ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH

THE EFFECT OF SOCIAL MARKETING STRATEGIES ON COMMUNITY - BASED HEALTH INSURANCE ENROLMENT IN LIDETA SUBCITY, ADDIS ABABA, ETHIOPIA

BY

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Acronyms

AOR	Adjusted Odd Ratio
CBHI	Community Based Health Insurance
CHE	Catastrophic Health Expenditure
EHIA	Ethiopian Health Insurance Agency
EFY	Ethiopian Fiscal Year
COR	Crude Odd Ratio
LMICS	Low and Middle Income Countries
MOH	Ministry of Health
NHA	National Health Account
UHC	Universal Health Coverage
SMS	Social Marketing Strategies
SHI	Social Health Insurance
WHO	World Health Organization

Abstract

Background: Health insurance system is one of the means to enhance access to health care services and to protect individuals from catastrophic health expenditures. Social marketing strategies such as radio, television, print media, facility &community based sensitizations have been used to augment enrollment in to community-based health insurance (CBHI) schemes in Ethiopia. However, there is gap of evidence on the influence of existing social marketing strategies on CBHI enrollment in Ethiopia.

Objectives: This study aims to assess the effect of utilization of social marketing strategies on households to join CBHI and associated factors with enrollment in Lideta Sub City, Addis Ababa.

Methods: A cross sectional study was conducted among a sample of 422 randomly selected households of Lideta sub-city, Addis Ababa in two randomly selected woredas using structured questionnaires. Epi-data version-3.1 and SPSS version-25 were used for data entry and analysis respectively. Descriptive statistics were used and data were presented using tables and figures. A binary & multiple logistic regression models were used to determine the odds of enrollment for each predictor. The investigator obtained ethical clearance from Addis Ababa University ethical review committee.

Results: The level of utilization of social marketing strategies for CBHI among households was 75.6% (69% enrolled and 31% not enrolled) with level of utilization of house to house sensitization (18.9%), local radio (11.1%), national radio (8.3%), and health facility based sensitization (5.7%). The most motivator of the households to join CBHI was house to house sensitization (37.81%). Multivariate Logistic regression revealed no significant association between social marketing strategies and enrollment, but only house hold income (AOR = 0.023, 95% CI; 0.006–0.092, $p<0.001$) and family size (household with ≥ 4 members) (AOR = 10.99, 95% CI; 3.19–37.83, $p<0.001$) were significant factors associated with enrollment.

Conclusion and recommendations: In this study, the overall level of utilization of existing social marketing strategies was high but not significantly associated with households CBHI enrollment. Family size and average monthly income of households were significant determinants of enrollment and also most members were enrolled after being sick, indicating that sensitization at the health facility by health service providers was the common social marketing strategy. Thus, the study indicated evidence of adverse selections. The government may need to look for options to make the CBHI scheme contribution based on the economic status of households and compulsory.

1. INTRODUCTION

1.1.Background

Health status is uncertain in the sense that it is unpredictable. Various actions can be taken as a response to uncertainty regarding future health status. The major alternative to these actions is insurance, where by some of the costs of ill- health can be pooled across a group of individuals (1).

Every year, about 44 million households, or more than 150 million individuals, throughout the world face catastrophic expenditure, and about 25 million households or more than100 million individuals are pushed into poverty by the need to pay for services. The bulk of these people reside in developing countries (2, 3) .

In most developing countries, healthcare cost is mainly paid at the time of sickness and out-of-pocket (OOP) at the point of service delivery, which potentially could inhibit access. Direct payment for seeking care is considered as regressive as it inhibits access to the health services for the poor (4) .

Financial risk protection from high out- of-pocket payments (OOP) of households and individuals can be achieved either by risk pooling through health insurance scheme or by funding the health services. Several countries have been implementing pre-payment schemes for keeping the households' from catastrophic health spending(5, 6) .

The health care financing in Ethiopia is composed of donor financing, direct out-of-pocket (OOP) and government financing, which were 36%, 33% & 30% respectively (7).

In order to reduce out of pocket spending for health care and increase utilization of health services sustainably, Ethiopia established community-based health insurance scheme (CBHI) by June, 2011 as a pilot CBHI in 13 districts across the four main regions of the country (Amhara, Tigray, Oromia and SNNP). This was the result of health sector reforms in the health system financing that is, from the provision of free health care services to the introduction of a cost sharing policy in 1993. Now community based health insurance is being scaled up in additional regions including Addis Ababa. According to the Ethiopian health insurance agency 2019 final report, CBHI coverage is 45% in 508 woredas (8, 9) .

The community based health insurance in Ethiopia is a voluntary pre-payment scheme & membership is based on house-hold enrollment without a pre-defined house-hold size. The membership renewal is every 12 months, and the annual contributions from each household is defined by the respective regional governments, which ranges from ETB 240-350.The CBHI schemes are also subsidized by the government (10).

Indeed, in Addis Ababa community-based health insurance has been implemented since December 2018 in all sub-cities and in 10 selected woredas in each sub-city. The implementation was the

result of health care financing strategy reform in providing quality health services in an equitable manner for Ethiopian people residing in both rural and urban households for those who work in informal sectors. In 2019/2020, 40 woredas have already begun CBHI in the city and now being scaled up. The enrollment and re-enrollment in the established woredas is 80% and 66% respectively(10-12).

Studies conducted in India & China, revealed that health insurance scheme has failed to prevent the house- holds from catastrophic health expenditure(13, 14). However, studies conducted in Ethiopia identified that CBHI schemes prevent households from catastrophic health expenditure. Likewise, insured households were found that they had higher health service utilization than non- insured households in Ethiopia(15, 16).

Despite the success in the scale up of CBHI schemes, a study in Ethiopia identified that there is high drop- out rate as the challenges for further development & low enrollment according to the target set by 2020 (17). Evidences elsewhere & in Ethiopia showed that CBHI awareness, family health status, community solidarity, quality of service of health institutions, and wealth were major factors that most determine the household decisions to enroll in the system(18).

A study in Tanzania indicated that high level utilization of the existing social marketing strategies was found to be facilitators for enrollment but a study conducted in Burkina Faso revealed that information was not enough for insurance(19, 20).

Social Marketing discipline mainly relies on the principles and techniques developed by the commercial marketing sectors to influence consumer behavior by raising awareness. Social marketing may apply these to changing health behaviors, while emphasizing a set of communication or behavior change activities that are applied to market a product for a social good. The social marketing approach is an important tool, as it promotes demand creation. Social marketing has been demonstrated to have an impact on other interventions, such as encouraging people to sleep under treated mosquito nets, discouraging people from excessive alcohol intake and cigarette smoking, and condom use promotion (21).

In Ethiopia, with the introduction of community based health insurance social marketing strategies such as television, radio, brochure & other print media, facility &community based sensitization etc. have been used to enhance enrollment through increasing community awareness about CBHI schemes. However, there is gap of evidence on the influence of existing social marketing strategies on CBHI enrollment in Addis Ababa and its effect as a whole in Ethiopia.

1.2. Statement of the problem

Moving to the goal of Universal Health Coverage (UHC) will require strengthening service delivery and overcoming significant financial barriers. Yet, worldwide, every year around 150 million people suffer from financial catastrophe and about 100 million are pushed into poverty because of high out- of -pocket payments for health care services. Bulks of these people belong to in developing countries (2, 3, 22).

In most developing countries, healthcare cost is mainly paid at the time of sickness and out-of-pocket (OOP) at the point of service delivery, which potentially could inhibit access. Direct payment for seeking care is considered as regressive as it inhibits access to the health services for the poor. It is also considered to contribute to the impoverishment of families due to having to pay for unexpected health care services at the time of illness .There are evidences that introduction of a health insurance scheme is one of the ways to try the inequalities and improve access to health care services, thus, protecting the individuals from catastrophic health payments (4, 23). As a result, many countries have been implementing prepayment schemes for protecting the households' catastrophic health spending (6) .

Poor health care financing is one of the major challenges for the health system of Ethiopia. Although the health financing in Ethiopia comes from a variety of sources, direct out-of-pocket (OOP) spending accounts 33% for a significant portion of health sector spending in the country, which creates financial barriers to access health services and puts people at risk of impoverishment (7).

The per capita expenditure is US$29, which explains that the country's spending remains below the national target of US$32 and the World Health Organization's recommended level of US$60 for low-income countries. Those situations, high out of pocket payments & low per-capita expenditure leads to low utilization of health care services by the people and hard to cover basic health services (7) 23).

Ethiopia, with the aim of achieving universal health coverage by substantially reducing out of-pocket spending for health care and increasing utilization of health care services, established community-based health insurance scheme in 2011 in 13 woredas in four regions & now is being scaled up to 508 woredas with 45% coverage including Addis Ababa city (8 ,12).

Studies conducted in Ethiopia revealed that the health insurance scheme has to prevent the households from catastrophic health expenditure (CHE) , medical impoverishment & increase utilization of health care service(15, 16). Despite this success, there is an evidence that CBHI schemes suffered low re-enrollment rates & low enrollment according to the target set by MOH to reach 80% of the people by 2020(17) ,9).

Studies conducted in Ethiopia & elsewhere revealed that CBHI awareness was among the most determinant factors that affects the household decisions to enroll in the system(18). Evidence in Tanzania indicated that high level utilization of social marketing strategies were found to be facilitators for enrollment through increasing households' awareness (19).

The Social Marketing discipline mainly relies on the principles and techniques developed by the commercial marketing sectors to influence consumer behavior by raising awareness. Social marketing may apply these to changing health behaviors, while emphasizing a set of communication or behavior change activities that are applied to market a product for a social good (23).

In Ethiopia, with the advent of community based health insurance, social marketing strategies such as radio, television, print media, social media, facility &community based sensitizations have been used to enhance enrollment in to CBHI schemes. However, there is gap of evidence on the influence of existing social marketing strategies on CBHI enrollment in Addis Ababa, Ethiopia.

1.3. Significance of the study

The purpose of this study is to assess the influence of social marketing strategies used to enroll people in to CBHI schemes and associated factors in Addis Ababa, Ethiopia. The city government of Addis Ababa is implementing CBHI and is expanding it. Thus, knowledge about the effect of social marketing strategies on CBHI performance is vital for evidence based decision making in the implementation and scale up of the community-based health insurance.

Data generated from this study will help in planning, implementing and strategizing effective and appropriate social marketing strategies for CBHI program; thus, it will help to design strategies that will increase households' CBHI enrollment, which will in turn improve the households' access to health service utilization that contributes to better health status.

On top of this, the study can serve as a spring board for those who are interested for further investigation.

2. LITERATURE REVIEW

2.1. Overview of Health Insurance

Providing health care for poor people who work in informal sector or live in rural areas is considered as one of the most difficult challenges that many developing countries are facing(24). Despite remarkable efforts in controlling these challenges by development agents and states, they remain as severe barrier to economic growth since illness does not only affect the welfare but also increases risks of impoverishment. This is because of high cost associated with health problems, especially in the absence of any form of health insurance. Subsequently, households may decide to leave illness untreated or opt for use of poor quality health care or even self -administration medication (25). It is argued that more than 150 million people face catastrophic health expenditure each year and most of them fall in- to poverty worldwide because of out of pocket health payment. This is an indication that health problems and associated costs are main causes that drive people in to poverty especially in developing countries where the health care payment is still made out of pocket (26).

Health insurance is among the solutions promoted in developing countries since the 1990s to improve access to health care services because it avoids direct payment of fees by patients and spreads the financial risk among all the insured. Many mutual health insurance organizations have been developed in sub-Saharan Africa, and over the past several years some African countries have set up national health insurance systems. However, in these countries that elect to give an important role to health insurance, it remains to be much tied whether such insurance really reaches those who are most vulnerable in terms of access to services: the poor. In fact, lack of funds creates problems at two levels, when it comes time to pay premium, and when the insured need to use health care services (27).

Health insurance schemes can be national, community or private. They can be mandatory or voluntary. Mandatory schemes are usually national, in which there is a legal obligation for people to pay in -to them and are based on the principle of social solidarity. Community based health insurance schemes are usually run by community based or nongovernmental organizations, and may also be referred to as mutual health insurance, micro-insurance or community health funds. Community based health insurance schemes often have high administrative cost and revenue collection costs (28).

The non- profit principle, the premium calculation independent of individual risk and participatory decision making are clearly distinguish CBHI from commercial health insurance, with which it shares voluntary affiliation. Participatory decision making, community based pooling,(usually)flat

membership premiums, and voluntary affiliation distinguish CBHI from other social health insurance, with which it shares the nonprofit character(23).

If universal healthcare coverage is to be financed through insurance, the risk pool needs the following characteristics: “”1)compulsory contributions to the risk pool (otherwise the rich and healthy will opt out); 2) the risk pool has to have large numbers of people, as pools with a small number cannot spread risk sufficiently and are too small to handle large health costs; and 3)where there is large number of poor, pooled funds will generally be subsidized from government revenue “”(23).

2.2. Social Marketing for Health

Social marketing defined as” the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society”. Social marketing could be used to “sell” ideas, attitudes, and behaviors(29).

Social marketing employs the principles of commercial marketing to influence consumer behavior and decision-making and attempts to influence voluntary behavior by offering or reinforcing incentives and/or consequences in an environment that invites voluntary exchange (30).

According to CDC health marketing defined as: “Creating, communicating, and delivering health information and interventions using customer-centered and science-based strategies to protect and promote the health of diverse populations(31).

In public health; education, marketing, and law enforcement are three main approaches applied to achieve behavior change. For people who consider the behavior change but do not have the required knowledge or skills, education is effective. Enforcement of laws and regulation is appropriate for the entrenched people who have no desire to change and resist deliberately. Marketing can be useful to bridge the gap between these two approaches and will be a good solution for those who are aware of the need to change but have not considered changing(32).

In general, Social marketing is an approach to persuade people to accept ideas and attitudes, perform healthy behaviors, refer to health facilities, and receive health products (33).

2.3. Determinants of CBHI Enrollment

In Africa, about half of all health care expenses are covered through out-of-pocket payments (OOP). Cost is a major barrier to those who would seek health care services and has led to inequalities in access to health care services; deprive the poorer classes while pushing the middle class into financial insecurity. Introduction of a health insurance scheme is one of the ways to try the inequalities and improve access to health care services, thus, protecting the individuals from catastrophic health payments. There has been evidences that community based health insurance reduces catastrophic health care expenditures and increases access to health care services (4), 23).

Identification of the factors related to enrollment to community based health insurance is pivotal in formulating evidence based policy so that it will reduce house hold out of pocket expenditure fast. Different factors affect utilization of CBHI schemes. These are:

Systematic review and meta-analysis confirm the demand-side factors positively affecting enrolment in CBHI include education, being female household head, and the socioeconomic status of households. Moreover, when individuals understand how their CBHI functions they are more likely to enroll and when people have a positive claims experience, they are more likely to renew. The second insight is that trust in the scheme enables enrolment. Thirdly, clarity about the legal or policy framework acts as a factor influencing enrolments(34) .
On the other hand, a systematic review done on developing countries identify that lack of funds, poor quality of care, and lack of trust are major reasons for low CBHI coverage in LMICs(35).

Another systematic review discovered that individual factors included awareness and understanding of the concept of CBHI, trust in scheme and scheme managers, perceived service quality, and demographic characteristics, which influenced enrollment and sustainability. Interpersonal factors such as household dynamics, other family members enrolled in the scheme, and social solidarity influenced enrollment and renewal of membership. Community-level factors such as culture and community involvement in scheme development influenced enrollment and sustainability of scheme (36).
A study done in Indian household's socio-economic status does not seem to play a large role in hindering renewal. In some instances, a greater understanding of the scheme boosts renewal. The link between health status and use of health care in maintaining renewal is mixed (37).

A study conducted in Burkina Faso revealed drop-out rate, however, has been high ranging from 30.9% to 45.7%. It is found that female household head, higher age or lower education of ahouse hold head, lower number of illness episodes in the past three months, fewer children or elderly in a household, poor perceived health care quality, less seeking care in the past month positively affected on drop-out, increasing the rate. In contrast, a higher household expenditure and a shorter distance to the contracted health facility increased the drop-out (38).

A study conducted in Ethiopia identified greater understanding of health insurance, and experience with and knowledge of the CBHI scheme are associated with lower dropout rates. The high retention rate may be attributed to affordable premiums, successful awareness-raising activities, the use of existing social programs to disseminate knowledge and the embedding of the scheme within existing government structures (17).

A study in Burkina Faso concludes that information is not enough to increase insurance uptake and discuss the role of other factors that might matter including the political context in which our experiment was implemented (18).

However, a study in Tanzania indicated that low level of utilization of available social marketing strategies and socio-demographic factors are the barriers for attracting members to join the schemes (19).

Four interventional studies conducted in Iran to realize the application of social marketing in health on reducing risky driving behaviors among taxi drivers in Tehran, using personal protective equipment (PPE) in workplaces, promoting mammography in Iranian women and promoting normal vaginal delivery were resulted the interventions statistically significant towards target behaviors in the intervention group as compared with the control group (39-42).

Households with elderly members or children under-five years were also more likely to enroll. Poor Understanding of risk pooling deterred people from joining the scheme and was the main reason for not renewing membership. On the supply side, poor quality of public care services, the limited benefit package and a lack of provider choice were the main factors for low enrolment indicated by a study conducted in Tanzania (43) .

A study in Ethiopia revealed CBHI awareness, family health status, community solidarity, quality of service of health institutions, and wealth were major factors that most determine the household decisions to enroll in the system. Therefore, in-depth and sustainable awareness creation programs on the scheme; stratified premium- based on economic status of households; in corporation of social capital factors, particularly building community solidarity in the scheme implementation are vital to enhance sustainable enrollment. As perceived family health status and the existence of chronic disease were also found significant determinants of enrollment, the Government might have to look for options to make the scheme mandatory (18).

There is a very low participation in CBHI schemes among the informal sector workers. This is mainly due to the lack of awareness and limited knowledge on the basic concepts of a CBHI by this target population. Solidarity based community associations to which the vast majority of this target population belong are prime areas for sensitization on CBHI schemes. Hence these associations could possibly decentralize to create CBHI schemes designated by a Pan African medical journal (44).

A Nepal study investigated enrolment of households in national health insurance program was found to be associated with ethnicity, socio-economic status, past experience of acute illness in family and presence of chronic illness. The households that belonged to higher socio-economic status were about four times more likely to enroll in the scheme (45).

Despite the fact that utilization of social marketing strategies essential for CBHI enrollment and its performance, there is a gap of evidence about the effect of social marketing strategies for enrollment in to CBHI in Addis Ababa, Ethiopia. Thus, this paper aims to fill this gap using primary data collected from the study area.

2.4. CONCEPTUAL FRAMEWORK

Conceptual framework for this study shows how the particular variables in the study connect with each other and identifies the variables required in the research investigation. It was developed after reviewing various literatures about factors that have been contributing for enrollment in to CBHI schemes. It is used as a road map in pursuing the investigation.

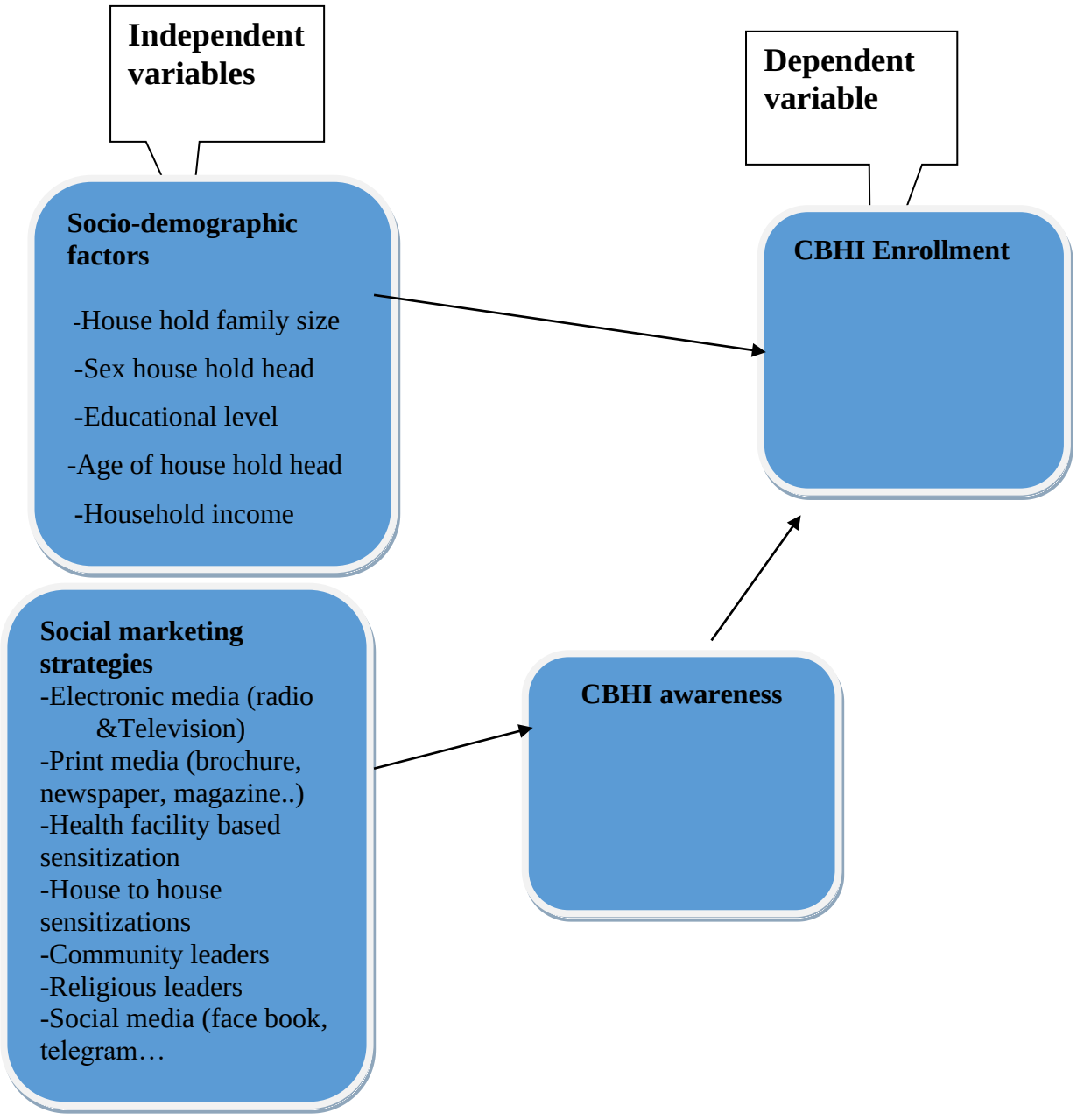


Figure I: Conceptual framework based on related literature review

3. OBJECTIVES

3.1. General Objective:

- To assess the influence of social marketing strategies and associated factors on community based health insurance (CBHI) enrollment among households in Lideta Sub-City Addis Ababa, Ethiopia, 2019/2020.

3.2. Specific objectives:

- To assess the utilization of existing social marketing strategies among households in Lideta Sub-City, Addis Ababa
- To identify the social marketing strategies which motivates more households to join CBHI in Lideta Sub-City, Addis Ababa
- To assess factors associated with CBHI enrollment among households in Lideta Sub City, Addis Ababa.

4. METHODS

4.1. Study Design:

A community- based cross- sectional study was conducted from October 2020 to December 2020 in Lideta Sub City, Addis Ababa.

4.2. Study Setting:

The study area was Lideta Sub City of Addis Ababa. Addis Ababa is the capital city of Ethiopia and the African Union and is often called the "African Capital" due to its historical, diplomatic and political significance for the continent.

Addis Ababa is located in the foothills of the Entoto Mountains and stands 7,726 feet (2,355 meters) above sea level. It is the third highest capital in the world and located in the geographic center of the country with a population of 3,627,934 as of 2007 population survey, it is the world's largest city in a landlocked country.

Currently, the city has 10 sub cities and 119 woredas. Among these sub cities Lideta is the one with 10 woredas. It has a total area of 9.18 square kms and encompasses 10 woredas with an estimated population of 214,769.

By the end of 2019, out of the 119 total woredas, 40 began community-based health insurance program in Addis Ababa. Out of these, 4 woredas are found in Lideta sub city; namely, woreda 01, woreda 03, woreda 07 & woreda 10.

4.3. Source and Study Population:

4.3.1. Source Population:

The source population for this study was all enrolled and not enrolled households in Lideta sub city, which has already begun the community based health insurance program.

4.4.2. Study Population:

The study population was the randomly selected enrolled and not enrolled households found in Lideta sub city woreda 01 and 03.

4.5. Eligibility Criteria

4.5.1. Inclusion Criteria

Household heads older than 18 years old was included in the study.

4.5.2. Exclusion criteria

Either household heads or spouses who were severely ill / unable to communicate during data collection were excluded from the study.

4.6. Sampling

4.6.1. Sample size determination

The sample size was calculated using the following standard sample size formula (Cochran W.G, 1977).

$$n = p * (1-p) * (Z_{\alpha/2})^2 / E^2$$

The total sample size was calculated with assumption of**:**

- P: 0.5, P- The prevalence of utilization of social marketing strategies. As the proportion was not known from the previous study. Then by default value p=0.5
- E: Margin of error or level of precision or maximum error to commit = 5 %
- Zα/2: Critical value at 95% confidence interval = 1.96.
- n: Required sample size

  $$n = (Z_{\alpha/2})^2 * p * (1-p) / d^2$$

  $$n = (1.96)^2 * 0.50* (1-0.50) / (0.05)^2 = 384$$

By considering 10% for non-response rate, the final sample is **422**.

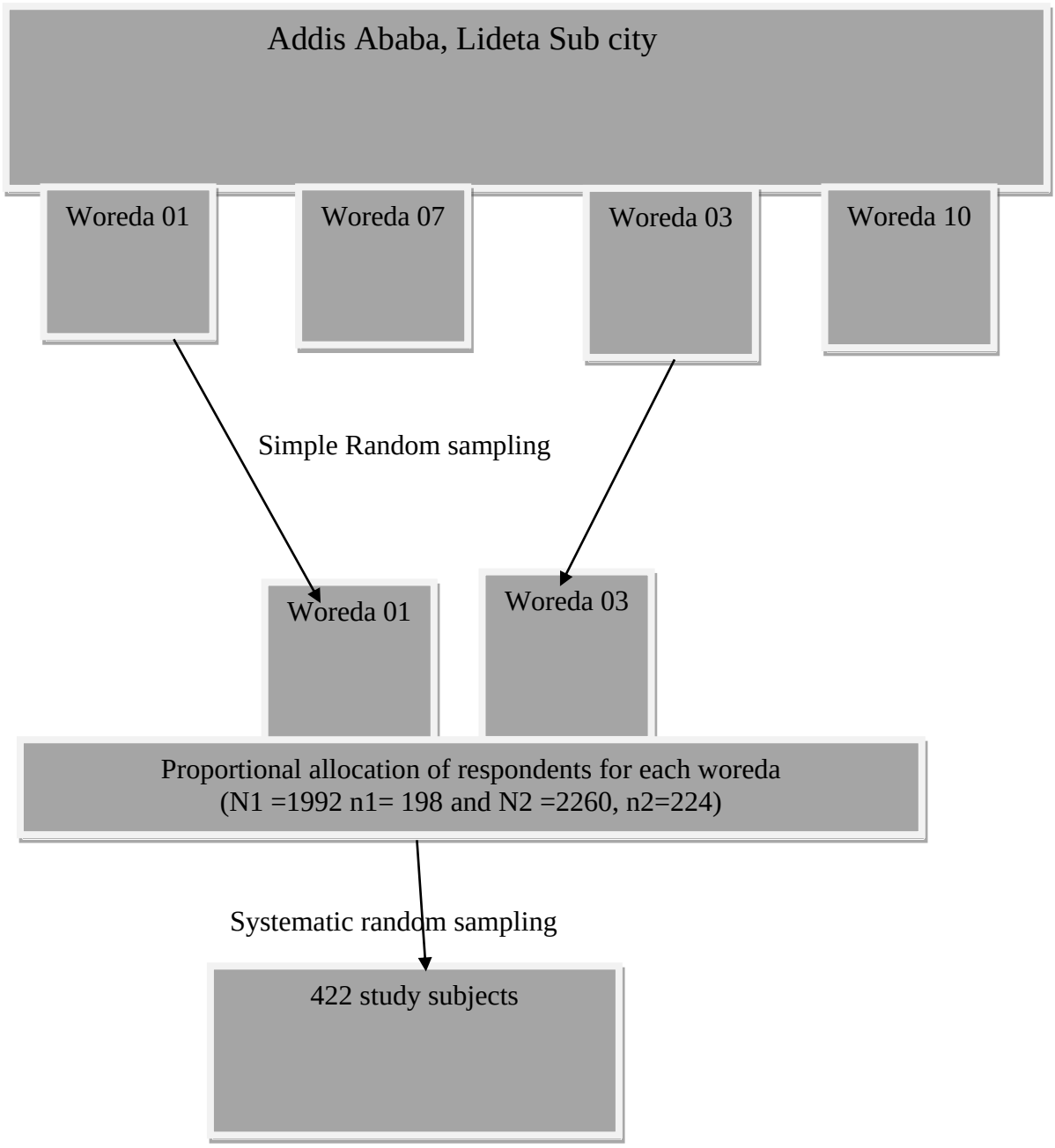
4.6.2. Sampling Procedure

Data found from Ethiopian Health Insurance Agency and Lideta sub city Health Office had shown that a total of 4 woredas began Community-based Health Insurance by the year 2019 in Lideta sub city.

First, two Community Based Health Insurance woredas (woreda 01 and 03) were selected randomly by using simple random sampling from the sub city which had already established Community Based Health Insurance program.

The second step from the woredas CBHI family folder, a study population sampling frame containing list of all the enrolled & not enrolled households of the woredas was used to track the final samples. The samples were allocated proportionally to each woreda.

Finally, by using the family folder from the woredas as a sampling frame 422 eligible respondents were included in the study by systematic random sampling. The number of enrolled and non-enrolled was balanced (1:1 ratio) to ensure representation of all community members and so as to see whether some independent variables have differentials across members and non-member households. Whenever more than one eligible respondent was found in the same selected household, only one respondent /house -hold head/ was chosen.



Note; N1=Total eligible households of woreda01, n1= total sampled households of woreda 01

N2= Total eligible households of woreda03, n2= total sampled households of woreda 03

Figure II: Schematic presentation of sampling procedure

4.7. Data Collection tools and Procedure:

A data collection instrument for this study was structured questionnaire designed to assess the level of utilization of social marketing strategies and factors associated with CBHI enrollment among households in Addis Ababa. In developing the questionnaires various literatures were sought for reference and took with appropriate modifications to meet the intended purpose. Attempts were made to maintain the objective of the study during the design of the questionnaire, and in the meantime efforts were made in avoiding redundancy and maximizing relevance to the objective of the study. All the questionnaires were translated from English into the local language (Amharic) and back translated to English to check for consistency. A pre-test was conducted on 5% of total sample size outside the study woreds; i.e. Bole Sub-City woreda 10 and was modified based on the information obtained from the pre-test results.

Two Professionals with B.Sc. degree were engaged in the interview as a data collector and one senior Professional with B.Sc. degree experienced with data collection was engaged as supervisor. Two days training was given for the data collectors and supervisor on the questionnaire and method of interview.

4.8. Variables:

4.8.1. Dependent variable:

- CBHI enrollment (Enrolled and Not enrolled)

4.8.2. Independent variables:

- Social marketing strategies (main independent variables);-electronic media (radio, television), print media (brochure. newspaper, magazine….), sensitization by (health service providers, community leaders, and religious leaders), house to house sensitizations, social media (face book, telegram…

- Socio-demographic factors; sex of house hold head , age of house hold head, house hold family size ,educational level, income of house hold

4.9. Operational definitions;

Social marketing strategies:

For this study, social marketing strategies mean the existing social marketing's used by the EHIA calculated to influence the acceptability & utilization of community based health insurance. These includes electronic media (television, radio both national & local), print media (brochure, newspaper, etc ….), health facility based sensitizations ,influence by community & religious leaders, house to house sensitizations, social media and other mixed methods.

CBHI Enrollment:

1. All members of the community in the informal sector (for the population living in rural areas and urban people working as farmers, merchants and small enterprises).
2. Paying both registration & the regular annual contribution to the scheme for those who can pay or
3. Annual contributions paid by the third party for those who cannot pay

Enrolled:

All members of the community in the informal sector who paid the annual contribution to the scheme and own CBHI identification card.

4.10. Data Management

Prior to data entry, questionnaire was checked for completeness and consistency, coded and next the data was entered in to Epidata version 3.1 software. Cleaning was done to avoid missing values, outliers and other inconsistencies. Cleaned data was exported to SPSS version 25 for analysis. Frequency distributions tables, diagrams, summary figures and percentages was used to present study findings as appropriate. Bivariate and multivariate analysis was carried out to gain more specific information about the strength of relationship between those variables. P-values and Odds Ratios were also used to measure associations and interpret the survey findings.

4.11. Data Analysis

Descriptive statistics was used to describe the study populations using frequency distribution, measures of central tendency and dispersion that was displayed using tables and figures. Due to the binary nature of the outcome variable, binary logistic regression analysis was run to determine the COR and 95% CI that is used to check the association between dependent and independent variables individually. Variables which had an association with the dependent variable in the bivariate logistic regression were entered into multi-variable logistic regression to control the possible effects of confounders. Based on AOR with 95% CI, variables with $p < 0.05$ were considered as significant independent factors.

4.12. Data Quality Assurance

Structured questionnaire modified from various literatures was used to assure data quality. Prior to data collection, two days training was given to the data collectors and supervisor on study purpose, data collection tool and procedures and ethical issues related to this research in order to fill the questionnaire appropriately and to reduce bias. Additionally, the questionnaire was translated from English to Amharic and back-translated to English using standard procedure to check its validity. A pre-test was conducted on 5% of total sample size outside the study woredas; i.e. Bole Sub-City woreda 10 and was modified based on the information obtained from the pre-test results.

Each data collector checked the questionnaires frequently for completeness and consistency. At the end of the day, the supervisor checked all the filled questionnaires. The principal investigator cautiously observed and followed the overall activities of the study.

4.13. Ethical consideration

Ethical clearance was taken from Addis Ababa University, College of Health Sciences, School of Public Health ethical review committee with a project number of 001. An official letter was written to Addis Ababa City Health Bureau and their respective offices in the sub city. Permission was also obtained from the above sectors.

The aim and method of the study and importance of their participation were clearly explained to each study participant. The study participants who fulfilled the criteria for the study and agreed to participate were given Amharic written consent and signed before data collection started. Issues of rights, privacy, and confidentiality were ensured during data collection period. Confidentiality was kept by making anonymous and assuring information will not be accessible to anyone except the research personnel. Privacy was maintained by arranging a silent and comfortable place to the interviewer and study participants. Participants had the right to participate or not and to withdraw at any time when they feel discomfort. The study participant did not get a direct benefit like money but they become a beneficiary in the future from the study.

4.14. Dissemination of the Results

The result of this study will be submitted to the School of Public Health, Addis Ababa University, Addis Ababa City Administration Health Bureau, Ethiopian Health Insurance Agency as well as the respective sub city and woreda health offices of Lideta sub-City Administration. In addition, the finding of the research will be presented during seminars and it will be published in peer-reviewed journals.

5. RESULTS

A total of 422 individuals from two CBHI woredas were selected to participate in this study, of which 386 involved with a response rate of 91.5%. Thirty six individuals were not willing to give consent and were excluded from the study.

5.1 Socio-demographic characteristics of respondents

Out of 386 respondents, 274 (71%) were males and 112 (29%) were found between the ages of 25-54 years. The mean age of the respondents was 45.23 ± 10.29 standard deviation. One hundred eighty seven (48.7%) respondents were married and 111 (28.8%) of the respondents attended secondary education. The mean monthly income of the respondents was 2634.35 ETB ± 1419.09 standard deviation and the mean family size was 4.01 ± 1.58 standard deviation (**Table 1**).

Table 1 Socio-demographic characteristics of study participants in Lideta sub city, Addis Ababa, 2019 (n=386)

Variables	Frequency	Percentage
Sex		
Male	274	71.0
Female	112	29.0
Age in years		
below 25	2	0.5
25-34	61	15.8
35-44	168	43.5
45-54	94	24.4
55 and above	61	15.8
Marital status		
Single	61	15.8
Married	187	48.4
Divorce	53	13.7
Widowed	45	11.7
Others	40	10.4
Religion		
Orthodox	208	53.9
Muslim	77	19.9
Protestant	58	15.0
Others	43	11.1
Educational status		
Illiterate	37	9.6
Read & write	79	20.5
Primary education	121	31.3
Secondary education	111	28.8
Certificate and above	38	9.8
Monthly income in ETB		

≤2634	217	56.2
>2634	169	43.8
Size of family		
<4	223	57.8
≥4	163	42.2
Household enrollment		
Enrolled	203	52.6
Not enrolled	183	47.4

5.2 Social marketing strategies used in enrolling people to CBHI

A total of 292 (75.6%) from 386 respondents received CBHI informative messages. House to house sensitization messages via woreda health office delegates 73 (18.9%), local radio media 43 (11.1%), national radio media 32(8.3%), local television (6.0%) and sensitization from health facility via health service providers 22 (5.7%) were the most common marketing strategies utilized by the respondents (Table 2).

Table 2 Social marketing strategies reported by study participants in Lideta sub city, Addis Ababa, 2019 (n=386)

Variable	Frequency	Percentage
National radio	32	8.3
Local radio	43	11.1
National television	15	3.9
Local television	23	6.0
Brochure	9	2.3
Newspaper	8	2.1
Magazine	7	1.8
Facility based sensitization	22	5.7
House to house sensitization	73	18.9
Community leaders	19	4.9
Religious leaders	8	2.1
Social media	10	2.6

Mixed methods	18	4.7
Others	5	1.3
Total	292	75.6

Others=relatives, neighbors

5.3 Social marketing strategies which motivates more households to join CBHI

The predominant social marketing strategies which more encourage enrolled study participants to join the community based health insurance scheme were house to house sensitization (37.81%) and sensitization from health facility via health service providers (37.31%).

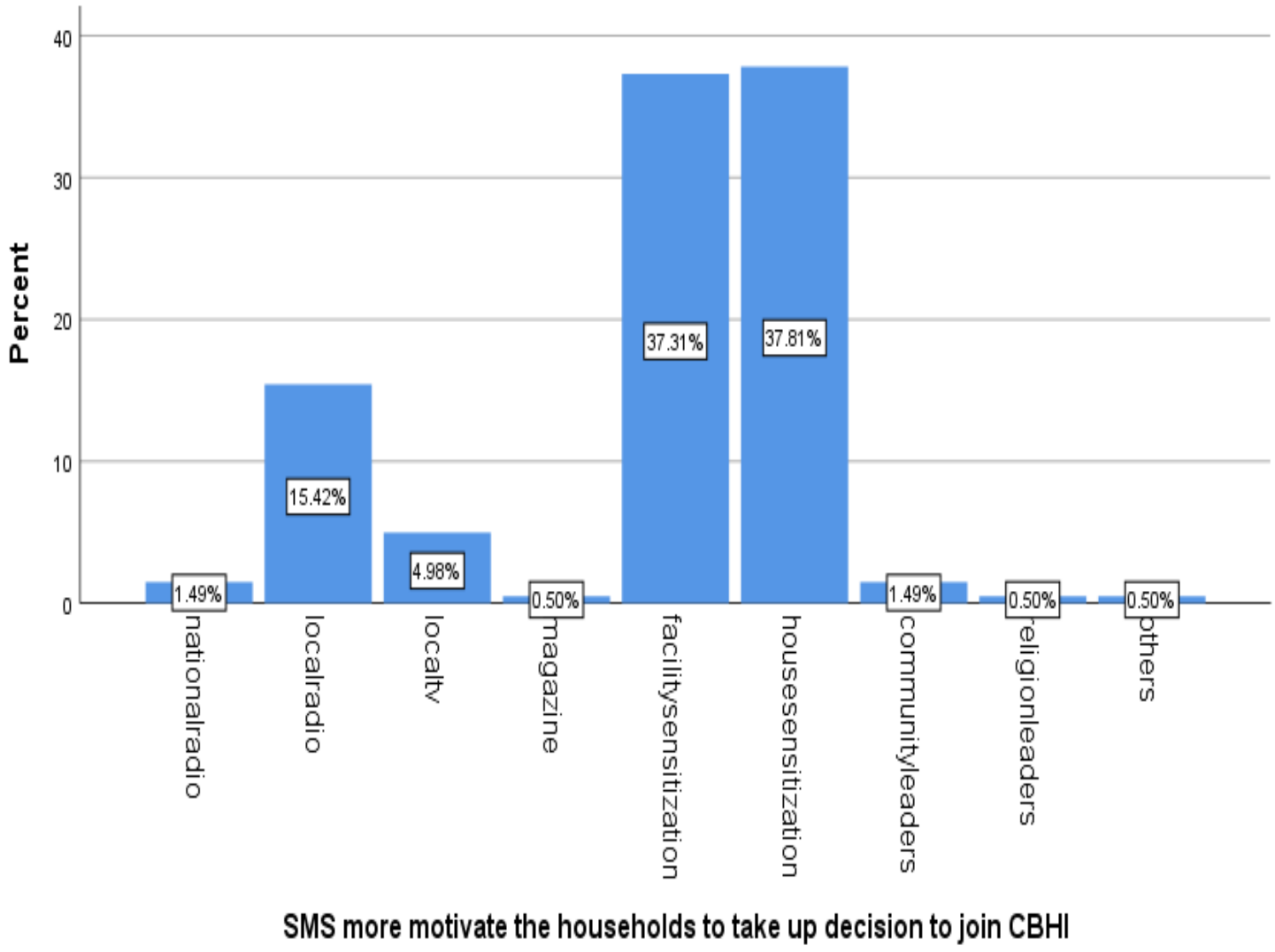


Fig 3 Social marketing strategies reported by enrolled client which more motivates to join CBHI in Lideta Sub city, Addis Ababa

5.4 Factors associated with CBHI enrollment among households

5.4.1 Bivariate Analysis

Age of participants, sex, marital status, educational status, monthly income, household family size and utilization of social marketing strategies were significantly associated with community-based health insurance enrollment in bivariate analysis ($p < 0.05$).

The odds of enrollment among female headed households was 3.456 times higher than that of male headed household family size below the mean (AOR = 3.456, 95% CI; 2.136-5.593, p = 0.000).

The odds of enrollment among house hold ages between 45-54 was 42.9 times higher than that of household head ages between 34-44 (AOR = 42.9, 95% CI; 14.67-125.45, p = 0.000).

The odds of enrollment among married households was 6.77 times higher than those never married households (AOR = 6.77, CI; 2.37-19.36, p = 0.000).

House hold family size of respondents was significantly associated with enrollment among households. The odds of enrollment among households whose family size above the mean was 17.95 times higher than that of household family size below the mean (AOR = 17.95, CI; 10.41-30.96, p = 0.000).

Average monthly income of respondents was significantly associated with enrollment among households. The odds of enrollment among households who earned above the mean (>2634) was 0.015 lower than that of households which eared below the mean (AOR=0.015, CI; 0.008-0.029, p = 0.000).

Utilization of social marketing strategies was significantly associated with enrollment among households (Table 3).

Table 3 Bivariate analysis of CBHI enrollment and associated factors among households in Lideta Sub City, Addis Ababa, 2019/2020. (n=386)

Variables	CBHI Enrollment		COR (95% CI)	P-value
	Yes	NO		
Sex				0.000*
Male	121	153	1.00	
Female	82	30	3.456(2.136-5.593)	
Age in years				0.000*
34-44	40	104	1.00	
45-54	96	33	42.9(14.67-125.45)	0.000*
55 and above	66	4	5.67(1.919-16.768)	0.002*
Marital status				0.000*
Never married	6	55	1.00	
Married	99	88	6.77(2.37-19.36)	0.000*

Others	39	14	0.431 (0.22-0.84)	0.014*
Religion				0.171
Orthodox	115	93	0.65(0.40-1.04)	0.077
Muslim	43	34	0.63(0.35-1.15)	0.136
Others	45	56	1.00	
Educational status				0.000*
Illiterate	33	4	0.029(0.01-0.089)	0.000*
Read & write	66	13	0.048 (0.023-0.098)	0.000*
Primary education	75	46	0.148(0.086-0.256)	0.000*
Secondary education and above	29	120	1.00	
Monthly income in ETB				0.000*
≤2634	188	29	0.015 (0.008-0.029)	
>2634	15	154	1.00	
Size of family				0.000*
< 4	61	162	1.00	
≥4	142	21	17.95 (10.41-30.96)	
SMS utilization				0.000*
Radio	49	26	0.917 (0.451-1.861)	0.809
Television	18	20	1.919 (0.841-4.381)	0.122
Print media	7	17	4.19 (1.505-11.690)	0.006*
House and facility based sensitizations	90	5	0.096 (0.034-0.272)	0.000*
Others	38	22	1.00	

Note: 1.00 = reference value

*-variables which were significantly associated in bivariate analysis & included in multivariable analysis

5.4.2 Multivariate Analysis

After controlling the possible confounders, two variables, household family size and house hold average monthly income were significantly associated with community based health insurance enrollment in the final model ($p < 0.05$).

House hold family size of respondents was significantly associated with enrollment among households. The odds of enrollment among households whose family size above the mean was 10.99 times higher than that of household family size below the mean (AOR = 10.99, 95% CI; 3.19-37.83, p = 0.000).

Average monthly income of respondents was significantly associated with enrollment among households. The odds of enrollment among households who earned above the mean (>2634) was 0.023 lower than that of households which eared below the mean (AOR = 0.023, 95% CI; 0.006-0.092, p = 0.000).

Age of house hold head, educational status, marital status and utilization of social marketing strategies were not spastically significant in the final model multivariate logistic regression model even though they were significant in the bivariate analysis. (Table 4)

Table 4 Multivariate analysis of CBHI enrollment and associated factors among households in Lideta Sub City, Addis Ababa, 2019/2020. (n=386)

Variables	CBHI Enrollment		AOR (95% CI)	P-value
	Yes	NO		
Sex				0.708
Male	121	153	0.295(0.336-4.997)	
Female	82	30	1.00	
Age in years				0.100
34-44	40	104	12.628(0.95-167.45)	0.054
45-54	96	33	5.116(0.394-66.422)	0.212
55 and above	66	4	1.00	
Marital status				0.835
Never married	6	55	0.554 (0.049-6.315)	0.634
Married	99	88	1.018(0.180-5.768)	0.984
Others	39	14	1.00	
Educational status				0.901
Illiterate	33	4	2.627(0.160-43.129)	0.499
Read & write	66	13	1.039 (0.156-6.426)	0.968
Primary education	75	46	1.302(0.312-5.430)	0.718
Secondary education and above	29	120		
Monthly income in ETB				0.000*
≤2634	188	29	0.023 (0.006-0.092)	
>2634	15	154	1.00	
Size of family				0.000*
< 4	61	162	10.99(3.19-37.83)	
≥4	142	21	1.00	
SMS utilization				0.738
Radio	49	26	1.387 (0.305-6.309)	0.672
Television	18	20	1.176 (0.204-6.781)	0.856
Print media	7	17	1.484 (0.207-10.659	0.695
House and facility based sensitizations	90	5	0.344 (0.053-2.224)	0.263
Others	38	22	1.00	

Note: 1.00 = reference value
* -variables which were significantly associated in multivariable analysis

6. DISCUSSION

This study aimed at assessing the influence of marketing strategies and socio-demographic factors on enrollment in to Community-Based Health Insurance (CBHI) in Addis Ababa, Ethiopia.

The study found that there are several marketing strategies executed in the study area; the strategies extended from house to house sensitization, health-facility based sensitization, use of mainstream media to social media sensitization strategies. While social marketing in the field of community health insurance is a new approach, it has been used extensively in international health interventions; for instance, contraceptives and oral rehydration therapy, insecticide-treated mosquito nets, and intermittent preventive treatment for Malaria. Additionally, Social marketing is being used with more frequency for a diversity of health-related topics to achieve sustained changes in healthy behaviors. In the context of a community health insurance, social marketing approaches can be used to get to know the program. This in turn will build awareness among the beneficiaries in their decision to join community-based health insurance, as well as a possibility for behavior change(19, 21).

The finding of this study revealed that the overall level of utilization of social marketing strategies used to enroll people to community based health insurance schemes was high (75.6%).Thus, 75.6% of respondents used social marketing strategies in enrollment in to Community-Based Health Insurance schemes. Some of the major strategies described by households were house to house sensitizations (18.9%), local radio and national radio (11.1%, 8.3%), local television (6.0%) and health facility based sensitizations (5.7%). This finding was consistent with across sectional study done in Tanzania which indicated higher prevalence of utilization of social marketing strategies among households (19).

This study also discovered that the major social marketing strategies which motivates more the enrolled households to join CBHI schemes were house to house sensitizations via woreda health office delegates (37.81%) and facility based sensitizations by health service providers (37.31%). In this study, a major contribution to enrollment rates was attributed to the influence of house to house sensitizations. This point to the importance of involving such strategies, in view of enrolling more people in CBHI leading to increased financial and risk pooling. In addition, in this study sensitization by health service providers was major social marketing strategy used to enhance enrollment in to CBHI enrollment. Enrollment of members should be done before a

beneficiary is sick, since it was noted that a majority of CBHI members were sick at the time of registration that is they said they joined after being sensitized by health service providers at the health facilities. This may precipitate the utilization of the entire existing fund at once, implying little risk pooling and an adverse selection problem. This result, house hold were became a member of community health funds after being sick indicating that sensitization via health service providers found to be high was in line with the study done in Tanzania (19).

In this study, social marketing strategies was not significantly associated with CBHI enrollment in the final multivariate logistic regression model (p=0.738) even though the utilization was high (75.6%) as indicated in the result. The study revealed that high contribution to enrollment rates was attributed to the influence of house to house sensitization by local administrative delegates in the bivariate logistic regression model. This points to the importance of involving such mechanisms, in view of enrolling more people in CBHI. The finding of this study was in line with the community based cross sectional study conducted in Tanzania and a randomized experiment study in Burkina Faso, which prevailed utilization of social marketing strategies and having information on the scheme were not statically significant with enrollment respectively (19, 20).

But the study was in consistent with across sectional study conducted in North west Ethiopia and a systematic review done in Low and Middle Income Countries which stated awareness about the scheme increases enrollment in to CBHI(18, 34, 36) and four studies conducted in Iran to see the application of social marketing on health (39-42) . This might be due to social marketing approaches differences across a country, study area, study design, sample size and sociodemographic factors.

The findings from various studies have revealed that households and community characteristics, such as age of the head of the household, gender and income were among the factors determining households' membership in the health insurance schemes (18, 34, 36, 43). Socio-demographic characteristics of respondents were important in decisions to enroll in this study, namely:-house hold family size and average income were significantly associated enrollment in to the CBHI scheme.

In this study, house hold family size was significantly associated with enrollment. The odds of enrollment among households whose family size above the mean was 10.99 times higher than that of household family size below the mean (AOR = 10.99, 95% CI; 3.19-37.83, p< 0.001).This result was in line with a community -based cross sectional study conducted in North west Ethiopia on determinants of community based health insurance implementation which revealed that size of the family was positively associated with households' decisions to willingly enroll into the scheme. As the number of the household members increase, the probability of willingness to enroll increased (AOR=1.17, CI=1.02-1.35). It was also consistent with across sectional study on barriers and facilitators to enrollment and re-enrollment in to community health funds in Tanzania which found that family size (AOR = 1.5, 95% CI 1.0–2.5) was significant factors associated with enrollment/re-enrollment rate (18, 19).

Average monthly income was a significant determinant factor in enrollment in to CBHI as indicated in the result. Average income below the median more significantly increases enrollment. The results show that the odds of enrollment among households who earned above the mean was 0.023 lower than that of households which eared below the mean (AOR = 0.023, 95% CI; 0.006-0.092, p < 0.001). This result was in line with across sectional study done in north west Ethiopia which revealed that wealth were significant determinant factors for enrolment in to community based health insurance scheme , and also consistent with a mixed method analysis study conducted on determinants of enrollment in to community health fund in Tanzania that revealed the lower income quintiles were more likely to enroll (18, 43). Asystematic review done in low and middle income countries also identifed that low levels of income as amajor factor for enrollment (35).

In Ethiopia, such run-through also has a consequence on the scheme since it affect the risk pooling principle as those who join have large family size and low income thus increased chance of draining of all resource from the scheme within a short time.

7. STRENGTH & LIMITATIONS OF THE STUDY

7.1. STRENGTHS OF THE STUDY

Participants were all the selected community members might represent the true picture of the general population as the study is community -based survey. Furthermore, balance was made between the number of enrolled and non-enrolled of Community Based Health Insurance (CBHI) to ensure representativeness of the study.

This is the first community based, cross-sectional study in Addis Ababa, Ethiopia, which assessed social marketing strategies utilization and factors linked with enrollment among urban households.

7.2. LIMITATIONS OF THE STUDY

As this study was cross-sectional, the factors do not establish temporal relationship; therefore, inference of causation is not possible.

The program was new and the lack of previous similar studies made comparison difficult.

Respondents recall bias was possibly introduced during interviewing the study participants which may affect the outcome of interest.

Regarding to income data, the study participants might not tell the real house hold income because of fear of tax and different related issues which may affect the outcome of interest.

8. Conclusion and recommendation

8.1. Conclusion

According to the present study, the overall level of utilization of social marketing strategies among households was high though it was not statically significant with enrollment. This point does not imply that social marketing strategies do not have contribution to enrollment because higher proportion of those who gain educational messages are enrolled.

House hold average monthly income and house hold family size were significantly associated with community based health insurance enrollment which implies that those who join CBHI schemes have large family size and low income, thus; increased chance of draining of all resource from the scheme within a short time.

8.2. Recommendations

Based on study findings, the following important recommendations were suggested to improve the implementation of community-based health insurance.

In this study, household's family size and average monthly income were significant determinants of enrollment. Moreover, most members were enrolled after getting sick, indicating that sensitization at the health facility via health service providers was the common social marketing strategy. Thus, the study indicated evidence of adverse selections. The government may need to look for options to make the scheme contribution based on the economic status of households and compulsory.

Finally, further studies should be conducted for future by using strong study design.

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ANNEXES;

ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

Annex I. English version Participants Information Sheet for Interview

Greetings!

My name is _____ and I am working with investigator from Addis Ababa University College of Health Sciences, School of Public Health who is currently carrying out survey on effect of Social marketing strategies on enrollment in to CBHI in Lideta sub city, Addis Ababa Ethiopia for the partial fulfillment of Masters in Public Health. The survey mainly assesses the level of utilization of existing social marketing strategies of households and identify the social marketing strategies which more motivates the house-holds to take up decision to join CBHI. There may be no direct benefit from the study however the results obtained from this survey will be used to design evidence based plans, strategies, guidelines, manuals and interventions for the increment of CBHI performance. Participating to the study does not introduce any risk to the participants. Participating to this study may require about 25 minutes.

I would like to assure you that privacy will be strictly be maintained throughout. There is no need to put your name or roll number on the format. The study has ethical approval from School of Public Health. Finally I will say thank for important any kind of response on question and response.

If you have any question about the research you may contact Haimanot Abay (Principal Investigator) Addis Ababa University, College of Health Sciences, School of Public Health (Tel +251-912-46-27-14) .

Do you wish to participate in the study?

Yes ☐ No ☐

Informed Consent (English version)

Detail information about the study was explained to me. I have understood that the main objective of this study is to assess the influence of social marketing strategies used to enroll people in CBHI schemes in Lideta Sub-City, Addis Ababa, Ethiopia, 2019/2020.

In addition, I understand about how the data collection is proceeding and the time it takes to complete the data collection. I also understand that the research imposes no risk on me. I assured that there would be confidentiality of my response and collected data used only for the study. It also explained to me that I have the right to stop participation at any time.

In addition, I understood that participating in this study is important for scientific knowledge and base for further study. Therefore, I have now consented to participate in the study by signing this form.

Signature of participants_____date_____

Name and signature of data collectors_____date_____

Annex1: English version Questionnaire

Questionnaire on Effect of Social marketing strategies on enrollment in to CBHI in Lideta sub city, Addis Ababa Ethiopia, 2020

Identification of the selected household

INSTRUCTION:

1. Circle the response
2. First ask the household head, if not present ask the spouse.

1. Woreda _____
2. Household enrollment in CBHI 1. Enrolled 2. Not enrolled
3. Questionnaire number_____

SECTION I. HOUSEHOLD SOCIO DEMOGRAPHIC FACTORS			
Q.NO	Questions	Response	Remark
101	Age of the household head/spouse	_____	
102	Sex of the household head/spouse	1.Male 2.Female	
103	Marital status of the household head/spouse	1. Single 4. Widowed 2. Married 5. others 3. Divorced	
104	Religion of the household head/spouse	1. Orthodox 2. Muslim 3. Protestant 4. others,	
105	Educational status of the house hold head/spouse	1.Illitrate 2.Read and write 3.primary education (1-8) 4.Secondary education(9-12)	

		5.Tertiary education(above 12)	
106	What is your average income earned per month?	(ETB)_____	
107	What is the size of family of the house hold	_____	

SETION II: CBHI SOCIAL MARKETING STRATEGIES UTILIZATION			
Q. No	Questions	Response	Remark
201	Have you ever heard anything regarding enrollment to CBHI?	1.Yes 2.No	
202	If yes to QN 201 which social marketing strategies are you used in sensitizing communities to join CBHI?		
	a) National Radio	1.Yes 2.No	
	b) Local Radio	1.Yes 2.No	
	c) National Television	1.Yes 2.No	
	d) Local Television	1.Yes 2.No	
	e) Brochure	1.Yes 2.No	
	f) News paper	1.Yes 2.No	
	g) Magazine	1.Yes 2.No	

	h) Facility-based sensitization	1.Yes 2.No	
	I) House to house sensitization	1.Yes 2.No	
	j) influence from community leaders	1.Yes 2.No	
	k) influence from religious leaders	1.Yes 2.No	
	L) social medias	1.Yes 2.No	
	m) Mixed methods	1.Yes 2.No	
	Others (mention)_____		
203	If you are a new or old member of CBHI which way did motivate you to take up decision to join CBHI?		
	a) National Radio	1.Yes 2.No	
	b) Local Radio	1.Yes 2.No	
	c) National Television	1.Yes 2.No	
	d) Local Television	1.Yes 2.No	
	e) Brochure	1.Yes 2.No	
	f) News paper	1.Yes 2.No	
	g) Magazine	1.Yes 2.No	
	h) Facility-based sensitization	1.Yes 2.No	
	i) House to house sensitization	1.Yes 2.No	
	j) influence from community leaders	1.Yes 2.No	

	k) influence from religious leaders	1.Yes 2.No	
	L) social medias	1.Yes 2.No	
	m) Mixed methods	1.Yes 2.No	
	Others (mention)_____		

SETION III: INFORMATION ON CBHI IMPLEMENTATION

Q. No	Questions	Response	Remark
301	What do you advice to make the CBHI more engaging?		
	a)Medicine availability throughout the year	1.Yes 2.No	
	b) reduce the CBHI premium	1.Yes 2.No	
	c) Increase CBHI understanding by the community	1.Yes 2.No	
	d) improve customer handling by service providers	1.Yes 2.No	
	e) Make CBHI mandatory	1.Yes 2.No	
	Others (mention)_____		

አባሪ 2: የጥናቱ ተሳታፊዎች መረጃ መስጫ

የጥናቱ መግለጫ

ጤና ይስጥልኝ ስሜ፡ _____ ይባላል።በአዲስ አበባ ዩኒቨርሲቲ የድህረ ምረቃ የህብረተሰብ ጤና የድህረ ምረቃ ፕሮግራም ማሟያ ለሚሆን ጥናት ከአጥኚው ጋር እየሰራው እገኛለሁ። ጥናቱም የተዘጋጀው በአዲስ አበባ ከተማ ልደታ ክፍለ ከተማ እተሰራባቸዉ ያሉ የማህበረሰብ ዓቀፍ ጤና መድህን ግንዛቤ ፈጠራ ዘዴዎች በአባልነት ላይ ያላቸው ተጽዕኖ ምን እንደሚመስል እና የትኛዉ የግንዛቤ ፈጠራ ዘዴ አባላትን በማፍራት ረገድ የተሻለ መሆኑን ለማጥናት የተዘጋጀ ነው። የጥናቱ ጥያቄዎች ሞልቶ ለማጠናቀቅ ሃያ አምሰት ደቂቃ ያህል ሊወስድ ይችላል።

ጥናቱን አስመልክቶ እርስዎ የሚሰጡት ማንኛውም መረጃ ሚስጥር የሚጠበቅ በመሆኑ በማንኛውም መንገድ ለሶስተኛ አካል ተላልፎ አይሰጥም ወይም አይጋለጥም፤ማንነትዎ እንዳይታወቅም ስምዎ በጥያቄው ወረቀት ላይ አይመዘገብም።ይሁን እንጂ በጥናቱ ላይ በመሳተፍዎ የተለየ ጥቅም አይኖርም ነገር ግን በጥናቱ ላይ በመሳተፍዎ እና ለሚጠየቁት ጥያቄ ተገቢ የሆነ መረጃ በመስጠትዎ በማህበረሰብ ዓቀፍ ጤና መድህን ዙሪያ ላይ ለሚወጡ ፖሊሲዎች፤ ስትራቴጅዎችና መመሪያዎች/ማኑዋሎች ለማሻሻል ብሎም የፕሮግራሙን ተደራሽነት ለማሳደግ ከፍተኛ አስተዋጽዖ ያበረክታሉ።

በመጨረሻም ለሚሰጡት ለየትኛውም አይነት ምላሽ ከፍተኛ ምስጋናዬን አቀርባለሁ።ግልጽ ነው? ያልገባህ/ሽ ነገር አለ? ወይም መጠየቅ(ማነጋገር) የምትፈልጉት ነገር ካለ በግለፅ መጠየቅ ወይም ማነጋገር ይቻላል።

በመጨረሻም ለሚሰጡት ለየትኛውም አይነት ምላሽ ከፍተኛ ምስጋናዬን አቀርባለሁ።ግልጽ ነው? ያልገባህ/ሽ ነገር አለ? መጠየቅ(ማነጋገር) የምትፈልጉት ነገር ካለ በስልክ ቁጥር 09-12-46-27-14 - ሃይማኖት አባይ ደውለው መጠየቅ ይችላሉ።

በመሆኑም ከላይ የቀረበውን የጥናቱን አላማና ጥቅሙንም ተረድቼአለሁ፤ ሚስጥር እንደሚጠበቅና ለሶስተኛ አካል እንደማይተላለፍ ተገንዝቤአለሁ። ስለዚህ በጥናቱ፡-

እሳተፋለሁ ☐ አልሳተፍም ☐

Amharic version informed consent

<u>የስምምነት ማረጋገጫ ሰነድ፣</u>

ስለጥናቱ ጥናቱን ከሚካሄደው አካል በቂ መረጃ ተሰጥቶኛል። ከዚህ በተጨማሪም ከኔ የሚወሰደው መረጃ በእኔ ላይ ምንም አይነት ጉዳት የማያስከትል መሆኑን ተረድቻለው።እንዲሁም እኔን በተመለከተ የመረጃ ሚስጥራዊነት የተጠበቀ መሆኑን እና በጥናቱ ለመሳተፍ ፍቃደኛ ካልሆንኩ በጥናቱም ለመሳተፍ እንደማልገደድ ነገር ግን ስለ ማህበረሰብ ዓቀፍ ጤና መድህን ግንዛቤ መፍጠሪያ ዘዴዎች ያለኝን መረጃ በመስጠቴ ወደ ፊት በዚሁ ጉዳይ ዙሪያ ለሚሰሩ ስራዎች ግብአት መስጠት እና ወሳኝ መሆኑን ተረድቻለው።

ስለሆነም በዚህ ጥናት ለመሳተፍ የተስማማሁ መሆኔን በፊርማዬ አረጋግጣለሁ።

የተሳታፊው ፊርማ _____ ቀን _____

የመረጃ ሰብሳቢው ስምና ፊርማ_____ቀን _____

አባሪ2: አማርኛ ቃለ-መጠይቅ

በአዲስ አበባ ከተማ ልደታ ክፍለ ከተማ የማህበረሰብ ዓቀፍ ጤና መድህን ግንዛቤ ፈጠራ ዘዴዎች በአባልነት ላይ ያላቸዉን ተፅዕኖ ለማወቅ የሚደረግ ጥናት ፣2012 ዓ.ም

የተመረጠው ቤተሰብ መለያ

1. ወረዳ _____

2. ማዓጤመ አባልነት 1. አባል 2. አባል ያልሆነ

3. መጠይቅ ቁጥር _____

መመሪያ

1.የሚሰጥህን/ሽን መልስ በማክበብ አሳዩ

2.በመጀመሪያ የቤተሰቡን መሪ/ ራስ ይጠይቁ፡ ከሌለ/ከሌለችሚስቱን/ባሏንይጠይቁ።

ክፍል አንድ; የቤተሰቡን ማህበራዊ አኗኗር የሚገልፅ መጠይቅ			
ጥ.ቁ	ጥያቄዎች	ምላሾች	ምርመራ
101	የቤተሰቡ ራስ / የትዳር አጋር እድሜ ስነት ነዉ	_____	
102	የቤተሰብ ራስ / የትዳር አጋር ፆታ	1.ወንድ 2..ሴት	
103	የቤተሰብ ራስ / የትዳር አጋር የጋብቻ ሁኔታ	1. ያላገቡ 2. ያገቡ 3. ተፋተዋል 4.ባለቤቱየሞተችበት/ባለቤቷየሞተባት 5. ሌላ	
104	የቤተሰቡ ራስ / የትዳር አጋር ሃይማኖት	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት	

		4. ሌሎች	
105	የቤተሰቡ መሪ/ ትዳር አጋር የትምህርት ደረጃ	1.ማንበብ እና መጻፍ የማልችል 2.ት/ቤትገብቼየማላውቅግንማንበብመፃፍየምችል 3. የመጀመሪያ ደረጃ ትምህርት (1-8) 4. ሁለተኛ ደረጃ ትምህርት (9-12) 5. ከፍተኛ ደረጃ ትምህርት (ከ 12 በላይ)	
106	የቤተሰቡ አማካይ ወርሃዊ የገቢ መጠን	ብር----------	
107	የቤተሰቡ የአባላት ቁጥር ስንትነው?	----------	

ክፍል 2፡በማህበረሰብ ዓቀፍ ጤና መድህን ግንዛቤ ፈጠራ ዘዴዎች ላይ መረጃ			
ጥ.ቁ	ጥያቄዎች	ምላሾች	ምርመራ
201	ስለ ማህበረሰብ ዓቀፍ ጤና መድህን አባልነት ሰምተው ያውቃሉ?	1. አዎ 2. አይደለም	
202	ለጥ.ቁ 201 መልስዎ አዎ ከሆነ በየትኞቹን ማህበራዊ ግብይት/ግንዛቤ ፈጠራ ዘዴወች ስለማዓጤመ ሰሙ ?		
	ሀ) ብሄራዊ ሬዲዮ	1. አዎ 2. አይደለም	
	ለ) አካባቢያዊ ሬዲዮ	1. አዎ 2. አይደለም	
	ሐ) ብሔራዊ ቴሌቪዥን	1. አዎ 2. አይደለም	

	መ) አከባቢዊ ቴሌቪዥን	1. አዎ 2. አይደለም	
	ሠ) በራሪ ወረቀት	1. አዎ 2. አይደለም	
	ረ) ጋዜጣ	1. አዎ 2. አይደለም	
	ሰ) መጽሔት	1. አዎ 2. አይደለም	
	ሸ) ጤና ተቋም ከጤና ባለሞያዎች	1. አዎ 2. አይደለም	
	ቀ) ከቤት ለቤት ቅስቀሳ	1. አዎ 2. አይደለም	
	በ) ከማህበረሰብ መሪዎች	1. አዎ 2. አይደለም	
	ተ) ከሃይማኖት መሪዎች	1. አዎ 2. አይደለም	
	ቸ) ከማህበራዊ ሚዲያ (face book,telegram)	1. አዎ 2. አይደለም	
	ነ) የተቀላቀሉ ዘዴዎች	1. አዎ 2. አይደለም	
	ሌሎች (መጥቀስ) _____		
203	አዲስ ወይም ነባር አባል ከሆኑ ማዓጤመን ለመቀላቀል ውሳኔ እንዲወስዱ ያነሳሳዎ የትኛው መንገድ ነበር?		
	ሀ) ብሄራዊ ሬዲዮ	1. አዎ 2. አይደለም	
	ለ) አካባቢዊ ሬዲዮ	1. አዎ 2. አይደለም	
	ሐ) ብሔራዊ ቴሌቪዥን	1. አዎ 2. አይደለም	
	መ) አካባቢዊ ቴሌቪዥን	1. አዎ 2. አይደለም	
	ረ) ጋዜጣ	1. አዎ 2. አይደለም	

	ሰ) መጽሔት	1. አዎ 2. አይደለም	
	ሸ) ጤና ተቋም ከጤና ባለሞያዎች	1. አዎ 2. አይደለም	
	ቀ) ከቤት ለቤት ቅስቀሳ	1. አዎ 2. አይደለም	
	በ) ከማህበረሰብ መሪዎች	1. አዎ 2. አይደለም	
	ተ) ከሃይማኖት መሪዎች	1. አዎ 2. አይደለም	
	ቸ) ከማህበራዊ ሚዲያ (face book ,telegram)	1. አዎ 2. አይደለም	
	ነ) የተቀላቀሉ ዘዴዎች	1. አዎ 2. አይደለም	
	ሌሎች (መጥቀስ) _____		

ክፍል 3: በማዓጤመ አተገባበር ዙሪያ እይታዎች			
ጥ.ቁ	ጥያቄዎች	ምላሾች	ምርመራ
301	ማዓጤመን ይበልጥ የተሳካ ለማድረግ ምን መደረግ አለበት ይላሉ ?		
	ሀ) ዓመቱን በሙሉ የመድኃኒት አቅርቦት እንዲኖር ማድረግ	1. አዎ 2. አይደለም	
	ለ) የማዓጤመ አመታዊ መዋጮን መቀነስ	1. አዎ 2. አይደለም	
	ሐ) በማዓጤመ ላይ የማህበረሰቡ ግንዛቤን ማሳደግ	1. አዎ 2. አይደለም	
	መ) የጤና ተቋማት አገልግሎት አሰጣጥን ማሻሻል	1. አዎ 2. አይደለም	
	ሠ / ማዓጤመን ግዴታ ማድረግ	1. አዎ 2. አይደለም	

	ሌሎች (ሞጥቀስ) _____		