

CO-OPERATIVE HEALTH INSURANCE IN TANZANIA: PERCEPTIONS AND DETERMINANTS

Cyril Kalembana Komba^{1,*}, Emmanuel Lulandala² and Godamen Naiman³

¹Senior Lecturer, Moshi Co-operative University (MoCU), Tanzania, ORCID

Number: <https://orcid.org/0009-0004-3395-6540>

²Senior Lecturer, Moshi Co-operative University (MoCU), Tanzania.

³Co-operative Officer, Tanzania Co-operative Development Commission (TCDC)

*Corresponding Author's Email: cyrill.komba@mocu.ac.tz or cyrillkomba@gmail.com

Abstract

Co-operative health insurance refers mainly to community-based and mutual health insurance schemes especially important for people in the informal and rural sectors, who are often excluded from formal employment-based health insurance. This study was conducted to investigate the cooperative members' perceptions of the Ushirika Afya scheme (UAS) and to identify the key determinants of members' engagement. The study was guided by the theory of planned behaviour (TPB). The study adopted a cross-sectional research design. The target population and the unit of analysis included all Agricultural and Marketing Co-operative (AMCOS) members (both UAS members and non-members), resulting in a sample size of 300. Two other methods were involved in the process of data collection, which are focus group discussions; a total of five FGDs were conducted, and the interview method was used to interview five key informants. The study findings indicated that socio-demographic factors, including age, marital status, household income and size, level of education, and economic activity, significantly influence cooperative members in the UAS. Thematic analysis revealed that cooperative members' perceptions towards Ushirika afya were focused on health concerns, health protection, and support for old and aged cooperative members. Additionally, it was seen as a government-established programme for cooperative members in AMCOS, specifically for sick people. Moreover, the study concludes that there is limited engagement with the UAS among the youth and women. In contrast, the perception in many people's minds is that the UAS is for elderly people, sick people, and poor people. This is because the study has shown that there is a high rate of elders enrolled in the scheme compared to the youth. There is a need for increased investment in awareness campaigns and capacity-building programmes to enhance the publicity of the Ushirika Afya scheme, which will lead to an increased number of members.

Keywords: Ushirika Afya Scheme, Health Insurance, Co-operatives, Relative Importance Index.

AJCDT, Vol. 9 No. 1 (December, 2025), pp. 14 – 25, © 2025 Authors

INTRODUCTION

Health insurance is becoming more important in low- and middle-income countries to improve healthcare use and protect households from falling into poverty due to out-of-pocket medical costs. The World

Health Organisation and the World Bank have consistently supported reducing out-of-pocket payments and promoting universal health coverage. Universal health coverage means that everyone can access the full range of quality health services they need,

whenever and wherever they need them, without financial hardship. (WHO,2019). The Government of Tanzania established the National Health Insurance (NHIF) in 1999. Initially, the schemes aimed to cover all public servants, their spouses, and children or dependents (URT, 2018). In 1996, Tanzania piloted a Community Health Fund (CHF), which was later scaled up countrywide after showing promising results. In 2011, the Tanzanian government decided to reform the CHF and introduced an improved Community Health Fund (Tungu *et al.*, 2020). The government, through the National Health Insurance Fund (NHIF), created a unique voluntary health insurance scheme for co-operative members, namely “*Ushirika Afya*”. This is a voluntary health insurance scheme designed to serve co-operative members who have no formal and conventional access to health insurance (Nzowa *et al.*2023). The “*Ushirika Afya*” scheme (UAS) was primarily designed for workers in the agricultural sector to serve members of agricultural and marketing co-operative societies (AMCOS). The UAS acts as a supplementary scheme for co-operative members employed in the formal sector and has a statutory health insurance cover (Nzowa *et al.*2023). This service gives room to beneficiaries to offset their debts after selling their farm produce in the following harvest season (NHIF,2020). According to TCDC (2022) that in that year, there were about 250 AMCOS in Tanzania that had joined the UAS. The adoption of UAS through AMCOS is a welcome development that seeks to provide affordable health care to a larger segment of the population. The idea behind the UAS health insurance is to create a risk-sharing system that spreads the cost of health care over many members, thereby making health care accessible to a larger

number of people. The Ushirika Afya insurance facilitates and enables members to access any type of medical services, including major surgeries and full treatments for serious health conditions, including cancer and dialysis services for those facing kidney complications, at any health facility. In the process of ensuring universal health care through the introduction of the Ushirika Afya insurance scheme, one may wonder what is happening to the Cooperative members who join the Ushirika Afya scheme. Ushirika Afya scheme has become one of the best platforms for health insurance inclusion for individuals statutorily excluded from accessing health insurance. However, the Ushirika Afya scheme has been questionable (Nzowa *et al.*, 2023). This is due to the process of members’ enrolment, perception, Health insurance literacy, and Health care utilisation in terms of the range of services provided, reimbursement rate, as well as sustainability. These key issues form the direction of the study on assessing the perception of cooperative members on the Ushirika Afya scheme and establish factors contributing to low Ushirika Afya scheme coverage in Babati, Manyara. The government of Tanzania has been keen on ensuring that NHIF improves its operations for the betterment of Tanzanians, especially farmers who are in a cooperative society. Through doing that, the National Health Insurance Fund (NHIF) introduced the ‘Ushirika Afya’ product that sponsors health services to Agricultural Marketing Co-operative Societies (AMCOS) members. While the scheme plays an essential role in facilitating health care utilisation, there have been limited empirical investigations showing the extent to which co-operative members and other individuals have utilised such a platform (Kigume *et al*, 2021; Nzowa

et al., 2023). Despite the importance of the UAS, studies by (Nzowa *et al.*, 2023; Sambuo, 2022; Asfaw and Braun, 2004) have not focused on the dimensions such as perception of Co-operative members on the UAS, members' engagement, as well as members' satisfaction with health services they receive under UAS. Previous studies have largely focused on the single model of community-based health insurance (CBHI) through the National Health Insurance (NHIF), but the UAS offered through AMCOS is rare. This study, therefore, aimed to analyse co-operative members' perceptions of the UAS, taking Babati District in Manyara region as the case study. Specifically, the study analysed the socio-economic and demographic characteristics of co-operative members in the Ushirika Afya scheme, examined the perception of Co-operative members towards the UAS and examined the socio-economic determinants of members' engagement in the UAS. The study was guided by the Theory of Planned Behaviour (TPB) proposed by Ajzen (1991). The TPB describes that the intention to start an undertaking is influenced by different beliefs grouped in three categories (personal attitudes, subjective norms and the perceived control (Adesina, 2011; Green, 2014). Generally, the theory gives emphasis on the role of intention (Katundu & Gabagambi, 2016), which is assumed to capture the motivational factors that influence behaviour. Intentions are indications of how hard people are willing to join Health insurance, and how much of an effort they are planning to exert to perform the behaviour (Ajzen, 1991). The TPB is relevant to this study because it remains open to exogenous factors that may play a role in the development of beliefs and attitudes. One of the goals of sustainable development (SDG) is to ensure healthy lives

and promote well-being for all at all ages by 2030. Hence, the findings of this study are expected to contribute to the achievement of the 17 UN Sustainable Development Goals. By focusing on better health and well-being. One of the key indicators of Tanzania's Vision 2030 is to move towards the achievement of universal health coverage through an improved health insurance scheme for all citizens (Bernabe, 2018).

METHODOLOGY

Research Design and the Study Area: This study adopted a cross-sectional descriptive research design. This design allows researchers to collect information from a diverse group at a single point in time, making it efficient for understanding current trends and relationships between variables. The study was conducted at Babati District in the Manyara Region of Tanzania. The study area was chosen because its availability of 56 AMCOS that are in the UAS.

Sample Size and Sampling Techniques: The target population of the study was UAS users and non-users in AMCOS within the study area, comprising a total of 3,200 cooperative members from 56 AMCOS, including those under and not under the UAS. The sample size for the study was 300 members. The study adopted stratified purposive sampling, proportional sampling, and simple random sampling. Purposive sampling techniques were used because the sample of the cooperative society using Ushirika Afya consisted of members in the UAS. Proportional sampling was used to allocate respondents from each AMCOS.

Data Collection and Analysis Techniques: The household survey technique, through a questionnaire, was the main data collection technique. The questionnaire was monitored and administered by the researchers themselves. Other methods included the five focus group

discussions (FGDs), and five key informant interviews. The Statistical Package for Social Science was used to code quantitative data, which was responsible for determining the most and least determinant factors influencing the decision to enroll in the UAS through the Relative Importance Index (RII) method in the transformation matrix proposed and developed by Chen *et al.* (2010), cited by Komba (2024). The RII value ranged between 0 and 1; however, the 0 value was not included as proposed by Chen *et al.* (2010). The importance levels determining joining the UAS are derived from the RII in Table 1.

Table 1: Importance Level from RII

SN	RII Level	RII Ranging Level	Model Assumptions
1	High (H)	$0.8 < \text{RII} < 1.0$	An extremely important determinant factor
2	High-Medium (H-M)	$0.6 < \text{RII} < 0.8$	A Very Important Determinant Factor
3	Medium (M)	$0.4 < \text{RII} < 0.6$	Moderately important determinant factor
4	Medium-Low (M-L)	$0.2 < \text{RII} < 0.4$	Low important determinant factor
5	Low (L)	$0.0 < \text{RII} < 0.2$	Not at all an important determinant factor

The RII assumption was that the higher the value of RII, the more important the *determinant* factor. The RII formula is as follows:

$$\text{RII} = \frac{\sum (W/A) \cdot N}{\dots\dots\dots} \quad (1)$$

Where: W-Weighting that is assigned to each variable by the respondent=300

A- Highest weight = 5

B- N- Total number of respondents = 300.

FINDINGS AND DISCUSSIONS

3.1.1 Socio-demographic characteristics of the respondents: In the process of examining the UAS, it was also necessary to analyse the socio-demographic composition of the respondents, including sex (male or female), age, education level, household size, and the marital status (Table 2).

Table 2: Socio-demographic Characteristics of Respondents (n=300)

Characteristics	Attributes	Frequency	Percent (%)
Sex	Male	218	72.7
	Female	82	27.3
	Total	300	100
Age (Years)	18-25	20	6.7
	26-35	35	11.7
	36-45	51	17.0
	46-55	82	27.3
	56-65	90	30
	Above 66	22	7.3
	Total	300	100.0
	Primary	129	43.0
Education Level	Secondary	107	35.7
	Tertiary	39	13.0
	University	25	8.3
	Total	300	100.0
Household Size	1- 3	58	19.3
	4- 6	124	41.3
	7- 9	89	29.7
	10 and above	29	9.7
	Total	300	100.0
	Married	246	82.0
Marital status	Single	31	10.3
	Divorced	12	4.0
	Widow	6	2.0
	Widower	5	1.7
	Total	300	100.0

This was important simply because, in understanding the determining factors for the UAS, the assumption was that they were also responsible for decision-making. The findings in Table 2 indicate that 72.2% were males, while an analysis of age distribution 56-65 years 30%, 46-55 years (27.3%), and 36-45 years (17.0%). The results also indicate that the younger age groups (18-25) account for only 6.7%. The education level of the respondents shows that 43% had primary education, 35.7% had secondary education, and 21.3% possessed tertiary or university-level education. The findings further show that 41.3% of households have between four and six members, while 29.7% have between seven and nine household members.

3.1.2 Co-operative Members' Membership Status in the Ushirika Afya Scheme: The findings in Table 3 Show that 65.3% of the respondents were members of the UAS, while the remaining 34.7% have not joined the scheme. The findings, moreover, indicate that males represent a significantly higher proportion of UAS members compared to females, whereas more than half of the female respondents (52.4%) are not members of the scheme.

Table 3: Members' UAS Membership Status

Sex	Members	Percent (%)	Non-members	Percent (%)	Total
Male	157	72.1	61	27.9	218
Female	39	47.6	43	52.4	82
Total	196	-	104	-	300
Marital status	Members	Percent (%)	Non-members	Percent (%)	Total
Married	171	69.5	75	30.5	246
Single	13	41.9	18	58.1	31
Divorced	7	58.3	5	41.7	12
Widow	2	33.3	4	66.7	6
Widower	3	60.0	2	40.0	5
Total	196	-	104	-	300
Age (Years)	Members	Percent (%)	Non-members	Percent (%)	Total
18-25	9	45.0	11	55.0	20
26-35	15	42.9	20	57.1	35
36-45	24	47.1	27	52.9	51
46-55	57	69.5	25	30.5	82
56-65	78	86.7	12	13.3	90
Above 66	13	59.1	9	40.9	22
Total	196	-	104	-	300

The findings in Table 3 indicate that 72.1% of male respondents have joined UAS, while only 47.6% of female respondents have enrolled. The married individuals dominate membership status, whereas, among all UAS members 69.5% are married, 30.5% of married respondents are not members, showing a high enrolment rate among the married population, while 58.1% of singles are not enrolled in the scheme. The findings, moreover, show that UAS enrolment increases with age, whereas, the older age groups show higher rates: 56-65 (86.7%), 46-55 (69.5%), and above 66 years 59.1%.

3.1.3 Co-operative Members' Perceptions on Health Insurance and the UAS: The findings in Table 4 show that a substantial proportion of respondents 72% and 65% agreed and strongly agreed, respectively, suggesting that many cooperative members are aware of and knowledgeable about the UAS. However, 37% and 39% strongly disagreed and disagreed, indicating a significant portion lack adequate information. Notably, 82% of respondents gave neutral responses (neither agreeing nor disagreeing), suggesting considerable uncertainty or a lack of clear understanding about the actual benefits received and services offered. At the same time, 63% and 59% respectively agreed and strongly agreed, indicating that a notable number of members do perceive positive benefits from the UAS.

Table 4: Members' Perception of the UAS

Attributes	Perceived satisfaction and understanding of the UAS (%) responses				
	Fully disagree	Disagree	Neutral	Agree	Fully agree
Co-op members are aware of and know the UAS	37.0	39.0	61.0	72.0	65.0
Co-op members view the scheme positively in terms of the provided services and benefits accrued	47.	52.0	82.0	63.0	59.0
Co-op members have trust and confidence in the UAS	49.0	51.0	74.0	83.0	67.0
Members perceive that UAS services are affordable	58.0	69.0	52.0	52.0	41.0
Members perceive the healthcare services under UAS as substandard and delayed.	33.0	46.0	78.0	54.0	43.0
UAS is often viewed as a tool for social inclusion	39.0	47.0	58.0	79.0	69.0
Members perceive that UAS has administrative and operational challenges	55.0	53.0	49.0	54.0	63.0

Interestingly, despite nearly half of the respondents expressing disagreement regarding trust and confidence in the scheme, a majority 83% and 67% agreed and strongly agreed, respectively, that their trust and confidence in the UAS had increased due to various other factors. However, the high percentage of neutral responses (74%) further emphasises ongoing uncertainty or inconsistencies in members' experiences with the scheme (Table 4). The findings on perceived service quality and accessibility are critical for understanding members' experiences with the Ushirika Afya Scheme (UAS). A substantial portion of respondents

(78%) gave neutral responses, indicating limited direct experience or inconsistent knowledge regarding the quality and accessibility of UAS services. This neutrality may reflect a lack of engagement with the scheme or uncertainty about its effectiveness. In contrast, 54% of respondents agreed, and 45% strongly agreed that the services provided were substandard and often delayed.

3.1.4 Determinants of Members' Engagement in the Ushirika Afya scheme:

In this study, a total of ten determinants were subjected to the Relative Importance Index (RII) to identify the most and the least important determinant factors (Table 5).

Table 5: Determinants of Members' Engagement in the UAS

Factors	Extremely important affecting (5)	Very Important Affecting (4)	Moderately important affecting (3)	Lowly important affecting (2)	Not at all important affecting (1)	The total weight (W)	Total Number (N)	A*N	RII	Rank
Age	158	143	171	207	201	880	300	1500	0.586	M
Level of Education	289	272	201	287	187	1236	300	1500	0.824	H
Sex	215	283	216	207	199	1120	300	1500	0.746	H-M
Marital Status	275	279	198	214	195	1161	300	1500	0.774	H-M
Household Size	186	109	178	135	159	767	300	1500	0.511	M
Economic activities	204	182	192	201	215	994	300	1500	0.662	H-M
Trust in the health system scheme	205	279	264	217	252	1217	300	1500	0.811	H
Awareness and Information Access	265	293	275	269	219	1321	300	1500	0.880	H
Influence of Co-operative Leadership	113	203	270	289	268	1143	300	1500	0.762	H-M
Perceived Benefits and Costs	201	178	193	297	189	1058	300	1500	0.705	H-M

KEY: High (H), High-Medium (H-M), Medium-M

The analysis of determinant factors influencing members' decisions to enroll in the Ushirika Afya Scheme (UAS) was conducted using the Relative Importance Index (RII). Based on the model assumptions, RII values were used to categorise the importance of each factor. The findings in Table 5 indicate that three extremely important determinant factors were found to have a high index ($0.8 < \text{RII} < 1.0$). Others include five determinant factors with a high-medium index ($0.6 < \text{RII} < 0.8$), two factors have been ranked medium ($0.4 < \text{RII} < 0.6$).

3.2 DISCUSSION OF THE FINDINGS

3.2.1 Socio-demographic characteristics of the respondents: The findings in Table 2 indicate that many respondents were males, which reflects gender dynamics in cooperative membership and decision-making roles, particularly in rural Tanzania, where men often control household finances and are more likely to be cooperative leaders or representatives. Moreover, the low female representation suggests a gap in gender inclusiveness among the cooperative members in the study area. The analysis of age distribution shows that the largest group of respondents was 56-65 years, followed by those in the 46-55 years and 36-45. The findings suggest that most respondents are middle-aged to older adults (46-65), which aligns with the age of active cooperative members. The results also indicate that the younger age groups (18-25) have limited involvement in cooperative membership. This points to a need for youth-focused outreach or education about the benefits of insurance early in life. The education level of the respondents shows that a large group of the respondents had primary education, followed by those with secondary education, while a few of them possessed tertiary or

university-level education. This suggests that most respondents have relatively low education levels. The findings further show that many respondents' households had between four and six members, while a few of them had between seven and nine household members. This indicates that cooperative schemes might consider family or group coverage options to boost participation and lower per-person costs. Based on the marital status of the respondents, the findings show that high rates of marriage suggest respondents are likely to have family responsibilities; hence, married individuals may be more motivated to seek financial protection for dependents as well as positively influence participation in schemes like Ushirika Afya.

3.2.2 AMCOS Members' Membership Status in the Ushirika Afya Scheme:

Regarding the membership status the findings show many the respondents were members of the UAS, while few others have not joined the scheme. The findings, moreover, have indicated that males represent a significantly higher proportion of UAS members compared to females; many male respondents were members, while less than half of the female respondents were enrolled in the scheme. This could be due to multiple factors, like the limited control over finances in the households, especially in male-headed households, or also due to lower representation in cooperative leadership, and therefore, less access to scheme information or cultural norms that deprioritise women's access to decision-making. Since males dominate both cooperative membership and scheme enrolment, the health insurance decisions are likely to be male driven. However, men's dominant role does not automatically translate into family-wide coverage unless encouraged or incentivized.

While this may reflect men's greater access to cooperative resources and decision-making power, it raises concerns about equity and inclusion in access to health coverage in the study area. Addressing these gender disparities will be crucial for achieving universal health coverage among AMCOS members. This was also confirmed in one of the FGD session that:

".... Most members in cooperative are men because, men are the ones making decisions in everything, and men are the ones who participate in cooperative meetings, and the decision to join UAS is made by males as the members of AMCOS....." (FGD-Gallapo)

The findings align with those of Mwinuka *et al.* (2022), who, in their study on the uptake of health insurance and its associated factors, noted that men were more likely than women to attend groups and village meetings, giving them better access to information. The study further attributed women's lower participation in the uptake of the UAS through AMCOS to cultural norms, thereby limiting their access to information. The findings also have indicated that married individuals dominate membership status, showing a high enrolment rate among the married population. The findings suggest that the high enrolment among married individuals was expected, as married people often have greater family responsibilities, especially regarding the health of children and spouses. The findings have clearly presented that marital status is a strong predictor of membership in the UAS in the study area, whereas married individuals are the most likely to be enrolled, reflecting their heightened awareness of health needs and responsibilities. The single and widowed individuals, especially women, are underrepresented, pointing to potential

financial, informational, or social access barriers. This calls the need for addressing these gaps through targeted communication, inclusive premium structures, and supportive community networks to expand coverage and improve equity in health insurance participation. The findings, moreover, have revealed that UAS membership increases with age, whereas the older age groups show higher enrolment rates. This implies that older individuals are more likely to value or seek health insurance, likely due to various reasons like increased health risks with age, greater healthcare needs, as well as more life experience and understanding of medical cost burdens. However, the low enrolment rate among the youth may be due to the perception that they consider themselves healthier. It was, moreover, narrated by one of the KII:

".....at my age and my economic situation, the UAS is my security, I can run to the hospital and get treated. The UAS ID is my security guard in health issues." (KII-Dareda).

This statement proves that there is a clear positive correlation between age and the likelihood of enrolling in the UAS. As age increases, so does the percentage of enrolment, peaking among individuals based on the age groups.

3.2.3 Co-operative Members' Perceptions on Health Insurance and the UAS: The perceptions of co-operative members on health insurance and the UAS in the study area have been described by exploring several key emerging themes. The key themes analysed and examined in this study include awareness and understanding, perceived benefits and cost, trust and confidence in the scheme, affordability and willingness to pay, health service quality and accessibility, perception of equity and inclusion, as well as administrative and

operational challenges of the UAS. The findings show that a substantial proportion of respondents suggest that many cooperative members are aware of and knowledgeable about the UAS. However, a notable limited number of them indicated that they lack adequate information. This highlights presence of information gap, hence indicating the need for enhanced communication efforts to ensure dissemination of information regarding the UAS. The findings also reveal varied perceptions among cooperative members regarding the benefits and services provided by the UAS. Notably, many respondents gave neutral responses (neither agreeing nor disagreeing), suggesting considerable uncertainty or a lack of clear understanding about the actual benefits received and the quality of services offered by the scheme. Interestingly, despite nearly half of the respondents expressing disagreement regarding trust and confidence in the scheme, a majority agreed that their trust and confidence in the UAS had increased due to various other factors. These mixed perceptions suggest that while there is a growing base of trust and satisfaction with the UAS, a significant proportion of members remain uncertain or unconvinced about its benefits and service quality. This highlights the need for the scheme to improve transparency, communication, and service delivery to build stronger, more uniform confidence. The findings on perceived service quality and accessibility are critical for understanding members' experiences with the UAS. A substantial portion of respondents gave neutral responses, indicating limited direct experience or inconsistent knowledge regarding the quality and accessibility of UAS services. This neutrality may reflect a lack of engagement with the scheme or uncertainty about its effectiveness. These varying responses raise concerns about the quality-of-service delivery and signal a potential red flag for UAS stakeholders. These findings suggest an urgent need for UAS stakeholders to address

service delivery challenges to improve user satisfaction and trust.

3.2.4 Determinants of Members' Engagement in the Ushirika Afya scheme:

The study examined the important determinant factors in the members' decision to join the UAS. Based on the literature, there are several factors that may determine someone's decision or that can influence an individual's decision. The findings have indicated that three extremely important determinant factors were found to have a high index. This indicates that these factors are perceived by respondents as critical and significant in influencing their decision to join UAS. There were also other factors which indicated that they are to be considered very important, though slightly less influential. However, they are still significant motivators for the enrollment and should be actively addressed in implementation strategies. Moreover, there were other factors which were ranked medium, indicating that they are moderately determinant factors for individuals to enroll in the UAS. Additionally, based on the model assumption, there were neither low-important determinant factors nor, not at all important. They are seen as moderately important, influencing some individuals but not decisive for the majority. However, when combined with other factors, they may still play a role in an individual's decision. The findings are supported by those of Msuya *et. al.* (2007), which showed that community insurance scheme members were influenced by community development officers to join the insurance, and that advocating community health insurance was an important means to reach the poorest of the poor. Finally, the RII analysis indicates that all involved determinant factors have at least a moderate influence on members' decisions

to enroll in the UAS. The presence of three extremely important factors and five very important ones highlight the multifaceted nature of health insurance uptake. The findings imply that no single factor can drive membership alone; rather, a combination of affordability, trust, access, and awareness must be addressed collectively to increase engagement and sustainability of UAS.

CONCLUSION, RECOMMENDATIONS AND FURTHER RESEARCH

Conclusions: The analysis demonstrates that age is a significant determinant of membership in the UAS in the study area. The likelihood of joining the scheme increases with age. Whereas the younger adults have shown significantly lower enrolment rates in the UAS. This pattern suggests that older individuals perceive greater health risks, have more frequent healthcare needs, and therefore value health insurance more highly. Conversely, younger people may feel less urgency to enroll, possibly due to perceived good health, limited income, or lack of awareness. Regarding the Perception of Co-operative members towards UAS, the study revealed that members think the insurance is for elderly people, for sick people, and poor people therefore there is need of awareness and mind transforming training, among the AMCOS members and need for the promotion of youth engagement in the AMCOS. Shortly, the findings tell that age plays a critical role in shaping enrolment behaviour in UAS, and addressing age-specific needs and perceptions will be essential for expanding and sustaining scheme membership across all demographic groups.

Recommendations: The study recommends that AMCOS should:

- i) Develop age-specific education programs that emphasise the importance of early health insurance enrollment, even when one feels healthy. Also they can use youth-friendly platforms (e.g., radio programs, social media, village youth groups) to raise awareness among them.
- ii) In order to promote the UAS among members there is a need to include real-life stories or testimonials from peers to illustrate the risks of being uninsured. This should also go together with initiatives to offer youth-discounted premiums or starter packages for younger individuals, possibly through cooperative youth programs.
- iii) Provide family-based or bundled plans where younger family members can be included under a household policy.
- iv) Engage influential community figures to advocate for health insurance across all ages, particularly to reach youth and low-literacy populations with trusted voices.

This study was limited to the perceptions of AMCOS members on UAS services. We recommend that the further study can be done on UAS members' willingness to pay for the health insurance. The study was done in Babati district; we recommend that the same

study can be conducted elsewhere in a country with the same characteristics. However, the stated limitations do not nullify the significance of this study findings and its contribution to the literature.

REFERENCES

- Adesina, A. E. (2011). Perceived Impact of Primary Education on the Attainment of Nigerian Vision 2020. *Mediterranean Journal of Social Sciences*, 2, 2117-2039.
- Ajzen, I. (1991). The Theory of Planned Behaviour. *Organisational Behaviour and Human Decision Processes*, 50, 179-211.
- Amu, H., Dickson, K.S., Kumi-Kyereme, A., and Darteh, E.K.M. (2018). Understanding variations in health insurance coverage in Ghana, Kenya, Nigeria, and Tanzania: Evidence from demographic and health surveys. *PLoS ONE*, 13(8), e0201833. <https://doi.org/10.1371/journal.pone.0201833>
- Asfaw, A. and Braun, J. (2004). Is Consumption Insured against Illness? Evidence on Vulnerability of Households to Health Shocks in Rural Ethiopia. *Economic Development and Cultural Change*, Volume 53, Number 1. <https://doi.org/10.1086/423255>
- Cebul R., Rebitzer, J., Taylor, L. and Votruba, M. (2011). Unhealthy Insurance Markets: Search Frictions and the Cost and Quality of Health Insurance. *American Economic Review*, 101(5):1842-1871
- Chen, S., Zhang, Y.E. and Long, M. (2010). Supporting Online Material. *Science*, 330 (6011): 1682-1685 [DOI: [10.1126/science.1196](https://doi.org/10.1126/science.1196)].
- Green, P. (2014). The Importance of Reduced Meat and Dairy Consumption for Meeting Stringent Climate Change Targets, Climatic Change. *Journal of Agriculture, Ecosystem and Environment*, 1(24), 79-91.
- Katundu, M. A. & Gabagambi, D. M. (2014). Entrepreneurial Tendencies of Tanzanian University Graduates: Evidence from the University of Dar-es-Salaam. *European Journal of Research*, 1(12), 5525-5558.
- Komba, C. K. (2024). Factors Affecting People with Disabilities' Access to Micro-Finance Services in Kilimanjaro, Tanzania. *East African Journal of Management and Business Studies* 4(1), 73-79. DOI: <https://doi.org/10.46606/eajmbs.2024v04i01.0044>.
- Leedy, P. D. (1989). Practical Research: Planning and Design. New York: Macmillan.
- Msuya, J., Jutting, J.P. & Asfaw, A. (2007). Impact of Community Health Funds on the Access to Health Care: Empirical Evidence from Rural Tanzania. *International Journal of Public Administration*, 30 (8-9), 813-833.
- Mwinuka, B., Echoka, E. and Nyaberi, J.M. (2022). Uptake of Health Insurance and Its Associated Factors Among Informal Sector Workers in Dar Es Salaam,

-
- Tanzania. *Journal of Healthcare in Developing Countries*, 1(2), 20-25.
- NHIF (2020) Fact sheet as at 30th June 2020.
- Nzowa, P.G., Nandonde, F.A. & Seimu, S.M.L. (2023). Participation in health insurance and changes in the well-being status of co-operative members in Tanzania. *Decision*, 49 (5), 1-14.
<https://doi.org/10.1007/s40622-023-00362-z>
- Sambuo, D. (2022). The Sixth Principle of Cooperatives: Does Tanzania Succeed in Sectoral Cooperation Among Cooperatives during the Post-COVID-19 Era. In: 9th Technical Committee of the Africa Ministerial Co-operative Conference (TCAMCCO). Sarova Whitesand: Mombasa, Kenya.
- TCDC (2022). Establishment of National Cooperative Bank.
[\[https://www.ushirika.go.tz/index.php/resources/view/benki-ya-taifa-ya-ushirika-kuanzishwa\]](https://www.ushirika.go.tz/index.php/resources/view/benki-ya-taifa-ya-ushirika-kuanzishwa).
 Retrieved on March 11, 2023,
- Tungu, M., Amani, P. J., Hurtig, A. K., Dennis Kiwara, A., Mwangi, M., Lindholm, L., & San Sebastian, M. (2020). Does health insurance contribute to improved utilization of health care services for the elderly in rural Tanzania? A cross-sectional study. *Global health action*, 13(1), 1841962.
<https://doi.org/10.1080/16549716.2020.1841962>
- URT. (2018). *Social Security Laws and Regulations*. Dodoma: URT.
- WHO (2019) Global Spending on Health: A World in Transition Global Report. Geneva.