Analisa: Journal of Social Science and Religion 11(1) July 2026
https://doi.org/10.18784/analisa.v11i1.4017

OPEN ACCESS

Integrating Takaful Into Tanzania's Universal Health Insurance Framework: Policy Insights from Indonesia

Issa G. Ahmed*
Universitas Indonesia, Indonesia and Tanzania Cooperative Development Commission, Tanzania

Sylivia Aulila Lugereka
Universitas Sebelas Maret, Indonesia

Edmund Zakayo
Institute of Rural Development Planning, Tanzania

Article History

Received
March 24, 2026

Revised
July 11, 2026

Accepted
July 16, 2026

Published
July 31, 2026

Abstract

Tanzania's transition toward Universal Health Coverage (UHC) under the Universal Health Insurance (UHI) Act faces persistent challenges: insurance coverage remains near fifteen percent of the population, and high out-of-pocket costs continue to expose vulnerable households to catastrophic expenditure. At the same time, Tanzania introduced Takaful guidelines in 2022, spurring growth in Shariah-compliant financial products. This article examines how Tanzania's NHIF and UHI reforms can draw on Takaful principles and on Indonesia's comparative experience to design more inclusive, faith-sensitive health insurance. Drawing on Tanzanian statutory documents, TIRA's Takaful Guidelines, and secondary literature on Indonesia's Jaminan Kesehatan Nasional (JKN), the study applies a normative legal approach combined with comparative case study analysis, within a conceptual framework linking social health insurance theory, Takaful principles, and principal-agent theory. Indonesia offers an instructive comparator, having reached over ninety-five percent population coverage while integrating Islamic microinsurance. The analysis indicates that although Tanzania continues to face gaps in financial protection and enrolment trust, its regulatory environment is now favourable for integrating Takaful-based pooling and Shariah governance into national implementation. On this basis, the article proposes three design pathways: accredited Takaful health plans, community-based micro-Takaful linked to the UHI Equity Fund, and Takaful top-up products. These pathways represent one of the first systematic attempts to connect Tanzania's UHI reform agenda with Indonesia's Takaful-JKN experience and, paired with safeguards against risk-pool fragmentation, may help deepen health coverage in Tanzania. Empirical research is still needed to test their effectiveness in practice.

Keywords: *Universal health coverage; takaful; health financing; Islamic microinsurance*

**Correspondence: Issa G. Ahmed, Universitas Indonesia, Indonesia and Tanzania Cooperative Development Commission, Tanzania*
issa.g@ui.ac.id , issa.sako@yahoo.com

INTRODUCTION

Achieving Universal Health Coverage (UHC) remains a critical global priority within the Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being) and SDG 8 (Decent Work and Economic Growth) (Widyanata et al. 2024). The concept of UHC encompasses access to essential health services without exposure to financial hardship. Despite significant global progress, many developing nations, particularly in sub-Saharan Africa, continue to face structural barriers to achieving meaningful coverage, including fragmented insurance schemes, a large informal workforce, and deep-seated mistrust of financial institutions (Kaonga et al. 2026).

In recent years, the integration of Islamic finance instruments, specifically *Takaful* (Islamic insurance), has emerged as a transformative mechanism for health financing in developing nations (Nuraini 2023). *Takaful* fundamentally differs from conventional insurance by operating on the principles of mutual assistance (*ta'awun*) and voluntary donation (*tabarru'*), thereby eliminating elements of uncertainty (*gharar*), gambling (*maysir*), and *usury* (*riba*) (Widyanata et al. 2024). For Muslim-majority and Muslim-minority populations in low- and middle-income countries, these ethical distinctions are not merely theoretical: they directly shape willingness to participate in formal financial protection mechanisms. Following the global economic shocks of the COVID-19 pandemic, consumer awareness and demand for health *Takaful* surged significantly, demonstrating the industry's resilience and its critical role in mitigating catastrophic health expenditures during crises (Fodol and Aslan 2023; Abdullah 2021).

In the case of low-income communities, conventional health insurance premium costs prove to be too high, which in turn increases out-of-pocket expenditures on healthcare. To address this issue, the literature has extensively explored the concept of micro-*Takaful*, which has been specifically designed for underserved and informal communities (Rapi and Kassim 2023; Salleh et al. 2018). The literature has established that micro-*Takaful* can offer financial protection at a relatively low premiums and can be innovatively linked with Islamic social finance tools, such as *zakat* (almsgiving) and *waqf* (endowment), in order to cross-subsidize the contributions of the poorest households (Azizah 2025). Moreover, when financial products are framed in a manner that aligns with the religious values of individuals, research has established that this increases the intention of faith-sensitive demographics to participate (Megawati and Rifda Zahirah 2025).

Tanzania has embarked on major health financing reforms to accelerate progress towards UHC. Historically, the National Health Insurance Fund (NHIF) primarily covered formal sector workers, while fragmented community-based schemes such as the Community Health Fund (CHF) and its successor, the improved Community Health Fund (iCHF), targeted the informal sector with limited success (Binyaruka et al. 2023). Recent National Health Accounts show that total health expenditure relies heavily on government and donor funding, but out-of-pocket (OOP) payments still account for about a quarter of current health expenditure, and health insurance contributes less than 15% (Osoro et al. 2024).

Tanzania's Universal Health Insurance (UHI) Act 2023 aims to increase compulsory coverage, deepen risk pooling, and strengthen cross-subsidisation across population groups (Binyaruka et al. 2023). At the same time, studies have indicated that households, especially in rural and low-income areas, have continued to experience catastrophic health spending even with voluntary health insurance products (Kagaigai et al. 2023). This indicates that legal frameworks might not be enough without developing models that consider

aspects like affordability, trust, religious acceptability, and quality of service. In parallel, developments in Tanzania's financial sector, including the introduction of dedicated *Takaful* (Islamic insurance) regulations, indicate recognition of *Shariah*-compliant risk pooling as a means of promoting financial inclusion.

Takaful Guidelines, the emergence of a state-backed *Takaful* company in Zanzibar, and CRDB Bank's launch of *Takaful* products in partnership with ZIC illustrate this momentum (TIRA 2022; AlHuda CIBE 2022). Given that roughly one-third of Tanzanians are Muslim, *Takaful*-inspired health insurance could help expand *bima ya afya jumuishi* (inclusive health insurance) in culturally congruent ways. Indonesia offers a useful comparator: its National Health Insurance (Jaminan Kesehatan Nasional, JKN) has achieved over 90 to 95% population coverage while reducing OOP expenditure and catastrophic health spending, supported by broader growth in Islamic finance and micro-*Takaful* initiatives (WHO 2024).

The case for examining *Takaful* as a complement to Tanzania's health financing reform is further strengthened by demographic and sociological realities. Tanzania's Muslim population is estimated at approximately 35% of the mainland total and over 97% in Zanzibar, representing a substantial segment of the population for whom *Shariah*-compliant financial instruments hold particular salience (AlHuda CIBE 2022). Beyond religious affiliation, studies across sub-Saharan Africa consistently show that enrolment in community-based health schemes is strongly mediated by social networks, trust in community institutions, and prior experience with financial cooperatives (Kagaigai et al. 2023). *Takaful*, by embedding insurance within familiar structures of mutual assistance and religious duty, could activate these dynamics, though its success still depends on institutional design, regulatory oversight, and the quality of health services members can actually access.

Despite this momentum, the existing literature has not systematically examined how *Takaful* principles might be integrated with Tanzania's NHIF/UHI framework, nor has it drawn structured lessons from jurisdictions, such as Indonesia, that have already combined national social health insurance with Islamic microinsurance. This represents a clear research gap. Addressing it matters because Tanzania's reform window is currently open: the UHI Act is newly enacted and the *Takaful* Guidelines are newly issued, which means design choices made now will shape whether Islamic insurance reinforces or fragments the national risk pool for years to come.

This study therefore addresses the following question: how can Tanzania's NHIF and UHI reforms use *Takaful* principles and Indonesia's experience to create more inclusive health insurance schemes for both formal and informal sector populations? The article uses secondary data, literature, and policy analysis to explore this question, situating its contribution within the fuller discussion of the research gap.

Literature Review

The literature reviewed below spans five bodies of work: health financing and UHC in sub-Saharan Africa, Tanzania's own NHIF and iCHF reforms, the global *Takaful* and Islamic microinsurance literature, Indonesia's JKN experience, and Tanzania's emerging Takaful landscape. Read together, these bodies of work establish two things that motivate this article: first, that enrolment and financial protection in low-income settings depend as much on trust, service quality, and cultural acceptability as

on legal mandates; and second, that *Takaful*, precisely because it is built on mutual assistance and religious duty, is a plausible mechanism for building that trust, provided it is integrated into a national risk pool rather than left to develop in parallel to it. The review closes by identifying the specific gap this article addresses.

Health Financing and Universal Health Coverage in Sub-Saharan Africa

The global commitment to UHC has accelerated health financing reform across sub-Saharan Africa, yet structural obstacles remain formidable. A fundamental tension exists between the aspirational goal of universal coverage and the institutional realities of low- and middle-income countries, where large informal labour markets, weak administrative capacity, and limited fiscal space constrain the expansion of contributory insurance schemes (Kagaigai et al. 2023). Scholars have distinguished between coverage in law and coverage in practice, which depends on whether insured individuals can actually access services of adequate quality without incurring financial hardship (Binyaruka et al. 2023). The mismatch between these two dimensions is particularly pronounced in rural and peri-urban communities, where health infrastructure remains sparse and provider responsiveness is often poor (Nuru and Ngowi 2025).

Health financing reform models in sub-Saharan Africa have broadly followed three trajectories: tax-financed systems, social health insurance schemes, and community-based health financing arrangements, each carrying distinct equity implications. Tax-financed systems offer the broadest potential for cross-subsidisation and are generally considered most progressive, but depend on sufficient domestic resource mobilisation, which many low-income African countries struggle to achieve (Osoro et al. 2024). Social health insurance schemes, including payroll-based contributions, have been championed as a middle path but are inherently limited by the size of the formal employment sector.

In Tanzania, as in many comparable economies, formal employment accounts for less than 10% of total employment, meaning that payroll-based models can never, by design, achieve universality (Kagaigai et al. 2023). Community-based health financing (CBHF) schemes, by contrast, were initially heralded as an innovative mechanism for extending coverage to the informal sector, but longitudinal evidence has consistently demonstrated their limitations: small, fragmented risk pools lead to adverse selection, high administrative costs per member, and insufficient actuarial reserves to manage catastrophic claims (Kapologwe et al. 2024).

The broader literature on health financing equity in sub-Saharan Africa also highlights the gendered dimensions of coverage gaps. Women in informal employment, particularly smallholder farmers, petty traders, and domestic workers, are disproportionately excluded from contributory schemes and face additional barriers related to mobility, documentation, and decision-making autonomy within households (Binyaruka et al. 2023). Faith-based and community-trust networks have been identified as potentially powerful channels for reaching these groups, a finding with direct relevance to the *Takaful* integration debate in the Tanzanian context.

Health financing and NHIF reforms in Tanzania

Tanzania's health system is financed through a mix of general taxation, donor support, OOP payments and multiple insurance schemes. Health insurance coverage has remained low and segmented

(Haazen 2012). NHIF historically covered civil servants and formal workers, iCHF targeted rural and informal groups at district level, while private schemes covered mainly higher-income urban residents (Binyaruka et al. 2023). National Health Accounts and recent analytic work indicate that health insurance contributions account for about 8 to 11% of current health expenditure, while OOP payments have hovered around 22.7%, exposing households to financial risk (AlHuda CIBE 2022).

Studies on iCHF highlight both progress and persistent challenges. Scale-up analysis using the Expand Net framework found that the redesigned iCHF partially reduced fragmentation by pooling funds at regional level and harmonising benefit packages, yet enrolment remained modest and implementation capacity varied across districts (Kapologwe et al. 2024). Household-level analyses show that iCHF membership is associated with higher health-care utilisation and lower catastrophic health expenditure than among non-members, though benefit gaps, stock-outs, and co-payments mean many insured households still face financial risk, with national enrolment reaching only about 25% by 2018/2019 (Kagaigai et al. 2023; Nuru and Ngowi 2025). Trust and perceived value shape these outcomes directly: Nuru and Ngowi (2025), in a cross-sectional study across the Manyara region, found that drug availability, provider attitude, and responsiveness at the point of care were stronger predictors of enrolment than premium affordability, consistent with evidence that households who have experienced stock-outs or unofficial payments are rational to doubt that formal insurance will translate into effective coverage (Kagaigai et al. 2023). Any reform model that includes *Takaful*-inspired designs must therefore address service delivery quality alongside financial architecture.

The UHI Act 2023 responds to these weaknesses by mandating universal coverage, rationalising multiple schemes, and introducing an equity fund for subsidising vulnerable groups (Osoro et al. 2024). However, commentary from Tanzanian and international health-financing experts warns that contributory models in low- and middle-income countries often struggle to cover large informal sectors and may deepen inequities if contributions are regressive or enforcement is weak (Kagaigai et al. 2023). The Act's success will therefore depend heavily on the implementation architecture, particularly the design of the Equity Fund, the mechanisms for enrolling informal sector workers, and the regulatory capacity to manage an expanded pool of accredited insurers.

Takaful, Islamic microinsurance and health coverage

Takaful is a *Shariah*-compliant form of mutual insurance based on shared responsibility, solidarity and risk-sharing, where participants contribute to a common pool (*tabarru'*) managed by an operator under *wakala* (agency) or *mudaraba* (profit-sharing) contracts. Surpluses are normally shared with participants, and investments must comply with Islamic finance principles (no *riba, gharar* or *maysir*). Recent bibliometric reviews of Islamic microinsurance highlight its potential to support social protection and risk-management among low-income Muslim communities, especially when integrated with microfinance, *zakat* and *waqf* instruments (Puspita and Kartikawati 2022).

The global *Takaful* industry has grown rapidly over the past two decades, with contributions rising from under USD 2 billion in 2005 to over USD 27 billion by the early 2020s, driven predominantly by markets in Southeast Asia and the Gulf Cooperation Council (Nuraini 2023).

Health *Takaful* has emerged as one of the fastest-growing segments, reflecting rising Muslim middle-class demand for *Shariah*-compliant financial protection and heightened awareness of health risks following the COVID-19 pandemic (Fodol and Aslan 2023). The pandemic context is particularly instructive: Fodol and Aslan find that while conventional insurers suffered significant underwriting losses from pandemic-related health claims, the cooperative structure of *Takaful*, including the surplus-sharing mechanism and the *tabarru'* pooling model, contributed to greater resilience, as participants absorbed collective losses through the mutual fund rather than through sharp premium increases.

Indonesia has been a pioneer in Islamic microinsurance, launching *Shariah*-compliant microinsurance products in 2014 and subsequently expanding offerings that cover life, health and disaster risks for low-income households and micro-entrepreneurs (Puspita and Kartikawati 2022). Digital platforms have increasingly been used to distribute small-ticket *Takaful* products, reducing transaction costs and improving access in remote areas (Sintarini 2024). The literature suggests that governance quality (*Shariah* boards, transparency of surplus distribution) and alignment with broader social finance instruments are critical for trust and sustainability of *Takaful* schemes (Tri Puspita and Ratna Kartikawati 2022).

A critical body of literature has also examined the determinants of micro-*Takaful* uptake among low-income populations. Rapi and Kassim (2023) applying Ajzen's Theory of Planned Behavior to Indonesian respondents, find that subjective norms, particularly endorsement by religious leaders and community figures, are among the most significant predictors of intention to participate in micro-*Takaful* schemes. This finding has important practical implications: distribution through mosque networks, Islamic cooperatives, and community savings groups (*arisan*) can leverage existing social trust to overcome the scepticism that has historically constrained formal insurance enrolment among Muslim populations. Megawati and Zahirah (2025) further demonstrate that the alignment of financial products with spiritual and religious values substantially increases intention to use *Shariah*-compliant insurance, independent of premium level or benefit design. Together, these findings support the hypothesis that *Takaful*, when properly embedded in community structures, can overcome the trust deficit that has plagued conventional insurance schemes in many Muslim-majority contexts (Megawati and Zahirah 2025; Rapi and Kassim 2023).

The integration of *Takaful* with Islamic social finance instruments, particularly *zakat* and *waqf*, represents a promising but underexplored avenue for extending coverage to the ultra-poor. Azizah (2025) proposes a framework in which *zakat* revenues, collected by state or mosque-based institutions, are channelled directly into the *tabarru'* fund to cover the contributions of the most vulnerable households, effectively creating a form of faith-based cross-subsidization. The scale of this opportunity is unlikely to be uniform across regions: spatial clustering of *zakat* potential across Indonesian provinces shows that collection capacity varies considerably by economic base, with agricultural and plantation income driving much of the variation between provinces, which suggests that a *zakat*-linked *Takaful* subsidy mechanism would need to be calibrated to local *zakat* capacity rather than applied as a single national formula (Karim et al. 2022). This model has theoretical parallels with the government-financed premium subsidies used in Indonesia's JKN but draws on voluntary

religious obligation rather than fiscal transfers, potentially reducing the political economy constraints associated with public subsidy programmes. Devi (2024) raises important *Shariah* governance questions about the conditions under which *tabarru'* donations can legitimately be used to cover health claims, underscoring the need for robust independent *Shariah* board oversight in any integrated *Takaful*-health insurance model.

Indonesia's JKN and financial protection

Indonesia introduced JKN in 2014 to unify multiple insurance schemes and expand coverage nationwide. At the time, less than half of the population was financially protected and OOP spending represented around 45% of current health expenditure. By December 2023, JKN covered over 260 million people, more than 95% of the population, and reduced OOP spending to 27.5% of current health expenditure, while catastrophic health expenditure fell from 4.5% in 2017 to 2% in 2021 (WHO 2024).

WHO (2024) documentation attributes this progress to strong political commitment, consolidation of risk pools, and subsidisation of contributions for the poor, alongside continuous technical support for strategic purchasing, benefit design and equity monitoring. A particularly instructive feature of JKN's design is its dual-layer structure: the programme mandates membership for all Indonesian citizens but provides differentiated contribution pathways for formal sector workers (payroll-based), informal sector workers (voluntary contributions), and the poor and near-poor (fully government-subsidised premiums). This architecture avoids the classic coverage gap associated with purely contributory models while preserving financial sustainability through diversified revenue streams.

The JKN experience also yields important cautionary lessons. (Dartanto et al. 2020) conducted a large-scale analysis of premium compliance among informal sector JKN members and found that irregular payment was strongly associated with low perceived quality of care, geographic distance from health facilities, and limited understanding of the insurance mechanism. These findings suggest that enrolment alone does not guarantee effective coverage: sustained utilisation and continued contribution depend on a positive feedback loop between insurance membership and experience of quality health services. This insight is directly transferable to Tanzania, where the evidence base on iCHF similarly shows that the quality of care received by insured members is as important as premium levels in determining continued enrolment (Nuru and Ngowi 2025).

In parallel, Indonesia's Islamic finance sector, including micro-*Takaful*, has grown rapidly, offering complementary *Shariah*-compliant products that can top up or sit alongside JKN coverage for specific risks (Puspita and Kartikawati 2022). Sintarini (2024) document the increasing role of digital platforms in distributing micro-*Takaful* products, reaching rural and peri-urban populations that conventional insurance agents have historically failed to serve. The Indonesian model thus illustrates a complementary rather than competitive relationship between social health insurance and Islamic microinsurance, with JKN providing the foundational coverage architecture and micro-*Takaful* filling specific benefit gaps for Muslim households who prefer *Shariah*-compliant arrangements.

Emerging *Takaful* landscape in Tanzania

In 2022, TIRA issued dedicated *Takaful* Guidelines, effective from May of that year, to provide a regulatory framework

for Islamic insurance and digital insurance platforms. The guidelines aim to increase insurance penetration to 50% of adults by 2030, promote digital distribution, and ensure that *Takaful* products comply with *Shariah* requirements (AlHuda CIBE 2022). Zanzibar has since launched the country's first full-fledged *Takaful* Company under the Zanzibar Insurance Corporation (ZIC), positioning the island as a hub for Islamic banking, Sukuk, Islamic social security, and *Takaful* in East Africa (Suleiman 2025).

On the mainland, CRDB Bank's *Al Barakah* Islamic banking window has introduced *Shariah*-compliant products and, in partnership with ZIC *Takaful* and its bancassurance arm, launched *Takaful* insurance products reaching several hundred customers in the first year (Suleiman 2025; The Guardian 2024). Bukanu and Mukama (2025) provide important context on the regulatory challenges facing Islamic banking in Tanzania's predominantly conventional financial system, noting that the co-existence of *Shariah*-compliant and conventional products within the same regulatory framework creates interpretive ambiguities that can constrain product innovation and market confidence. Despite these developments, the academic literature on *Takaful* in Tanzania remains sparse, and there has been virtually no scholarly analysis of how *Takaful* principles might be integrated with the NHIF/UHI framework, representing a significant research gap that this article seeks to address.

Sub-Saharan African experiences with community-based *Takaful*-adjacent schemes, while limited, offer additional context. In Kenya and Uganda, faith-based cooperative savings groups, often organised through mosques and churches, have provided informal health risk-pooling for decades, demonstrating that community solidarity mechanisms can function effectively even in the absence of formal insurance regulation (Puspita and Kartikawati 2022). These informal arrangements share structural features with both CBHF schemes and *Takaful*, voluntary contribution, community governance, moral rather than actuarial framing, and their persistence suggests a genuine preference for solidarity-based risk pooling that formalised micro-*Takaful* products could channel into a regulated framework.

Research gap and contribution

The existing literature, while rich in insights on Tanzania's health financing challenges and global *Takaful* development, has not systematically explored the intersection of these two domains. Studies on iCHF and NHIF reform focus primarily on administrative and financial architecture, with limited attention to the cultural and religious dimensions of enrolment behaviour. Conversely, the *Takaful* and Islamic microinsurance literature have concentrated on markets in Southeast Asia and the Gulf, with very limited empirical work from sub-Saharan Africa (Puspita and Kartikawati 2022). The Indonesian comparative literature, while valuable, has predominantly focused on JKN's administrative and financial performance without systematically drawing out lessons for African reform contexts (WHO 2024).

These gaps span four distinct dimensions. Empirically, no published study has examined how *Takaful*-linked products affect enrolment, trust, or financial protection within Tanzania's NHIF/UHI system specifically, as opposed to *Takaful* markets generally. Theoretically, no prior work has integrated social health insurance theory, *Takaful* principles, and principal-agent theory into a single explanatory framework for a reform of this kind. Methodologically, the Tanzania-Indonesia comparison has not previously been attempted through structured

qualitative content analysis of legal and policy documents of the kind undertaken here. Contextually, the bulk of existing *Takaful* scholarship concentrates on Southeast Asia and the Gulf Cooperation Council, leaving Muslim-minority sub-Saharan African settings such as Tanzania largely unexamined despite their growing regulatory relevance.

This study contributes to the literature in three ways: first, by providing one of the first systematic comparative analyses of Tanzania's NHIF/UHI reform agenda alongside Indonesia's JKN and micro-*Takaful* experience; second, by identifying concrete design pathways for integrating *Takaful* principles into Tanzania's emerging UHI framework; and third, by situating these pathways within a conceptual framework that links social health insurance theory with Islamic finance principles and principal-agent theory. In doing so, the article responds to calls in the health financing literature for more contextually sensitive reform designs that account for cultural, religious, and trust-related dimensions of coverage expansion in Muslim-minority and Muslim-majority populations.

Conceptual Framework

This study is anchored in two interrelated theoretical traditions: the social health insurance paradigm and the solidarity-based principles underpinning Islamic finance. Of the two, the social health insurance paradigm serves as the primary analytical lens, since the article's central question concerns how Tanzania's national UHI architecture can accommodate *Takaful* rather than the reverse; *Takaful* and principal-agent theory are treated as complementary lenses that refine this primary framework rather than as parallel, equally weighted theories. Understanding both traditions, and their points of convergence, is essential for developing a coherent analytical framework for the integration of *Takaful* principles into a national universal health coverage architecture. Trust functions as the connective construct across all three lenses: it is what social health insurance theory identifies as necessary for voluntary compliance and cross-subsidisation to hold, what *Takaful* is theorized to build through faith-congruent framing and community governance, and what principal-agent theory treats as the outcome placed at risk when information asymmetries between operators and the public pool go unmanaged.

The social health insurance model posits that universal health coverage is best achieved through pooling contributions across large populations, enabling cross-subsidisation of high-risk and low-income groups (Haazen 2012). This framework emphasises equity, financial protection, and the role of institutional governance in sustaining risk pools over time: solidarity (healthy and wealthy subsidise the sick and poor), risk-pooling (broad enrolment spreads idiosyncratic health shocks), and strategic purchasing (the insurer acts as an active buyer, incentivising provider quality and efficiency).

The Islamic finance paradigm draws on *Shariah* principles of mutual assistance (*ta'awun*) and charitable donation (*tabarru'*). In the *Takaful* model, participants donate to a common fund from which claims are settled, and any surplus is redistributed, thereby aligning financial solidarity with religious obligation (Devi 2024). Importantly, the prohibition on *riba, gharar*, and *maysir* addresses ethical objections that some Muslim populations hold towards conventional insurance (Widyanata et al. 2024). The *Takaful* model is also distinguished by its governance architecture: an independent *Shariah* Supervisory Board (SSB) oversees all aspects of product design, investment policy, and surplus distribution, providing a

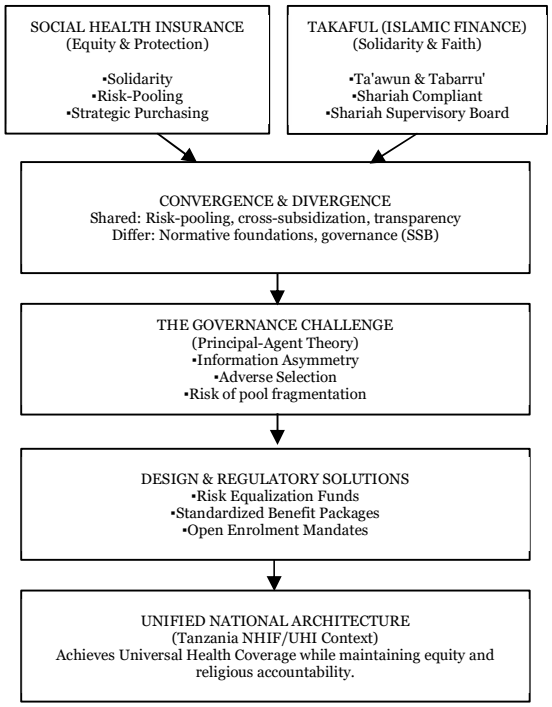
layer of religious accountability that has no direct equivalent in conventional insurance regulation.

A key analytical question is whether *Takaful*'s solidarity principles are compatible with the equity imperatives of universal social health insurance, or whether faith-segmented pools would undermine cross-subsidisation across religious communities. Drawing on Indonesia's JKN experience, this article argues the two are compatible under specific design conditions, particularly when *Takaful* products are integrated into a unified national risk pool through reinsurance or risk-equalisation.

The framework also draws on principal-agent theory to analyse the governance challenge of integrating private *Takaful* operators into a publicly-mandated system. The central problem is information asymmetry: private operators can identify and select lower-risk customers, potentially leaving the public NHIF pool with an adverse selection of high-risk, low-income members. Here, the principal is the national UHI system and the agents are accredited *Takaful* operators; the risk is that agents pursue selection strategies that undermine the principal's equity mandate. Addressing this requires risk equalisation funds, standardised benefit packages, and open enrolment mandates that align operator incentives with the framework's equity objectives.

The theoretical contribution lies in treating *Takaful* not as a freestanding alternative to social health insurance, but as a design layer evaluated by the same criteria, solidarity, risk pooling, and governance, while principal-agent theory explains why that layer requires active regulatory management rather than passive coexistence. This framework guides both the comparative analysis with Indonesia and the policy options that follow.

Figure 1: Analytical Framework for Integrating *Takaful* into Universal Health Coverage



Source: Author's Illustration. *The framework illustrates the two foundational paradigms (social health insurance and Takaful), their points of convergence, the governance challenge informed by principal-agent theory, and the regulatory mechanisms that enable a unified national architecture. It guides the analysis of Tanzania's NHIF/UHI reform in light of Indonesia's JKN experience.*

RESEARCH METHOD

This study employs a qualitative, comparative policy research design combining normative legal analysis with qualitative content analysis. It examines Tanzania's developing Universal Health Insurance (UHI) framework and compares it with Indonesia's established Jaminan Kesehatan Nasional (JKN) and *Takaful* sectors, to identify policy mechanisms that could make Tanzania's health financing both more equitable and more faith sensitive. A qualitative, document-based strategy was considered appropriate given

the aim of examining legal scaffolding and policy texts rather than evaluating programme outcomes empirically. Data collection relied entirely on secondary sources through library research.

Indonesia was purposively selected as the comparative case because it has implemented one of the world's largest Universal Health Coverage programs while simultaneously developing a mature *Takaful* sector. Although Indonesia and Tanzania differ in population size and institutional capacity, both are lower middle-income countries undertaking major health financing reforms, both have substantial Muslim populations, and both seek to expand equitable access to health care. These shared structural characteristics make Indonesia an appropriate policy comparator for identifying transferable lessons, without assuming direct transferability of outcomes.

Document selection followed purposive sampling. Primary sources included Tanzania's Universal Health Insurance Act (2023) and the TIRA *Takaful* Operational Guidelines (2022), since these constitute the principal legal and regulatory framework governing health insurance and *Takaful* in Tanzania. Comparative evidence was drawn from Indonesian policy documents, World Health Organization reports, and peer-reviewed literature addressing JKN, *Takaful*, and Universal Health Coverage more broadly. Only documents directly relevant to the study's objectives were retained for analysis.

The data were analyzed using qualitative content analysis in four stages: documents were read repeatedly for familiarity; relevant passages were coded against categories drawn from the conceptual framework (risk pooling design, subsidization mechanism, governance and Shariah compliance, distribution channel); themes identified for Tanzania were compared systematically with Indonesia's experience across these categories; and the coded themes were interpreted through the conceptual framework to explain how *Takaful* principles could support Tanzania's UHI reforms. Each thematic claim is traceable to a specific statutory provision, regulatory guideline, or peer-reviewed source, and comparative claims about Indonesia were cross-checked against at least two independent sources where available. The normative legal component involved reading the UHI Act 2023 against the equity, sustainability, and financial protection objectives in Tanzania's health sector strategic plans, identifying not only what the law states but where legislative silence, particularly on *Takaful* accreditation and Shariah governance, may create implementation challenges. Information was triangulated across legislation, policy documents, international reports, and peer-reviewed literature using consistent analytical categories throughout. Because the study relies exclusively on secondary, publicly available data and policy documents, it did not involve human participants and thus did not require ethical clearance.

RESULT AND DISCUSSION

Results

Document analysis shows that NHIF and UHI reforms pursue three main objectives: (i) expanding population coverage towards UHC; (ii) consolidating multiple risk pools; and (iii) improving financial protection and equity. The UHI Act mandates health insurance for all Tanzanian residents, with contributions collected through payroll for formal workers, premiums for informal sector groups, and government-financed subsidies for the poor and vulnerable (Osoro et al. 2024). The Act also establishes an Equity Fund to pool subsidies and redistribute resources to those unable to contribute, potentially addressing long-standing concerns that contributory schemes

disadvantage informal and low-income households (Hafidz et al. 2023). At the same time, current coverage estimates indicate that only about 15.3% of the population is insured, with NHIF accounting for around 8%, iCHF about 6% and other schemes the remainder (Osoro et al. 2024). Read against the conceptual framework set out above, this is a risk-pooling shortfall; most people remain uninsured.

A normative reading of the UHI Act reveals a specific silence that matters for this study's argument. The Act sets out contribution pathways for formal workers, informal workers, and the poor, and it creates an Equity Fund, but it does not address how a *Shariah*-compliant contribution or benefit design would satisfy its own compulsory-coverage and accreditation requirements. This is not a drafting failure so much as a sequencing one: the Act was written before the 2022 *Takaful* Guidelines matured into an active market, so the two instruments were never harmonised at the drafting stage. Left unaddressed, this ambiguity could permit or bar *Takaful* accreditation. The policy options developed later in this article are, in part, a response to that legal ambiguity.

Empirical studies reveal persistent gaps between policy intentions and financial protection outcomes. Using household survey data from rural districts, Kagaigai et al. (2023) show that OOP payments account for around a quarter of current health expenditure in Tanzania and that approximately 15% of households experience catastrophic health expenditure (CHE) at a 40% non-food expenditure threshold. Enrolment in iCHF is associated with higher utilisation of formal services and lower CHE compared with non-members, but insurance does not eliminate the risk of catastrophic spending due to limitations in benefit packages and medicine availability. Other work on iCHF scale-up highlights operational challenges, including inadequate awareness, weak provider payment systems, delays in claims processing and variability in district-level governance (Kapologwe et al. 2024). A cross-sectional study in the Manyara region finds that enrolment is significantly associated with perceived quality of care, drug availability and provider attitudes, underscoring that service delivery factors are as important as premium levels in shaping demand for voluntary insurance (Nuru and Ngowi 2025).

Taken together, these findings indicate that, even under reformed NHIF/UHI arrangements, expanding coverage among informal and rural populations will require models that address trust and acceptability, not legal obligation alone. This is precisely the gap that the conceptual framework identifies *Takaful* as potentially able to fill, since its central mechanism, faith-congruent framing of contribution as a moral and religious act, targets trust and acceptability directly rather than relying on the legal mandate to generate compliance.

Indonesia's JKN offers several instructive lessons. First, consolidating fragmented schemes into a single national pool with a unified benefit package has enabled large-scale risk-sharing and simplified administration, contributing to coverage above 95% and substantial reductions in OOP spending and CHE. Second, the state's decision to fully subsidise premiums for the poor and near-poor has been critical to equity as well as political legitimacy. Third, continuous technical support from WHO for health accounts, strategic purchasing and equity analysis has allowed iterative adjustments to JKN design and implementation (WHO 2024). In parallel, Indonesia's Islamic microinsurance sector has developed *Shariah*-compliant products tailored for low-income people, often delivered through digital platforms and partnerships with

microfinance institutions and community organisations. *Takaful* products provide funeral, hospital cash and income-replacement benefits that complement JKN's in-kind service coverage, while reinforcing principles of mutual assistance (*ta'awun*) and social solidarity. Scholarly reviews emphasise the importance of transparent surplus distribution, dedicated *Shariah* boards, and integration with *zakat* and *waqf*, to maintain trust and outreach among poor Muslim clients (Tri Puspita and Ratna Kartikawati 2022).

Table 1 compares Tanzania's NHIF and emerging UHI reforms against Indonesia's JKN model, highlighting the gaps in risk pooling, subsidization, and Islamic finance integration that *Takaful* models could help bridge.

Table 1. Comparative Overview of Health Financing and Islamic Insurance Integration

Feature	Tanzania (NHIF & Emerging UHI)	Indonesia (JKN & Micro-*Takaful*)
National Coverage Rate	15.3% (NHIF accounts for 8%)	>95% (Over 260 million people)
Out-of-Pocket (OOP) Expenditure	25% (High risk of catastrophic expenditure)	Reduced to 27.5%
Scheme Structure	Historically fragmented (NHIF, iCHF, private); moving to mandatory UHI	Unified national pool (JKN) with standardized benefits
Subsidization Strategy	Newly established Equity Fund for vulnerable groups	State fully subsidizes premiums for the poor and near-poor
Islamic Finance Integration	Nascent; TIRA Guidelines (2022) established, isolated bancassurance products	Highly integrated; Micro-*Takaful* acts as a top-up/complement to JKN
Distribution Channels	Traditional banking (e.g., CRDB), state companies (ZIC)	Digital platforms, microfinance, mosques, *zakat*/waqf integration

Source: *Authors' compilation (2026). Processed from WHO and NHIF Data.*

Discussion

Studies highlight that Tanzania's regulatory environment already exhibits several enabling factors for *Takaful*-aligned health coverage: the 2022 *Takaful* Guidelines, Zanzibar's dedicated *Takaful* company, and CRDB's *Al Barakah* bancassurance products together signal that both the legal framework and market appetite for *Shariah*-compliant insurance are taking shape (AlHuda CIBE 2022; The Guardian 2024). The move towards mandatory UHI adds a further enabling condition: it creates a natural space to consider *Takaful*-compliant pathways for contributions and pooling among Muslim and faith-sensitive communities, particularly in Zanzibar and the coastal regions where demand for such products is growing.

However, there is currently limited explicit linkage between *Takaful* regulations and NHIF/UHI reforms. This gap presents both a challenge and an opportunity: without careful design, *Takaful* products could fragment risk pools; with appropriate integration, they could reinforce equity and trust within a unified UHI framework. The parallel regulatory evolution of *Takaful* guidelines and UHI legislation suggest that Tanzania already possesses the institutional foundation for such integration, provided that TIRA, NHIF, and the Ministry of Health develop a coherent inter-agency policy dialogue that explicitly addresses the interface between Islamic insurance and national health financing objectives. This is also a political economy question and not only a technical one: TIRA, NHIF, and the Ministry of Health have distinct institutional mandates and incentives, so coordinated action will require an explicit inter-agency mechanism rather than an assumption that alignment will emerge on its own.

Conceptually, *Takaful* and social health insurance share important features:

both rely on risk-pooling, cross-subsidisation and solidarity. The main distinction lies in governance and compliance with *Shariah* principles. Embedding *Takaful* principles into NHIF/UHI could therefore enhance acceptability among Muslim populations while preserving universalism (Amoumri 2025). Amoumri (2025) comparative institutional analysis demonstrates that *Takaful*'s risk-sharing architecture, when properly governed, can achieve levels of social resilience and equity comparable to those of well-functioning conventional social insurance, while offering additional dimensions of moral and community accountability that may strengthen participant commitment and reduce moral hazard.

Three broad complementarities emerge. First, faith-sensitive risk pooling: *Takaful* structures can address religious reservations about conventional insurance by framing contributions as donations (*tabarru'*) to a mutual fund, with clear rules for surplus sharing and *Shariah*-compliant investments. For some Tanzanians, this may reduce ethical objections and build trust, particularly when combined with community-based enrolment strategies (Devi 2024). The communication of insurance as a collective religious duty, analogous to *zakat*, rather than a commercial transaction, has been shown in multiple Southeast Asian studies to significantly increase uptake among populations that previously avoided conventional insurance on *Shariah* grounds (Megawati and Zahirah 2025; Rapi and Kassim 2023).

Second, community-level micro-pools linked to UHI: experience from iCHF demonstrates that district-level pools can increase utilisation and reduce CHE but face challenges with enrolment and sustainability (Kagaigai et al. 2023). Re-designing such community pools along *Takaful* lines, using mosques, Islamic microfinance institutions and faith-based organisations as distribution points, could help mobilise informal workers while maintaining linkage to a national UHI pool for high-cost risks. The mosque network in Tanzania, particularly on Zanzibar and the mainland coast, is a largely untapped resource for insurance education and trust-building, echoing the trust-conferring role that Rapi and Kassim identify as decisive for micro-*Takaful* uptake in Indonesia.

Third, digital micro-*Takaful* as a complement to NHIF benefits: Indonesia's use of digital platforms to distribute Islamic microinsurance suggests that Tanzanian *Takaful* operators could offer low-cost health-related riders (e.g., hospital cash, transport, or non-covered medicines) that complement NHIF benefit packages, particularly in rural areas (Sintarini 2024). With mobile money penetration among the highest in sub-Saharan Africa, Tanzania already has a technological infrastructure that could support *Takaful* premium collection and claims disbursement at very low marginal cost, replicating the digital distribution models that have driven micro-*Takaful* growth in Indonesia.

Finally, integrating *Takaful* products into the NHIF/UHI system for premium collection, claims processing, and data exchange adds operational complexity that will require interoperable digital platforms and clear agreements on roles and risk-sharing between public and private actors. This analysis draws heavily on Indonesia's JKN experience and on Islamic microinsurance evidence from Southeast Asia and Malaysia; transferability to Tanzania is bounded by real differences in fiqh traditions, fiscal capacity, and market maturity, so the proposed pathways should be read as design hypotheses rather than validated solutions. Two further dimensions deserve attention. First, inclusiveness: any *Takaful*-linked pathway must remain an

opt-in complement within a single national risk pool, so that non-Muslim residents are neither excluded nor made to cross-subsidise on unequal terms; the unified-pool designs below are built to preserve this universalism rather than treat it as an afterthought. Second, gender: because women in the informal sector face compounded barriers of mobility, documentation, and household decision-making, mosque-based distribution should be paired explicitly with women's savings groups to avoid replicating existing exclusion.

Policy for Integration

Three policy options follow from these findings. The first is *Takaful*-compliant UHI plans accredited under NHIF, in which licensed operators meet UHI's minimum benefit and contribution standards, with contributions treated as tabarru' but risk shared within the national pool through reinsurance or risk-equalisation. This most closely parallels Indonesia's JKN, where accredited private insurers operate under a unified regulatory and benefit architecture; its main challenge is building risk-equalisation mechanisms robust enough to prevent cream-skimming while preserving the governance autonomy that makes *Takaful* attractive to members.

The second is community-based micro-*Takaful* linked to the UHI Equity Fund, piloted in predominantly Muslim districts through mosques, savings groups, and Islamic microfinance institutions, with mosque leaders and women's groups engaged from the design stage rather than as downstream implementers. Premiums and *zakat* and *waqf* contributions could be matched by the Equity Fund for poor households, with automatic enrolment into the national pool for inpatient and referral care. Pilot sites require actuarial modelling.

The third is *Takaful* top-up products for services outside the UHI benefit package, such as private rooms, diagnostics, transport, or non-formulary medicines. This is the lowest-risk option for equity, since it does not compete with the core risk pool, but its impact on coverage expansion among the currently uninsured is correspondingly limited.

These options are not equally ready for implementation. Option 3 carries the least regulatory risk but does the least to expand coverage among the uninsured. Option 1 offers the largest potential coverage gain but demands risk-equalisation capacity Tanzania has not yet had to build. Option 2 sits between the two, targeting the informal, faith-sensitive populations that the Results section identifies as hardest to reach through legal mandate alone. A sequenced approach is therefore recommended: pilot Option 2 first to generate evidence on uptake, financial performance, and equity impacts, then use that evidence to inform Options 1 and 3 as regulatory capacity develops. Across all three options, the overriding principle is equity-enhancing design: *Takaful* should expand coverage rather than create a two-tier system, with effects monitored using equity metrics disaggregated by income, region, gender, and religious affiliation.

CONCLUSION

Tanzania's NHIF and UHI reforms offer a historic opportunity to build inclusive coverage, but persistent gaps in financial protection remain, especially among rural and disadvantaged groups. The parallel growth of *Takaful* regulation and Shariah-compliant financial products signals strong policy and market interest in Islamic finance as a route to financial inclusion. Drawing on Indonesia's JKN and micro-*Takaful* experience, this study concludes that *Takaful*-based models hold promise for deepening coverage in Tanzania, particularly through trust, cultural acceptability, and community engagement, provided their integration is

designed to prevent fragmentation and inequity.

The article's contribution is conceptual and comparative rather than empirical: one of the first frameworks linking social health insurance theory, *Takaful* principles, and principal-agent theory to show how a faith-based mechanism can be integrated into a national UHC architecture without undermining its universalism, translated into three sequenced policy pathways grounded in Indonesia's documented experience. JKN's success factors, political commitment, pool consolidation, subsidisation of the poor, and continuous technical monitoring, offer a relevant roadmap for Tanzania, while the conceptual convergence between *Takaful* solidarity and social health insurance equity provides a theoretical basis for integration that does not treat *Takaful* as a substitute for universal coverage.

This study's main limitation is also a research priority: relying exclusively on secondary data and policy documents, it cannot speak to the lived experience of Tanzanian communities, Muslim and non-Muslim alike, and the proposed pathways should be read as hypotheses rather than validated solutions. Policy designed without community input risks repeating the top-down failures that have constrained iCHF enrolment. Further mixed-methods research is needed to test the three pathways, incorporate participatory design, and quantify distributional impacts across socio-economic, gender, and religious lines. This study provides the analytical foundation for that next phase, and suggests that similar *Takaful*-UHC questions will likely recur across sub-Saharan Africa as other countries pursue UHC reform and Islamic finance growth simultaneously.

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