika hospitali husika
   (e.) Sababu nyinginezo (Taja)

14. Umejiunga linina mafao ya matibabu? Taja miaka mingapi
    Mwezi 1 – 2miaka
    Zaidi ya miaka 2

15. Je ulishawahi kubadilisha mtoa huduma? Kutoka hospitali moja kwenda nyingine?
    (a.) Ndiyo
    (b.) Hapana

16. Kama jibu ni ndiyo, sababu zipi zilikufanya ubadilishe mtoa huduma?
    (a.) Kusubiri muda mrefu kabla ya kupatiwa matibabu (foleni)
    (b.) Ukosefu/upungufu wa dawa
    (c.) Umbali kutoka ninapoishi mpaka hospitali
    (d.) Wahudumu wa afya kutokuwajali wateja
    (e.) Sababu nyinginezo (Zitaje)

17. Huduma zitolewazo chini ya mafao haya ya matibabu zinakidhi mahitaji yako ya afya?
    (a.) Ndiyo
    (b.) Hapana

18. Watoa huduma (hospitali) waliosajiliwa chini ya mpango huu wa mafao ya matibabu wanakidhi mahitaji yako ya matibabu?
    (a.) Nakubali
    (b.) Sikubali
    (c.) Nakubali sana
    (d.) Sikubali sana
    (e.) Sijui

19. Watoa huduma (hospitali) waliosajiliwa chini ya mpango huu wa mafao ya matibabu wanafikika kiurahisi?
    (a.) Nakubali
    (b.) Sikubali
    (c.) Nakubali sana
    (d.) Sikubali sana
    (e.) Sijui

20. Unapokwenda kutibiwa chini ya mpango wa matibabu wa NSSF, huwa unapata dawa za kutosha?
    (a.) Nakubali
    (b.) Sikubali
    (c.) Nakubali sana
    (d.) Sikubali sana
    (e.) Sijui

21. Ni nani anayelipia gharama za matibabu kwa wanachama wa NSSF?
    (a.) Mwajiri
    (b.) Serikali
    (c.) Mwanachama mwenyewe
    (d.) NSSF
    (e.) Sijui

22. Ili kujiunga na mafao haya ya matibabu mwanachama anatakiwa;
    (a.) Awe amejiunga na NSSF kwa kipindi kisichopungua miezi 3
    (b.) Awe na pesa taslimu za kulipia huduma
    (c.) Ruhusa kutoka kwa mwajiri
    (d.) NSSF ndiyo huchagua wanachama ili kujiunga
    (e.) Uwe mwanachama wa NSSF kwa zaidi ya mwaka mmoja

23. Je kujiunga na matibabu kutaathiri michango yako ya kila mwezi?
    (a.) Ndiyo
    (b.) Hapana

24. Je unafanya mazoezi ya viungo mara kwa mara
    (a.) Ndiyo
    (b.) Hapana

25. Unafanya mazoezi mara ngapi kwa wiki?
    (a.) Mara moja kwa wiki
    (b.) Mara mbili kwa wiki
    (c.) Mara tatu kwa wiki
    (d.) Mengineyo (taja)

26. Je unaugua ugonjwa wowote sugu kwa sasa?
    (a.) Ndiyo
    (b.) Hapana

27. Je mwenza au watoto wako wanaugua ugonjwa wowote sugu kwa sasa?
    (a.) Ndiyo
    (b.) Hapana

28. Je unatumia aina yeyote ya kilevi?
    (a.) Ndiyo
    (b.) Hapana

29. Unatumia kilevi kiasi gani kwa wiki?
    (a.) Category 1 500mls – 1000mls
    (b.) Category 2 > 1000mls
    (c.) Category 3 Don’t drink

30. Je unavuta sigara?
    (a.) Ndiyo
    (b.) Hapana

31. Unavuta sigara ngapi kwa siku? Taja
    (a.) No smoking
    (b.) 1 – 5 cigarattes
    (c.) >5 cigarrates

Appendix 3B: Maswali kwa Watakaoshiriki Kujibu DodosoWanachama wa NSSF ambao hawajajiunga na SHIB ***(zungushia jibu utakaloona ni sahihi)***

Dodoso namba _____

Sehemu ya kwanza

1. Jina la mwajiri …….
2. Umri …….
3. Jinsia: mme mke
4. Wilaya unayoishi
   (a.) Ilala
   (b.) Kiondoni
   (c.) Temeke

5. Hali ya ndoa
   (a.) Nimeoa/Nimeolewa
   (b.) Sijaoa/ Sijaolewa
   (c.) Nimeacha/Nimeachika
   (d.) Mjane/Mgane

6. Elimu
   (a.) Sijasoma
   (b.) Elimu ya Msingi
   (c.) Elimu ya Secondari
   (d.) Zaidi ya Elimu ya Secondari

7. Je unafanya kazi katika kampuni/taasisi ya
   (a.) Serikali
   (b.) Binafsi ikiwemo *(mashirika ya kidini)*

8. Ulishawahi kusikia kuhusu bima ya afya?
   (a.) Ndiyo
   (b.) Hapana

9. Kama jibu ni ndiyo, taja jina la bima hiyo au bima hizo.
   (a.) Bima binafsi
   (b.) NHIF
   (c.) NSSF
   (d.) Sijui

10. Je mwajiri wako anatoa/kulipia matibabu yako kupitia bima yoyote?
   (a.) Ndiyo
   (b.) Hapana

11. Pindi unapougua ni nani hugharamia gharama za matibabu?
   (a.) Mwajiri
   (b.) Nalipa mwenyewe
   (c.) Bima ya afya
   (d.) Gharama huchangiwa na mwjiri na mwajiriwa
   (e.) Nyinginezo (Eleza) _____

12. Kama jibu la swali la 14 ni (C) taja jina la bima hiyo
   (a.) binafsi
   (b.) NHIF
   (c.) Ingine

13. Kwa maoni yako, ni sababu zipi zinakufanya usijiunge na matibabu?
   (a.) hakuna muda ugumu wa kutimiza mahitaji ya usajili
   (b.) hofu ya kukatwa michango ya unachama
   (c.) kushindwa kugharamia usajili
   (d.) kutumia huduma za bima ingine

14. Je ulishawahi kusikia kuhusu mafao ya matibabu yanayotolewa na Shirika la Taifa la Hifadhi ya Jamii?
   (a.) Ndiyo
   (b.) Hapana

15. Kama jibu ni ndiyo, taja huduma zitolewazo ndani ya mafao hayo ya matibabu
    (a.) kumuona daktari, uchunguzi wa maabara, dawa, rufaa, upasuaji mkubwa na mdogo
    (b.) jibu sio sahihi
    (c.) sijui

16. Taja sifa mbili ambazo mwanachama wa NSSF anatakiwa kuwa nazo ili aweze kujiunga na mafao ya matibabu.
    (a.) awe mwanachama na amechangiwa miezi 3
    (b.) mwanachama na analipiwa michango yake kila mwezi
    (c.) sifa tofauti na hizi

17. Unatibiwa wapi pindi uuguapo?
    (a.) Watoa huduma za afya binafsi
    (b.) Hospitali za Serikali
    (c.) Tiba asilia
    (d.) Nanunua kwenye duka la dawa
    (e.) Hospitali za kidini

18. Je huwa unatibiwa kwenye hospitali zaidi ya moja?
    (a.) Ndiyo
    (b.) Hapana

19. Ni sababu zipi zinakufanya uchague kutibiwa kwa mtoa huduma maalum
    (a.) Unafuu wa bei
    (b.) Ubora wa huduma
    (c.) Ukaribu wa hospitali kutoka mahali niishipo
    (d.) Umaarufu wa daktari katika hospitali Husika
    (e.) Sababu nyinginezo (Taja)

20. Ni nani anayelipia gharama za matibabu kwa wanachama wa NSSF?
    (a.) Mwajiri
    (b.) Serikali
    (c.) Mwanachama mwenyewe
    (d.) NSSF
    (e.) Sijui

21. Ili kujiunga na mafao haya ya matibabu mwanachama anatakiwa;
    (a.) Awe amejiunga na NSSF kwa kipindi kisichopungua miezi mitatu
    (b.) Awe na pesa taslimu za kulipia huduma
    (c.) Ruhusa kutoka kwa mwajiri
    (d.) NSSF ndiyo huchagua wanachama ili kujiunga
    (e.) Uwe mwanachama wa NSSF kwa zaidi ya mwaka mmoja

22. Ni nani wategemezi wa mwanachama wa mafao haya ya matibabu?
    (a.) Mwenza na wazazi
    (b.) Wazazi na watoto
    (c.) Watoto na mwenza
    (d.) Watoto, mwenza na wazazi
    (e.) Mwenza na wategemezi wengine wane

23. Je Shirika la Taifa la Hifadhi ya jamii huwa linakata michango ya mwachama ya kila mwezi ili kilipia gharama za matibabu?
    (a.) Ndiyo
    (b.) Hapana

24. Je ulishawahi kukosa matibabu kwasababu ya kushindwa kulipia gharama?
    (a.) Ndiyo
    (b.) Hapana

25. Kama jibu ni ndiyo, ni kiasi gani kilihitajika kulipia matibabu hayo?
    (a.) 1 Tshs 1000 -10000
    (b.) 2 Tshs 11000-30000
    (c.) 3 Tshs 31000-100000
    (d.) 4 Tshs > 100000

26. Katika kipindi cha miezi mitatu iliyopita ni mara ngapi umekwenda hospitali kutibiwa?
    (a.) mara 1 hadi 2
    (b.) mara2 hadi 3

27. Unapougua unatumia njia gani kulipia gharama za matibabu?
    (a.) Fedha taslimu
    (b.) Bima ya afya
    (c.) Kuchangia gharama kwenye hospitali za serikali
    (d.) Natibiwa bure

28. Kuna umbali gani kutoka nyumbani kwako na unapotibiwa?
    (a.) Chini ya mita mia tano
    (b.) Kati ya mita mia tano na kilomita moja
    (c.) Kati ya kilomita moja na kilomita tano
    (d.) Zaidi ya kilomita tano

29. Je kuna mtu katika familia yako alishafariki kwa kushindwa kulipia gharama za matibabu?
    (a.) Ndiyo
    (b.) Hapana

    Kama jibu ni ndiyo;

    _____

    _____

30. Una uhusiano gani na huyo mtu?
    (a.) Mwenza
    (b.) Mtoto
    (c.) Ndugu mwingine

31. Ni kiasi gani kilikuwa kinahitajika kulipia gharama za matibabu?
    (a.) 1000 – 10000
    (b.) >10000 - 30000
    (c.) >30000 - 100000
    (d.) >100000

32. Je unachanzo kingine cha mapato ukiondoa kazi?
    (a.) Ndiyo
    (b.) Hapana

33. Je unadhani kujiunga na matibabu kutaathiri michango yako ya kila mwezi?
    (a.) Nakubali
    (b.) Sikubali
    (c.) Nakubali sana
    (d.) Sikubali sana

34. Je unadhani kujisajili kwenye mafao ya matibabu kuna hatua ndefu za kufata?
    (a.) Nakubali
    (b.) Sikubali
    (c.) Nakubali sana
    (d.) Sikubali sana

35. Umeugua lini kwa mara ya mwisho
    (a.) Ndani ya mwezi 1
    (b.) Zaidi ya mwezi 1

36. (i) Ulitibiwa wapi ugonjwa huo? Taja

(a.) kituo cha

(b.) kujitibia mwenyewe

(c.) tiba asili

(ii) Je ulilipia kiasi gani kupata matibabu hayo?

(a.) 1000 – 10000

(b.) >10000 – 30000

(c.) >30000 – 100000

(d.) >100000

37. Je unafanya mazoezi ya viungo mara kwa mara

(a.) Ndiyo

(b.) Hapana

38. Unafanya mazoezi mara ngapi kwa wiki?

(a.) Mara moja kwa wiki

(b.) Mara mbili kwa wiki

(c.) Mara tatu kwa wiki

(d.) Mengineyo (taja)

39. Je kuna historia ya ugonjwa wowote sugu kwenye familia yako?

(a.) Ndiyo

(b.) Hapana

40. Kama jibu ni ndiyo, ni nani katika familia yenu alishaugua ugonjwa huo?

(a.) Baba/mama

(b.) Kaka/dada

(c.) Babu/bibi

(d.) Wengineo (taja)

41. Je unatumia aina yeyote ya kilevi?
    (a.) Ndiyo
    (b.) Hapana

42. Unatumia kilevi kiasi gani kwa siku?
    (a.) 500mls – 1000mls
    (b.) >1000mls
    (c.) Sinywi

43. Je unavuta sigara?
    (a.) Ndiyo
    (b.) Hapana

44. Unavuta sigara ngapi kwa siku? Taja
    (a.) sivuti sigara
    (b.) 1 – 5 sgara
    (c.) >5 sigara

Appendix 4: Ethical Clearance

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

Directorate of Postgraduate Studies

P.O. BOX 65001
DAR ES SALAAM
TANZANIA.

Website: http://www.muhas.ac.tz

Tel: +255-(0)22-2150302 Ext 207.
Tel (Direct): +255-(0)22-2151378
Telefax:255-(0)22-2150465
E-mail: *dpgs@muhas.ac.tz*

Ref. No. MU/PGS/SAEC/Vol. VI/

15th January, 2013

Zakia Mohamed
MPH-Executive Track
MUHAS.

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED "FACTORS AFFECTING ENROLMENT IN SOCIAL HEALTH INSURANCE BENEFIT A CASE OF EMPLOYEES' PERSPECTIVE IN DAR ES SALAAM"

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has on behalf of the Senate approved ethical clearance for the above-mentioned study.

Thus ethical clearance is granted and you may proceed with the planned study.

Prof. O. Ngassapa
DIRECTOR, POSTGRADUATE STUDIES

/emm

cc Vice Chancellor, MUHAS
cc Deputy Vice Chancellor – ARC, MUHAS
cc Dean, School of Public Health and Social Sciences

Appendix 5: Introduction Letter

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

Directorate of Postgraduate Studies

P.O. BOX 65001
DAR ES SALAAM
TANZANIA.

Website: http://www.muhas.ac.tz

Tel: +255-(0)22-2150302 Ext 207.
Tel (Direct): +255-(0)22-2151378
Telefax:255-(0)22-2150465
E-mail: *dpgs@muhas.ac.tz*

Ref. No. HD/MUH/T.225/2010

16th January, 2013

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Re: INTRODUCTION LETTER

The bearer of this letter Ms. Zakia Mohamed is a student at Muhimbili University of Health and Allied Sciences (MUHAS) pursuing in MPH – Executive Track.

As part of her studies she intends to do a study titled: ***"Factprs affecting enrolment in Social Health Insurance benefit a case of employees' perspective in Dar es Salaam".***

The research has been aproved by the Chairman of MUHAS Research Ethics Committee.

Kindly provide her the necessary assistance to facilitate conduct of her research.

We thank you for your cooperation.

Tija Ukondwa
For: DIRECTOR, POSTGRADUATE STUDIES

cc: Ms. Zakia Mohamed
cc: Dean, School of Public Health and Social Sciences