Addis Ababa University

College of health sciences

School of public health



Assessment of utilization of fee waiver system among beneficiaries in Addis Ababa, Ethiopia, 2017.

BY: Hana Tesfaye (BSc)

A THESIS SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH FOR THE PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF PUBLIC HEALTH

Advisors: Professor Damen Haile Mariam (MD, MPH, PhD)

Ms. Birhan Tassew (MPH)

May 2017

Addis Ababa Ethiopia

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Declaration

I, the undersigned, declared that this is my work and that all sources of materials used for this Thesis has duly acknowledged.

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Acronyms and Abbreviations

BPR	Business Process Re-engineering
CI	Confidence Interval
COR	Crude Odds Ratio
EHRIG	Ethiopian Hospital Reform Implementation Guidelines
EMOH	Ethiopia Ministry of Health
FWS	Fee Waiver System
HCFR	Health Care Financing Reform
HMIS	Health Management Information System
HSDP	Health Sector Development Program
NGO	Non-Governmental Organization
SNNPR	Southern Nation Nationality People Region
USAID	United State Agency for International Development

Abstract

Back-ground: Fee waiver system is one component of health care financing reform; it is a system for granting access to health services for those who are unable to pay. Evidence shows that the implementation of fee waiver system have slower progress rates, and lack sufficient information on the privileges that come with the utilization of fee waivers. As a result, studying the utilization and factors that influencing implementation of waiver system is found to be crucial.

Objective: The main objective of the study is to assess utilization and factors that influence the utilization and implementation of waiver system in Addis Ababa 2017.

Method: A community based cross-sectional study design using both quantitative and qualitative methods, was conducted on 578 waiver beneficiaries and 15 key informants found in Addis Ababa from March to April 2017. The data were collected by using a structured interviewer based questionnaire for beneficiaries. Participants were selected using simple random sampling technique. Data were entered using EPI info version 7 and exported to SPSS version 20 for analysis. Descriptive statistics were used to summarize the data bi-variable and multivariable logistic regression was used to examine the relationship between outcome variable and independent variables. A cut of point P-value<0.05 was used to show the level of significance.

Qualitative data were collected by using semi structured open ended questionnaire for key informants. Transcription and translation of each record were made by principal investigator using MS word and translated data were analyzed and categorized by triangulation by using thematic approach.

Results: Among 578 beneficiaries who responded to the questionnaire, 438 (76%) of them had a health problem after being introduced to waiver privileges. Out of the latter, 367 (84%) had visited health facility. Of those who visited health facility, 273 (74%) utilized waiver privilege. The study showed that age, marital status, educational status, family size and visiting private health facility were significantly associated with utilization of waiver privilege. The key informant indicated that, fee waiver system implemented in public health institution but the system showed lack of effectiveness, because of lack of similar criteria, lack of training about the

implementation and beneficiary identification, leakage, under-coverage and service related factor such as unavailability of medication, laboratory service and other resources.

Conclusion; - Utilization of waiver privilege was seventy four percent. Among those who were utilizing the waiver system, availability of medication and other resources were found to be questionable. The system is also prone to the possibility of leakage and under-coverage. Addis Ababa city Administrators, Woreda administrators, and health facility medical directors monitor and evaluate the system. In addition, further public studies are needed.

Key words; - fee waiver, waiver beneficiaries, utilization, under-coverage, leakage

1. Introduction

1.1. Back-ground

Equity is the underlying principle of major global health policies such as the Global Primary Health Care Strategy, the Health for all strategy, and recently, the health sector reforms spearheaded by the World Bank which are based on the assumption that everyone should have the opportunity to attain good health status (1, 2). The target of equity in health and equal access to health care is based on the principle that health care should be provided according to needs, not according to factors such as the ability to pay for care (3).

Lack of adequate resources, both financial and non-financial, has been one of the most important factors limiting improved access and quality of the health care system in Ethiopia. The Federal Ministry of Health of Ethiopia developed the Health Care and Financing Strategy to address chronic under-financing of the health sector and mobilize the required resources (4,5).

Health Care Finance Reform (HCFR), among other health sector reforms, is a recognized strategy that states health care should be financed through multiple financing mechanisms to increase available resources for health services, increase efficiency of resource utilization in health, promote continuity of health services through sustainable financing and improve quality and coverage of health services and ensuring equitable distribution of health services for long-range sustainability. The strategies introduced in the HCFRs include revenue retention and use at health facility level, systematizing a fee-waiver system for the poor, standardizing exemption services, introducing private wing in public hospitals, and outsourcing of nonclinical service (6).

Fee waiver system (FWS), as one component of health care financing reform, is a form of direct targeting when a fee is eliminated or reduced for a person who cannot afford to pay a user fee for a service. The system is usually determined by the health facility or in the community by using means testing. It is implemented in public health facilities for those unable to pay to grant a household or individual that entitles the household/the individual to obtain health services in certain health facilities without direct charge or with reduced price to sustainable finance, while improving quality and equity. The purpose of fee waiver is to ensure equity by increasing access of health services to the poor and increase financial capacity of health facility to give quality of

care by using reimbursed cost from woreda finance for health centers and from regional finance for hospitals (6,7). This study aimed to assess the utilization of waiver privilege and associated factors in Addis Ababa.

1.2. Statement of the problem

The quality of health service in Ethiopia has been compromised by inadequate and poorly maintained infrastructure and equipment, scarcity of trained health personnel, and the unavailability of drugs and pharmaceutical supplies which mainly was associated with inadequate financing which was caused by poor budget allocation and utilization. To solve this problem, the government has focused on improving the organization and structure of the health delivery system (4)**.**

Health Care Financing Reform is the key strategy designed to improve the financial and organizational issue of the public health institutions. Nowadays health care financing reform components implemented in public health facilities and the progress made in the health care financing system is a little slow. The Ethiopian health care system still suffers from limited availability of health resources, over reliance on out-of pocket payments, and inefficient and inequitable use of resources. The government implemented a system of waivers to protect the poor and others vulnerable group and ensure delivery of specific services. In principle, waivers are expected to contribute to poverty reduction through increased access and coverage by the poor. Despite the existence of waivers, the cost sharing program has not fully addressed the problems of the poor and vulnerable groups (8)**.**

Some components like development of a legal framework, revenue retention and utilization, facility governance, and development of community-based health insurance are effectively implemented, but other components which is revision and updating of user fees, implementation of fee waivers and exempted services, development of a private wing and outsourcing of nonclinical services, and social health insurance are difficult to implement they have shown a slower development and have been facing more obstacles.

Implementation of fee waiver system has started in all the regions except Afar, Somali and Gambella. The number of beneficiaries identified by United State Agency for International Development (USAID) project were 1.3 million, 160,409 and 13,919 in Amhara, Oromiya and

southern nation and nationality's people regions (SNNPR) respectively. It was reported that out of the 157 woredas in SNNPR only 27 have started implementing fee waivers. The fee waiver systems was characterized by ineffectiveness in specifically targeting the poor, incompleteness of coverage of services, and lack of proper documentation (9). A Study conducted in Gondar indicated that there was leakage, the author of fee waiver giving free health care for those actually able to pay because of poor screening technique and lack of awareness(10). In addition to it, the system did not safeguard patients against having to pay for medicines because of the unavailability of drugs in public health facilities (6).

Two surveys in Armenia that were conducted before and after the implementation of the fee waiver system, shows that the average utilization failed by 12%. This resulted in a decrease of health service usage by the vulnerable group after started the wavier system (11).

The main factors influencing the implementation of waiver systems were lack of objective criteria, unavailability of specific standards by the woredas to set the waiver budget, allocation not based on the number of beneficiaries and the cost of health services and poor budget utilization and reimbursement.

Only a few studies have been conducted on the challenges of the implementation of fee waiver system and assumptions about utilization is all beneficiary used their fee waiver card but not have enough evidence in our country.

1.3. Significance of the study

This study comes handy to provide an insight into various factors that are likely to influence the implementation and utilization of fee waiver systems in Addis Ababa. The primary stakeholders, government and those having a low economic status are the main beneficiary. This motivates the concerned body to make decision on increasing the utilization of free health care delivery for the poor and vulnerable group. It will also contribute to generate information that might be helpful to understand the current situation of fee waiver system to monitor and evaluate proper functioning of the system. The study would also bring into light the various factors that the investors and the government need to focus on when targeting provision of free healthcare services. The results of this study would also be invaluable to researchers.

2. Literature review

The current health situation of Ethiopia, implementation of health sector reforms and related studies and reports that support the central idea of the study will be reviewed.

2.1. The Current Health Situation of Ethiopia

The government of Ethiopia issued its health policy in 1993 in 50 years setting with the vision for the healthcare sector development for the next two decades. The policy tried to reorganize the health services delivery system with the objective of contributing positively to the overall socio-economic development effort of the country. Major aspects of this policy focuses on fiscal and political decentralization, expanding the primary health care system, and encouraging partnerships and the participation of nongovernmental actors (4).

To implement the policy, the Health Sector Development Program (HSDP) was developed in1997/98, and a healthcare financing strategy in 1998 (12).

2.2. Health sector reforms in Ethiopia

As part of the national efforts to improve accessibility and quality of health service in Ethiopia, various reforms have been implemented. Health Care Finance Reform (HCFR), Business Process Re-engineering (BPR), Health Management Information System (HMIS), and the Ethiopian Hospital Reform Implementation Guidelines (EHRIG) are some of the reforms (5).

Business process Reengineering (BPR) has been used as a tool for comprehensive analysis, redesign and revamping of the health sector in Ethiopia. As a process itself forms a fundamental rethinking and requires a purpose full and radical redesign of health business process to achieve dramatic improvements in critical contemporary measures of performance such as cost, quality, service and speed. The purpose of BPR in the context of health sector is establish customer focused institutions, rapid scaling up of health services and enhancing the quality of care in order to improve the health status of the Ethiopian people as indicated in the mission of the health sector (4).

Health Management Information System and Monitoring and Evaluation (HMIS and M&E) are one of the priorities of the third Health Sector Development Program (HSDP III) 2005/06-2009/10). The purpose of HMIS is to routinely generate quality health information that provides

specific information support to the decision-making process at each level of the health system for improving the performance of health system and thereby the health status of the population (13).

2.3. Health Care Financing Reform (HCFR)

Ethiopia had endorsed a health care financing strategy in 1998 that envisioned a wide range of reform initiatives. It is a very important policy document for introduction of health financing reforms. The government recognized that health cannot be financed only by government and underscored the importance of promoting cost sharing in provision of health services, the main objective of the implementation of health care financing reform is to address the overall infrastructural as well the general dysfunctional health care system of the country. This will be done through: identifying and obtain resources that can be dedicated to preventive, promotive, curative, and rehabilitative health services, increasing absolute resources to the health sector, increasing efficiency in the use of available resources and promote sustainability of health care financing and improve the quality and coverage of health services (6).

Physical access to health service providers was beyond reach to many amongst the Ethiopian population, and even more difficult for the poorest segments of the population. The overall country budget was limited, resulting in inadequate financing of health care. In addition, health service delivery was inefficient and inequitable, and quality of health care was generally poor (6).

The key health financing issues of the country were associated with limited availability of health resources, overreliance on direct payments at the time people need care, and inefficient and inequitable use of resources (14).

The limited availability of resources for health in Ethiopia is very clear. The total health spending in Ethiopia increased from about uS$522 million in2004/05 to about uS$1.2 billion in 2007/08. However, overall health is under-financed, both in absolute terms and when compared to the sub-Saharan Africa average, as evidenced by per capita health spending of uS$4.5 in 1995/96 that reached only 16.10 in2007/08 (5).

The implementation of these reform initiatives was legalized through regional legislations. The strategy recognized that health care should be financed through multiple financing mechanisms to ensure long-range sustainability. The reforms introduced include implementing revenue

retention and use at health facility level, systematizing a fee-waiver system for the poor, standardizing exemption services, setting and revising user fees, introducing a private wing in public hospitals, outsourcing nonclinical services, and promoting health facility autonomy through the introduction of a governance system (6).

Health care financing reforms generally address questions about how funds are to be raised and allocated to pay for health care for the population. Many health systems are plagued by overall resource constraints as well as poor allocation of funds; some relatively well-off households consume more than their share of scarce public resources. Increasingly, policymakers in developing countries are basing decisions about financing and resource allocation on evidence about how much is spent on health, who pays, and who benefits from health spending (6).

Alternative financing approaches some long-term measures try to mobilize additional funds for health care and channel funds to the most effective uses, allowing more citizens to benefit from services and improving the quality of services. In order for such approaches to work well, however, systems must be strengthened and be able to identify and support those individuals most in need of public subsidies and support. Cost-sharing and risk-sharing arrangements are two types of alternative approaches. Cost sharing or cost recovery involves imposing user fees for some or all health services as a way to get clients to share the expense of services. One premise behind cost sharing is that clients who pay for services will demand better quality and that funds will be used to improve it. Another possibility is that fees from better-off clients could be used to help pay for services for those who cannot afford to pay. Achieving this objective involves establishing waiver systems to exempt the poorest clients from payment, but putting such systems into practice has proven difficult. In some cases, imposing fees has led to a decline in the use of health services, and improvements in quality have been questionable (12).

The principal components of Health Care Financing Reform include development of the legal and regulatory provisions related to: local retention and use of facility user fee revenue, fee waiver and exemption systems, establishing and operation of hospital management boards and related steps toward hospital autonomy, out sourcing of non-clinical services management and operation of private wings in public hospitals, revenue retention and utilization is the autonomy given to hospitals in the proclamation 10/95 for the collection of revenue from various hospital services and utilization of it. The revenue is used under the principles and law of finance

administration and its main objective is to fulfill the gaps of human resource, medication and medical equipment's in order to provide better and quality service (6).

2.4. Fee waiver system

Fee waiver system is one of the major components of health care financing reform. Waiver system is implemented in public health facility, to increase access for those who cannot afford cost of health service, to increase the financial capacity of health facilities and to improve health service quality by using the reimbursed cost of the services they provide through fee waiver system. According to proclamation and regulation the following is receive as a beneficiary, households/Individuals who cannot afford to pay for health services and thus are provided waiver certificates from Woreda, street children and homeless citizens who can provide evidence from the bureau/office of labor and social affairs and persons receiving 24 hours' emergency care provided by health institutions, who cannot afford to pay for the service.

Woreda\kebele fee waiver selection committee identify the poor individuals by using procedures, and, Woreda/city administration fee waiver selection committee reviews and organizes list of potential fee waived it received from respective kebele fee waiver selection committee and, approve the final beneficiaries (7).

Woreda\ Kebele committees use, the following points to select the eligible households for the fee waiver**.** For rural areas Size of land holding, number of dependents, number of livestock holding, Level of harvest, physical ability to work and earn income, earning less than minimum wage, household size in relation to land holding/income. For urban areas homeless, and street dwellers, orphaned children who have no financial support from relatives or no adequate inheritance from their parents, households earning less than minimum wage, households whose living is based on petty trades and unable to meet their daily subsistence, physical ability to work and earn income, household size in relation to income, and also for both area use of other objective criteria in the locality to identify the poor.

Kebele fee waiver selection committee, woreda fee waiver selection committee, woreda / city administrations community, mobilization, labor and social affairs bureau/office and food security, disaster prevention and preparedness commission/office involve in fee waiver selection proses and all have specific duty and responsibility. And the waiver certificate is valid for one year. Based on the principle "no service is free" there is no free care in the health facility there is

reimbursement mechanism of fee waiver from woreda (WOFED) quarterly. And hospitals reimbursed by regional health office. And also each facility should have recording mechanism to make easiest the reimbursement proses. Health facilities present quarterly reports on services rendered to waiver certificate holders to board/governing body, woreda health office, woreda/city administration and BOFED/WOFED (7).

2.5. Utilization of fee waiver system

After introduction of fee waiver privilege, beneficiaries increased health service utilization. A study conducted in Nigeria showed an increase in free drug utilization by 58% (29). In another study done in Nepal, there were 57% increase in primary health care utilization after introduction of free health care (30). On the other hand, in a study done in Armenia, there was 12% decline in health care utilization after introduction of free health care (11).

2.6. Factors affecting utilization

Socio-demographic and economic factors

Socio – demographic and economic factors were mentioned to be important variables in the discussion of waiver utilization from different studies. Some of the studies showed that different demographic and personal characteristics such as female sex, age group 15-60, educational back ground, occupation, and family size were the predictors for utilization of waiver privilege (10). According to a study done in Jimma showed beneficiaries with low socio economic status found to relatively utilized waiver privilege more than those beneficiaries with higher socio economic status (17).

Service related factors

In Thailand and Namibia, beneficiaries were unwilling to identify themselves as poor b/c difficulty of obtaining a subsidy at the health service facility and fear of being charged and the stigma of claiming a subsidy (24).

Free health beneficiaries had varied opinion on the quality of service provided to free patients. A significant number, 642 (63.3%) thought that the service given free was equivalent to those who pay, while 365 (35.8%) asserted the service to be partial. Of the dissatisfied subjects, 159 (44.5%) attributed partiality to low attention and bad treatment of health workers. Some 139 (38.9%) expressed that there was proper drug provision for free patients. Among that using

poverty certificate some patients used to visit private clinics. Many studies have also shown that users are willing to pay when the quality of health care improves (10).

In Ethiopia the fee waiver system did not safeguard patients against having to pay for medicines because of the unavailability of drugs in public health facilities. Moreover, the share of employer-provided drug insurance was only 0.2% of the total drug expenditure in 2005-2006 (8). A mixed method study done in Ethiopia in four national regional state and in Addis Ababa city shows beneficiaries tried to use waivers at one time, then decided against it after being denied and treated less well at health facility (22).

Information dissemination and level of awareness

In Kenya, 58% of respondent were aware about the waiver system but majority had scanty information about the waiver system. From those who heard about waiver program 54% of respondents got information from relatives and 25% of them from nurses. Female respondents were more likely to be aware about the waiver system than the male respondents. Similarly, married respondents were more likely to be aware of the waiver system than the single respondents or the widowed (15). Other study conducted in Kenyatta national hospital indicated greeter number of respondent have lack of awareness (23). Findings from a study conducted in Ethiopia in four National Regional States (Tigray, Amhara, Oromiya and Southern Nations, Nationalities and Peoples Region (SNNP) and Addis Ababa City showed that all most all participants were aware about waiver system (22).

2.7. Implementation of fee waiver system

A study conducted in Kapsabet Hospital in Kenya showed that 64.3% of respondent (key informant) says fee waiver system is not effectively implemented in that specific hospital (15).

According to EMOH quarterly health bulletin, 2,510,067 fee waiver beneficiaries were screened for all region except Afar and Somalia and the government allocated a budget of 25,527,418 ETB for beneficiaries (13) and in Amhara a total of 1,319,114 received free health care. But study in 2016 by UNICEF indicated fee waiver system covered 6% of those estimated to be living below the poverty line (16). Varies factors affecting waive policy such as:-

Leakage

Poor people pay less share than high income groups and the government sponsored health programs for those vulnerable (17).

A study in Gondar pointed out some factors that affect the implementation of fee waiver system and this finding showed leakage was considered as a problem (10). A study conducted in Ethiopia Jima town showed 37% had possibility of leakage or waiver applicants didn't deserve waiver but got them. Results from another study conducted in Northern Ethiopia were also complementary to these findings (19).

Financing

In Kenya, the poorest quintiles use primary facilities in good measure, gaining about one-fifth of the primary subsidy, a pattern similar to that found elsewhere in developing world on the other African countries, budget allocations alone would not necessarily fix the targeting problem. Cote divoire, Ghana, guinea, and Madagascar the share of the subsidy received by the poorest was low at all levels of health care, including primary facilities (20). And a study from Zambia indicated that despite the removal of user fees at primary health care level, there is significantly less financial protection that is going to the poorest sections of the population. Due to shortage of drug, travel cost for those living farther from the health institutions, informal charges like health workers received bribes to perform medical test (21).

A study in Ethiopia indicated budget allocation from woreda was not based on the number of beneficiary and the cost of service rather, the level of commitment and financial status of the woreda. And access to care was a dream for the poorest of poor in the country (22)

Beneficiary identification

Many countries use non-income criteria to define the poor. For example, Zambia has objective criteria, such as owing debt, not having any land, or owing few assets. Kenya has more subjective criteria household was assessed to be poor based on the following characteristics: such as appearance of clothes or shoes, appearance of living quarters or home, property (land, cattle, crops, other), education level of household members, number of children enrolled in school, or clothes and shoes worn (24, 25).

A study in Ghana found out that properly identifying the poor has been a very difficult task for the health providers. They further stated that, there were no clear criteria or guidelines available at any of the study sites on how to define the poor. The only quantitative finding from the study that provided demographic background information was that half who were classified as "paupers" spent less than 10,000 cedos/week (US$ 1.37/week) (26).

Some countries have attempted to set income criteria for identifying the poor, however there is still much difficulty in verifying the income levels. Literature reviewed found out that in Thailand, to qualify for the low income card, the income threshold level was 2000 Baht (US$78.34) per month for an individual and 2800 Baht (US$109.67) for a couple. Zambia, the income threshold for the poorest group is 15,000 Kwacha per month for an individual (US$ 3.65). For the case in Zimbabwe the income ceiling that would qualify someone for a waiver was ZWD $400/month (US$61.43) (24).

Findings Study conducted in USAID midterm evaluation report in Ethiopia is no good criterion for identify beneficiary for fee waiver even though the criteria is not implemented consistently from community to community, and pass a very bureaucratic process to get fee waiver certificate. In Amhara have better indigenous identification than other regions (9, 22) and other study showed there is no differences between the poorest and better-off households, the poorest households did not receive exemptions, and have a great range in the amounts of user fees people had to pay per visit. No differences in the user fees amounts are made according to income, lack of objective criteria and Using a quota system is affect involvement of all benefiters or the poor, (22) eligible beneficiaries are screened and identified through community participation(9) less than 50 birr per month established in 1967 and this was revised and changed 105 birr per month to get free health care in 1977 (27) A Study conducted in Jimma town indicates 38% of applicant the income level was less than 100 birr per month (18). There was a proclamation on made in 1981states that "the kebele dweller's association may examine in detail the means of livelihoods of any person who submits any application to get any kind of free service in court or government offices and grant certificate there to" (28).

Generally, the literatures discussed above indicate that the fee waiver system, which is one component of the HCFR, is aimed at increasing access for those unable to pay. There are limited studies regarding the implementation and determinant factors of fee waiver in our country and no

studies were done regarding the utilization and determinant factors. Our study tried to address the current magnitude and determinants of utilization of fee waiver in addition to exploring the challenges of implementation encountered using a qualitative approach

2.8. Conceptual frame work

A conceptual framework was developed after referring different literatures that were done in different countries concerning fee waiver system utilization and implementation. Utilization of Fee waiver system affecting by socio demographic factors, source of information and service related factors the reviewed literatures that were discussed above (8-10, 13, 15-30).

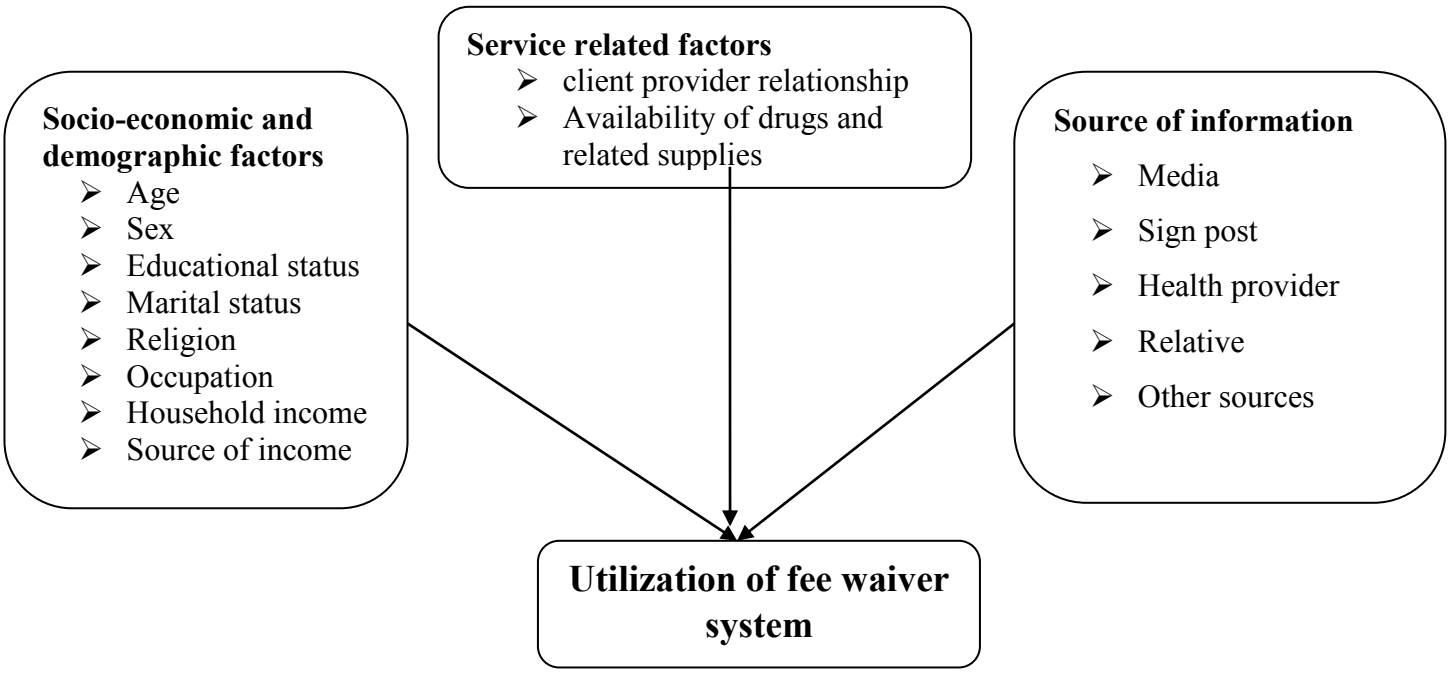


Figure 1 Schematic representation of conceptual frame work

3. Objective

3.1. General Objective

- To assess utilization and factor that influence the utilization and challenges on the implementation of the fee waiver system in Addis Ababa from March – April, 2017

3.2. Specific Objective

- To determine the utilization of free health care delivery system (fee waiver system) in Addis Ababa.
- To identify factors influencing utilization of fee waiver in Addis Ababa.
- To identify challenges on the implementation of fee waiver system in Addis Ababa.

4. Methodology

4.1. Study area and period

This study was conducted among fee waiver beneficiaries in Addis Ababa. Which is the capital city of Ethiopia, with a population of 3,194,990. The city is divided into 10 administrative sub cities. The city has 98 health centers of which 86 are governmental and the rest are owned by NGO, 52 hospitals (13-governmental, 35-private and 4 NGO) and 534 clinics out of which 34 are owned by NGOs. Under Addis Ababa city administer identified 162,915 beneficiaries in the household level from 10 sub city such as Arada, Addis ketema, Kolfie/keranio, Bole, Gulele, Yeka, Kirkose, Nifassilk/lafto, Lideta and Akaki/kality (31).

The study was carried out between, March 2017–April 2017 in Addis Ababa town.

4.2. Study design

A community based cross sectional study design mixing both quantitative and qualitative survey was conducted. The quantitative study conducted to assess utilization of fee waiver privilege and factor affecting waiver utilization among beneficiaries found in selected woreda in Addis Ababa. Qualitative study (in depth interview) was also conducted to assess the challenges to implement waiver system on key informants in Addis Ababa Ethiopia 2017.

4.3. Source population

Quantitative study – All waiver beneficiary households found in Addis Ababa.

Qualitative study – key informants (health center administrators, community leaders, Eder leaders, woreda administrators and woreda health office administrators found in Addis Ababa).

4.4. Study population

Quantitative – Randomly selected waiver beneficiaries in the selected woreda found in Addis Ababa.

Qualitative – the study subject were 15 key informants from woreda administrators, health center administrators, community leaders, woreda health office administrators and Eder leaders found in Addis Ababa.

Inclusion and exclusion criteria

Inclusion criteria

Members of Waiver beneficiary household's age ≥18 years old who lived in the area greater than one year and give consent included in this study.

Exclusion criteria

Members of waiver beneficiary households age ≥18 years old who are not able to participate in the study due to mental illness or severe physical illness was excluded.

4.5. Sample size

Sample size was calculated using single population proportion formula by taking the proportion (p) of free drug utilization to be 59.8% (29). The assumption of 95% confidence level (level of significance, α= 0.05), 5% margin of error and 10% non-response rate were used to determine the sample size. Accordingly, the total sample size was 607 after considering design effect of 1.5

$$\mathbf{N} = \frac{Z^{2*}p * q}{d^2}$$

$$n= \frac{(1.96)^{2} * (0.6) * (0.4)}{(0.05)^{2}}$$

N = 368 Plus 10% non-response rate and design effect of 1.5the final sample size equals

$$(368*1.5) *0.1 = \underline{\underline{607}}$$

4.6. Sampling procedure

For quantitative study; - stratified sampling technique was used to select samples for this study. Out of the 10 sub cities in Addis Ababa 4 sub cities was selected randomly using lottery method. And each selected sub cities have 10 woredas, from each 3 woredas were selected by using simple random sampling method. Sample size was calculated proportional to each sub cities, and the corresponding sample size was calculated proportional to each woredas. From the selected woreda who considered as a poor the respondents was identified from sampling frame that I got from woredas by using a simple random sampling method. In cases of non-voluntary respondents, the next beneficiary was interviewed.

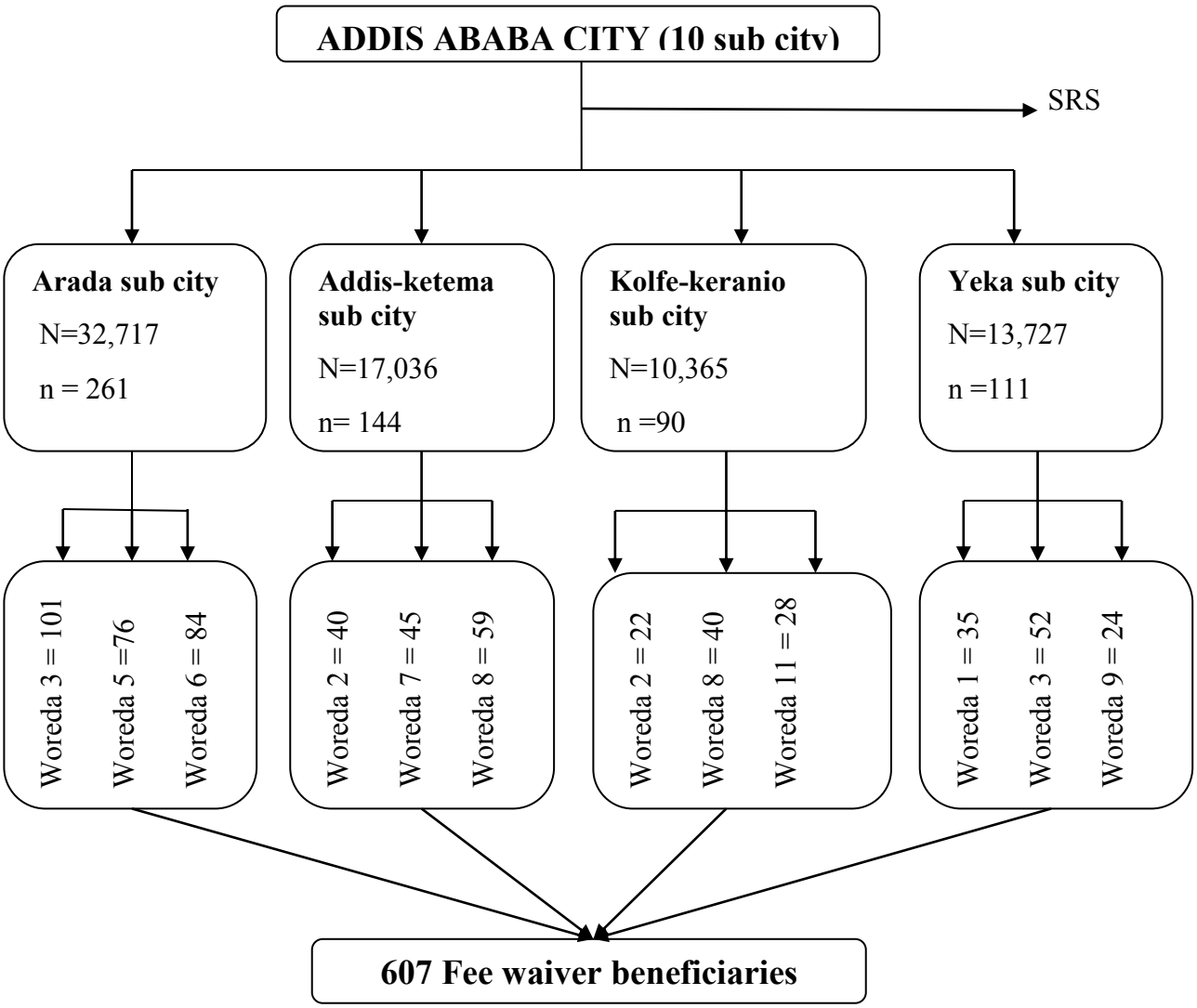


Figure 2: Schematic presentation of the sampling procedure.

4.7. Data collection tool and procedure

Quantitative study - data was collected using a structured, pre-tested in Gulele sub city woreda 5, interview based Amharic version questionnaires. Data were collected after two days of training about the objective definition of terms that are in the questioner and on issue of confidentiality and privacy by ten diploma nurses for interview based questioner and two BSc nurse to supervise the data collection. A closed ended structured questioner was prepared from literatures. The questioner was translated from English to Amharic and back to English by a person well versed with both languages to check for language consistency.

Qualitative study – Semi structured open ended questionnaires was used to collect data as in depth interview guide from fifteen key informants in Addis Ababa. The data was collected by the principal investigator. In depth interview was conducted to assess factors affecting the implementation of waiver system. During in depth interview, tape recording and note taking was done by principal investigator until saturation was reached. On average the interview lasted 25minutes. The interview style was narrative. Tape records was transcribed word by word in to Amharic language (language of interview) then translated to English by the principal investigator.

4.8. Variables

Dependent variable - utilization of fee waiver system (yes/no)

Independent variables

- socio demographic factors (age, sex, Educational status, Marital status, Occupation, Household income, Source of income, Family size)
- service related factors (client provider relationship availability of drugs and equipment's)
- source of information (media, health provider, relative, friends, sign post)

4.9. Operational definition

Beneficiaries: is the poor identified for use health service without charging or with reduce price.

Under coverage: is where the poor do not receive the intended benefit because they are either erroneously categorized as non-poor or they must still pay the despite their waiver

Leakage: is where the non-poor receive benefit intended for the poor. Here the non-poor receive the designation of poor, though they are not, which allows them to receive the services at no or a reduced charge though the person has the ability to pay for the services.

Utilization of waiver privilege: is waiver beneficiaries used their privilege on the time of illness (time of visiting public health facility) for once or more times.

Lack utilization of waiver privilege; beneficiaries not used their privilege on the time of visiting health facility

Effectiveness: The ability of waiver mechanisms to ensure that those who were intended to receive the benefit of not having to pay for health services receive that benefit.

Health problem: beneficiaries who had acute or chronic illness.

4.10. Data Analysis procedures & presentation

Quantitative study – data was entered and cleaned using EPI info 7 and exported to SPSS version 20 for analysis. First, Descriptive analyses carried out to explore the socio-demographic characteristics of the respondent. Bivariate analyses carried out to examine the relationship between outcome variable and independent variables. Factors for which significant bivariate association by considering P-value <0.20 absorbed and continue for multivariable analyses using multi logistic regression considering P-value < 0.05 as a cut of point for statistical significance. Odds ratios used to measure the strength of the association between dependent and independent variables and 95% CI used to determine the significance of associations.

Qualitative study –Transcription and translation of each tape records was made by MS word and translated data Amharic to English coded categorized. Thematic content analysis was done. Those who have the same idea were identified then summarized by the main theme.

4.11. Data quality assurance

The data was collected by 10 diploma nurses and supervise two BSC nurses and 3 days training was given for data collector and supervisor by principal investigator. The questionnaires was pretested on 5% of sample size in a woreda different from the sampled woredas to check for understandability. During data collection, there was a close day to day supervision in the data collection process. Collected data was checked for completeness and consistency by the supervisors and principal investigator each day.

For all in-depth interviews tape records was taken. The data was taken by 2 BSC nurses and 3 days training was given for interviewer. Field notes were also taken to support and cross check the tape records. Interviewees were selected purposively to enhance triangulation.

4.12. Ethical considerations

Ethical clearance was sought from Research and Ethical Committee of the School of Public Health of Addis Ababa University and Addis Ababa city administration and health bureau. A formal letter was also submitted to all concerned bodies to obtain their co-operation. Data collection was conducted after verbal and written consent was obtained from participants, which was taken from each selected participant after explanation of the survey purpose, description of the benefits and an offer to answer all inquiries was made to the respondents. It was explained that answering the interview questions have no harm on the participants and that their participation will help to create awareness concerning the issue. Also affirmation that they are free to withdraw collected information was ensured.

4.13. Dissemination of the results

The study conducted for the partial fulfillment for the requirement of degree of Masters in Addis Ababa University, college of health science, school of public health and the result of the study will be submitted to the institute. The study findings will also be given to relevant bodies such as Addis Ababa city administer and other responsible governmental and non-governmental organizations to serve as current source of information on the issue. Effort will be made to publish in peer- reviewed journals.

5. Results

5.1. Socio demographic characteristics of the respondent

Among 607 samples a total of 578 respondents participated in this study making a response rate of 95.2%. The mean age (±SD) of the beneficiaries was 48.56 ((±11.451) which ranged from 25-81years. Majority of participants 388 (67%) were females. The distribution of participants by marital status showed half of the respondents 328 (56.7%) were married. The distribution of the respondent by educational status revealed that 189 (32.8%) were illiterates. With the level of occupation 237 (41%) of participant were house waives.

From the total study participants, 276 (47.8%) of them have 2 room in their house, 356 (61.7%) of them have 3-5 family members live in the same house. Regarding to house ownership majority of participants 412 (71.3%) live in kebele houses. The mean (±SD) Monthly income were 1128.44 (±808.765SD) ETB respectively. (Table 1)

Table1: Socio-demographic characteristics of beneficiaries in Addis Ababa, Ethiopia 2017 (n=578)

Socio Demographic		Frequency (n=578)	Percent (%)
Sex	Male	190	32.9
	Female	388	67.1
Age	25-35	81	14
	36-45	212	36.7
	46-55	126	21.8
	56-65	108	18.7
	>65	51	8.8
Marital status	Single	47	8.1
	Married	328	56.7
	Divorced	59	10.2
	Widowed	144	24.9
Educational status	Illiterate	189	32.8
	Read and write	147	25.5
	Elementary	116	20.1
	Secondary school	93	16.1
	College and above	31	5.4
Occupation	Unemployed	67	11.6
	House wife	237	41.0
	Daily laborer	117	20.2
	Merchant	53	9.2
	Government employee	60	10.7
	Private employee	44	7.6
Family size	1-2	74	12.8
	3-5	356	61.7
	>5	147	25.5
Monthly income	<500	174	30.1
	500-1000	185	32.0
	1001-2000	157	27.2
	>2000	62	10.7
House ownership	Rented	58	10
	Private	107	18.5
	Not have	1	0.2
	Kebele house	412	71.3
Number of room	1	214	37.0
	2	276	47.8
	>3	88	15.2

5.2. Utilization of waiver privilege

Out of 578 waiver beneficiaries, 438 (75.8%) of them had health problems after having waiver privilege. Among them who had a health problem, 367 (83.8%) visited health facility. of those who visited health facility, 273 (74.4%) utilized their waiver privilege.

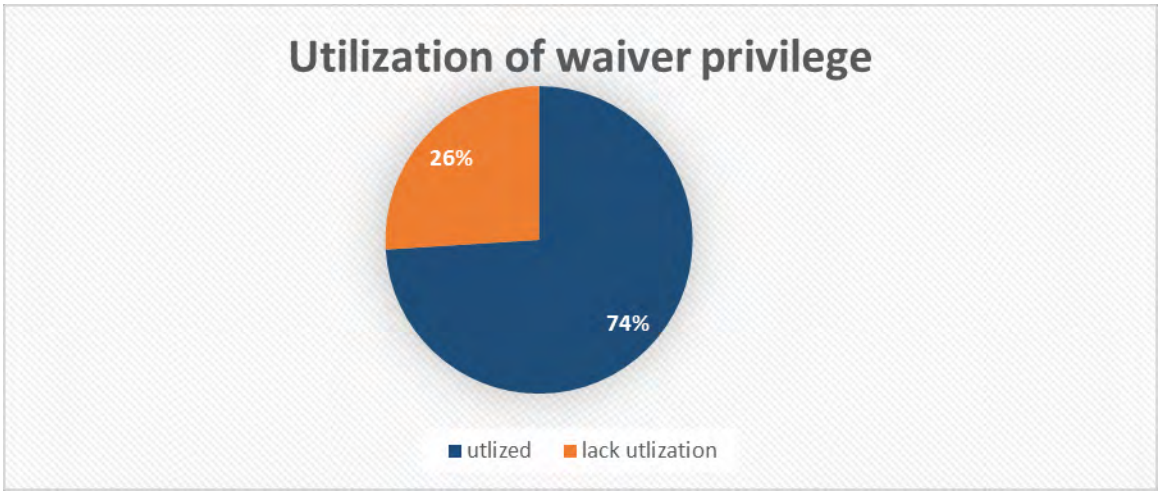


Figure 3: the magnitude utilization of waiver privilege among fee waiver beneficiary in Addis Ababa Ethiopia (n=367)

5.3. Reasons for lack of utilization

Among the 94 who had health problems and visited health facility but did not use waiver privilege, 38(40.4%) thought the services were of poor quality, 17(18%) thought there are no adequate drugs (kind, amount and availability), 7(7.4%) because of unavailability of service in public health facility, 20(21.3%) thought the provider has bad staff approach and 12(12.8%) had other reasons such as forgetting the waiver card, visited private clinic and so.

Table 4: Fee waiver beneficiary reasons for not utilizing the waiver privilege in Addis Ababa, Ethiopia (n=94)

	Frequency (n=94)	Percent (%)
Reason for not utilizing the waiver privilege		
Poor quality service	38	40.4
Lack of medicine	17	18.1
Unavailability of service	7	7.4
Bad staff approach	20	21.3
Other	12	12.8

5.4. Service related factors

Out of 273 used the waiver privilege, 79% of the respondents agreed that the providers had good staff approach, 156(57%) of them found all laboratory service in that specific health institution, 57(21%) of them found laboratory service partially in that specific health facility, 25 (9%) of them couldn't find laboratory service and 35 (13%) of them did not have laboratory request. Among those 213 participants who found all and partial laboratory service in public health institutions, 16(7.5%) of them paid total amount of the service, 7(3.3%) of them paid partially and the rest 190(89.2%) got free laboratory service.

Among those who utilized waiver privilege 109 (40%) found medication in that specific health institution, 117 (43%) of them found medication partially in that specific health institution, 41(15%) of them couldn't their medication and the rest 6(2%) of them did not have drug prescription. And among those 226 that found all and partially medicines in that health institution, 3(1.3%) paid total amount, 6(2.7%) paid partially and the rest 217(96%) got the medications for free.

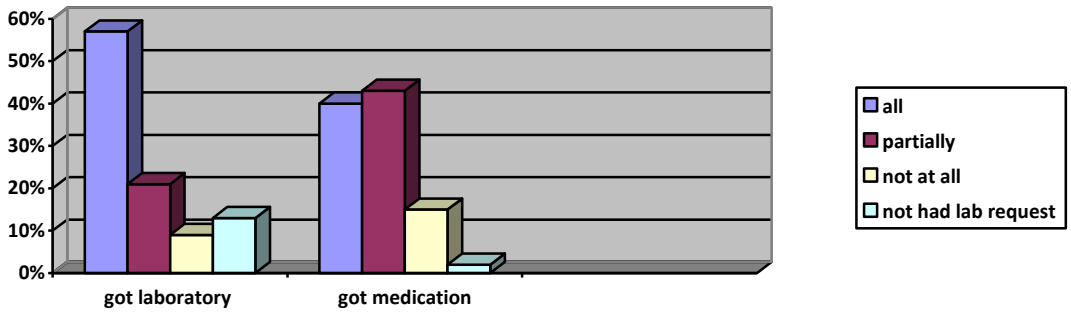


Figure 4: the availability of laboratory service and medications for waiver patents in Addis Ababa, Ethiopia 2017(n=273)

Among 367 who visited health facility at the time of illness 161(44%) of them visited private health facility once and more times. (Fig 5)

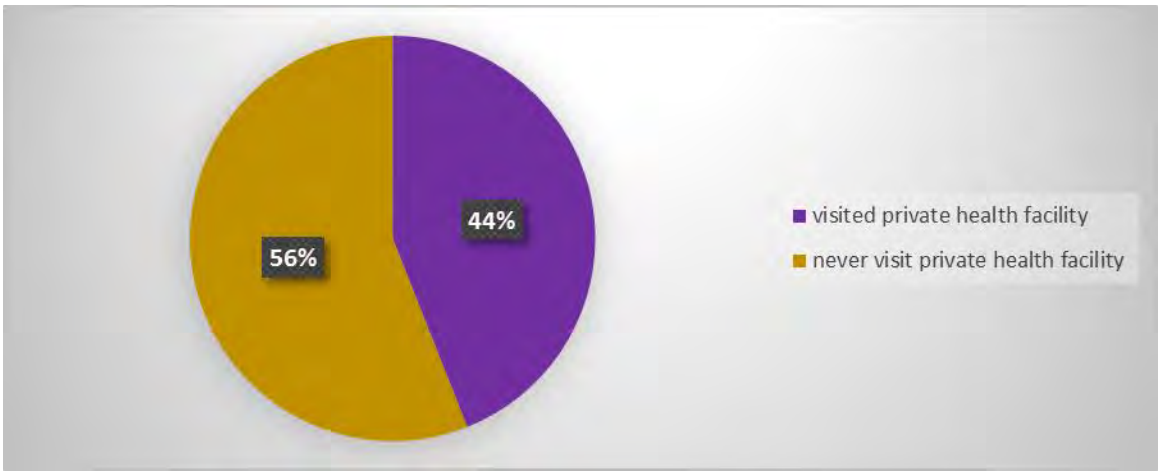


Figure 5: Visiting privet health facilities among beneficiaries that who visited health facilities on the time of illness, in Addis Ababa Ethiopia 2017 (n=367)

Among those 273 who used waiver privilege 221(81%) of respondent indicated that their health service utilization increased after introduction of waiver privilege, 175(64%) believe that the free health care service was not similar when compared to those who pay for the service.

Table 5: Usage of health service, service similarity and visited private health facility among waiver beneficiaries in Addis Ababa, Ethiopia 2017 (n=273)

Variable	Frequency	Percent (%)
Increase utilization of health service after waiver privilege		
No	52	19
Yes	221	81
Service similarity		
No	175	64
Yes	98	36

5.5. Source of information

Among 578 participants majority of the respondent 381 (66%) got information about waiver privilege from health provider, 84 (14.5%) of them got information from friends, 67 (11.6%) of them from relatives and the rest got information 14 (2.4%), 2 (0.3%), 30 (5.2%) from sign posted at the health facility, media and others respectively.

Table 6: Source of information for waiver beneficiaries in Addis Ababa, Ethiopia 2017(n=578)

Variable	Frequency (n=578)	Percent (%)
Source of information		
Sign posted at the health facility	14	2.4
From health provider	381	65.9
Relative	67	11.6
Friends	84	14.5
Media	2	0.3
Others	30	5.2

5.6. Bi-variable and multivariable binary logistic regression analysis results

Eight variables (age, marital status, educational status, occupation, family size, house ownership, visited private health facility and source of information.) that were significantly associated (p-value < 0.2) with utilization of waiver privilege at the bi-variable analysis were entered in to the multivariate model. The final predictors of utilization of waiver privilege were age, marital status, educational status, family size and visit private health facility.

As the result indicates, age was found to be significantly associated with utilization of waiver privilege. Age groups 36-45 years were less likely to utilize the waiver privilege than those in the age group of 25-35 years. [AOR= 0.32 (CI: 0.12, 0.85)]

The other socio demographic variable that was significantly associated with utilization of waiver privilege were marital status. Divorced were 11.2 times more likely to utilize waiver privilege than singles [AOR=11.22 (CI: 2.05, 61.25)]

Educational status also showed significant association with the outcome variable utilization of waiver privilege. Illiterates were 14.1 times more likely to utilize waiver privilege than those who study college and above. [AOR=14.14 (CI: 3.33, 59.96)], beneficiaries those attend primary school were 4.9 times more likely to utilize waiver privilege than those who study college and above [AOR=4.97 (CI: 1.18, 20.98)] and those who attend secondary school were 5.7 times more likely to utilize waiver privilege than those who attend college and above [AOR=5.73 (CI: 1.49, 22.06)].

Family size was also significantly associated with utilization of waiver privilege. Beneficiaries who have 3-5 family were 3.6 times more likely to utilize the waiver privilege than those who have 1-2 family [AOR=3.66 (CI: 1.46, 9.16)] And also beneficiaries who have >5 family were 2.9 times more likely to utilize the waiver privilege than those that have 1-2 family [AOR=2.95 (CI: 1.02, 8.53)].

Visiting private health facility was the effect to utilize waiver system. Beneficiaries who do not visit private health facility were 8.8 times more likely to utilize waiver privilege than those who visited private health facility one or more times [AOR=8.82 (CI: 4.59, 16.96)]

Table 7: Bivariate and multivariable logistic regression analysis of factors associated with utilization of waiver privilege of waiver beneficiaries in Addis Ababa, 2017 (n=578)

Variables	Utilization of waiver privilege		COR with 95% CI	AOR with 95%CI	P-value
	Yes (%)	No (%)			
Age					
25-35	40 (15)	11 (12)	1.00	1.00	
36-45	84 (31)	45 (48)	0.51 (0.24, 1.10)	0.32 (0.12, 0.85)	0.022
46-55	67 (25)	14 (15)	1.32 (0.55, 3.18)	0.81 (0.26, 2.50)	
56-65	53 (19)	19 (20)	0.77 (0.33, 1.79)	0.52 (0.16, 1.64)	
>65	29 (11)	5 (5)	1.10 (0.50, 5.09)	1.31 (0.30, 5.75)	
Marital status					
Single	19 (7)	11 (12)	1.00	1.00	
Married	150 (55)	58 (62)	1.50 (0.67, 3.34)	1.37 (0.471, 3.991)	
Divorced	38 (14)	3 (3)	7.33 (1.83, 29.45)	11.22 (2.05, 61.25)	0.005
Widowed	66 (24)	22 (23)	1.74 (0.72, 4.21)	1.40 (0.41, 4.80)	
Educational status					
Illiterate	98 (36)	12 (13)	5.94 (2.00, 17.67)	14.14 (3.33, 59.96)	0.000
Read and write	64 (24)	35 (37)	1.33 (0.49, 3.61)	2.41 (0.64, 9.05)	
Elementary	40 (15)	22 (23)	1.32 (0.46, 3.77)	4.97 (1.18, 20.98)	0.029
Secondary school	59 (22)	17 (18)	2.52 (0.88, 7.28)	5.73 (1.49, 22.06)	0.011
College and above	11 (4)	8 (9)	1.00		
Occupation					
Unemployed	36 (13)	6 (6)	2.25 (0.71, 7.14)	1.05 (0.24 ,4.51)	
House wife	105 (39)	36 (38)	1.09 (0.47, 2.57)	0.32 (0.10, 1.03)	
Daily laborer	48 (18)	25 (27)	0.72 (0.29, 1.78)	0.33 (0.10, 1.12)	
Merchant	28 (10)	8 (9)	1.31 (0.49, 3.93)	1.08 (0.26, 4.43)	
Government employee	32 (12)	10 (11)	1.20 (0.42, 3.41)	0.79 (0.22, 2.91)	
Private employee	24 (9)	9 (10)	1.00	1.00	
Family size					
1-2	25 (9)	19 (20)	1.00	1.00	
3-5	180 (66)	53 (56)	2.58 (1.32, 5.05)	3.66 (1.46, 9.16)	0.006
>5	67 (25)	22 (23)	2.32 (1.08, 54.98)	2.95 (1.02, 8.53)	0.046
House ownership					
Rented	23 (8)	12 (13)	1.00	1.00	
Private	60 (22)	14 (15)	2.24 (0.90, 5.55)	1.98 (0.59, 6.64)	
Kebele house	190 (70)	68 (72)	1.46 (0.69, 3.09)	1.12 (0.43, 2.92)	
Visited private health facility					
No	181 (66)	25 (27)	5.43 (3.22, 9.15)	8.82 (4.59, 16.96)	0.00
Yes	92 (34)	69 (73)	1.00	1.00	
Source of information					
Sign posted at health facility	8 (3)	3 (3)	0.49 (0.09, 2.66)	0.30 (0.04, 2.17)	
From health provider	176 (65)	68 (72)	0.47 (0.16, 1.42)	0.36 (0.10, 1.28)	
Relative	31 (11)	6 (6)	0.94 (0.24, 3.73)	0.36 (0.07, 1.73)	
Friends	34 (13)	13 (14)	0.48 (0.14, 1.65)	0.43 (0.10, 1.79)	
Media	2 (1)	0 (0)	293722702.6 (0.00)	959265754.1(000)	
Others	22 (8)	4 (4)	1.00	1.00	

5.7. Qualitative data results

Implementation of fee waiver

In-depth interviews were conducted among woreda administrators, woreda health office administrators, health center medical directors, community leaders and Eder leaders concerning the implementation of fee waiver privilege and challenges to implement. A total of 15 individuals were included.

All key informants indicated that fee waiver system were implemented in public health facilities. Majority of the key informants stated that the fee waiver beneficiaries were identified by the community leaders and finally approved by kebele political leaders.

Beneficiary identification

The study shows the author of fee waiver use income criteria with considering other objective criteria regarding to identify beneficiaries.

Beneficiary identification criteria had lack of similarity. Woreda administrators, woreda health office administrators, health center medical directors agree that the system of waiver privilege have criteria. The criteria included households who have household monthly income≤500 birr, this may also include a household monthly income >500 birr with the family members may had chronic disease and households have large family under the age of 18 years is identified as a beneficiary. And community leaders agree by the two criteria that household had large family and chronic disease but they identified beneficiaries with monthly income less than 300 birr. And also Eder leaders not agree by this idea and he thought beneficiaries identified without criteria.

Government body explained that *"……we identify beneficiaries by using criteria and the criteria is household's monthly income less than 500 birr and sometimes we consider households with chronic disease and have big family*."

Community leaders stated *"…beneficiary identification criteria is household monthly income ≤300 birr, have big family and had chronic disease identified as a beneficiary."*

Eder leaders stated *"….the waiver privilege is not have criteria and not consider the income of the people it distribute by family and friendly*."

Training

This study found that there was no current or refreshment training on the implementation of waiver and its procedures. Even though some beneficiaries do not know whether or not they fall under the beneficiary category. However the woreda health office give information yearly about how to identify the beneficiaries, before starting identification. Sometimes they have meeting to discuss about the budget.

Community leaders *".....we don't have training sometimes we have meeting to discuss the report of the budget."*

Eder leaders stated *"....we not have training or other meeting about the implementation and challenges of waiver. The community is not have knowledge about waiver, even the beneficiary not know about themselves whether they beneficiaries or not because of lack of information and training beneficiaries exposed to pay for service."*

Budget and reimbursement mechanism

Health facilities got funds from government of Ethiopia through the woreda finance office. As woreda administrators and health center medical directories stated, the budget is adequate to finance the health facility service, and the woreda finance office reimbursed to health centers every 3 months after received reports.

Woreda administration stated *"...we have enough budget to waiver beneficiaries and there is reimbursement mechanism, we reimburse after received 3 month report from health centers".*

Health center medical director supported the 1st idea and they said *"....woreda finance refunded all expenditure for waiver beneficiaries without dalliance"*

Leakage and under coverage

Majority of key informant stated leakage and under coverage commonly happened, when the woreda health office renew the waiver card without revise their status and also economical status by itself difficult to measure.

One of medical director of the health center stated *"....we get free patents have car and they seems like have >500 monthly income and we report for woreda immediately. And also show*

patents especially in emergency room not have money and family, for those patent we give 24 hours free care and report for woreda it shows there are leakage and under coverage,"

Woreda health office administer stated *"...we don't revise the beneficiary once they get the waiver card they renew yearly without revise their economic status because of this leakage may happened."*

Community leaders *"... the waiver benefits difficulty to give for rented person because of they don't have kebele ID card."*

Service related factors

The government bodies and the community leaders exhibited idea variations on the availability and similarity of services. Woreda administrators, and woreda health office administrators stated the service is delivered without discrimination. However community leaders stated the service were not similar from those payer for service. Free health care does not protected beneficiaries because of unavailability of drugs and other materials.

The medical director said *"....the service is given without discrimination, the health service is available for all laboratory and pharmacy delivered service for those free and payer patents but sometime may happen shortage of drugs at that time the free patents perceive that medication was not available only for them."*

Community leaders stated *".....the service is not similar from the payer for service, and the ambulance service is not come for beneficiaries and laboratory service not available to waiver beneficiaries mostly the waiver beneficiaries take laboratory service out of health centers or private clinics, and also medicines not available in the health center the beneficiaries get medicines in private pharmacy,"*

"....The health workers not refer the waiver beneficiaries, when the beneficiaries need refer to higher hospital they resist and the poor dead without getting high level health care."

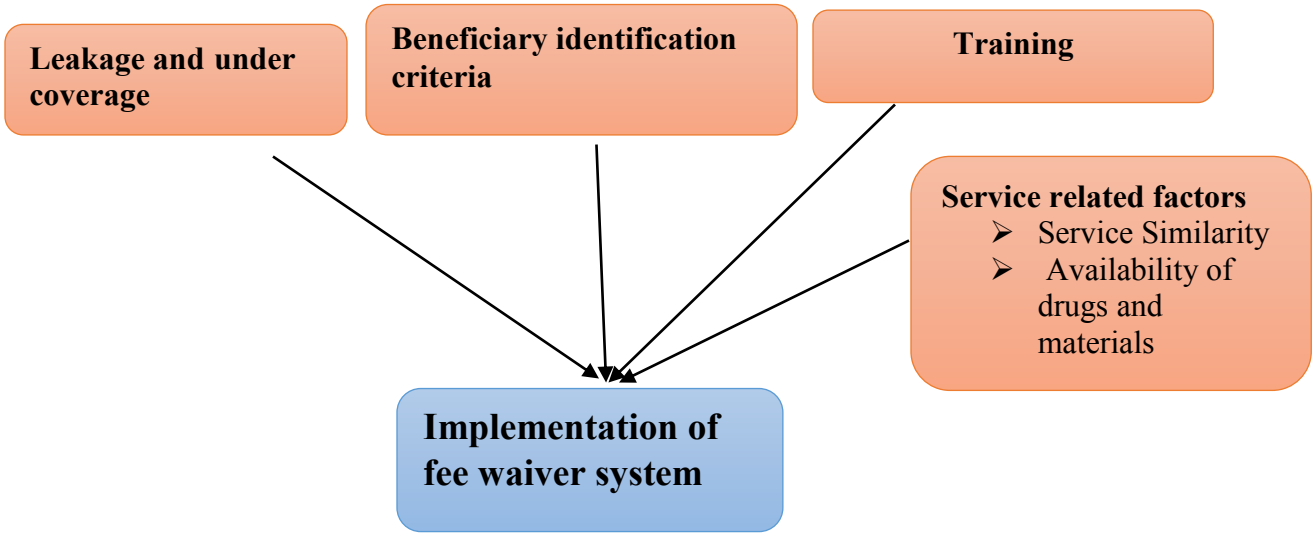


Figure 5: the result frame work of challenges on implementation of fee waiver policy developed from qualitative result in Addis Ababa Ethiopia 2017 (n=15 key informants)

6. Discussion

The fee waiver system is a form of direct targeting when a fee is eliminated or reduced for a person who cannot afford to pay a user fee for a health service (6).

This cross sectional study aimed at examining the implementation and utilization of fee waiver privilege and the factors associated with it.

In this study, the beneficiary were more than half of the respondent 76% ware had a health problems, among them 84% visited health care facilities, Among those who visited health facilities 74% had utilize waiver privilege, this is higher than 59.8% free drug utilization recorded in Nigeria (29). Various factors were also examined. The finding revealed that utilization of waiver privilege was significantly associated with age, marital status, educational status, family size and visiting private health facility.

The qualitative study of our finding indicates waiver privilege implemented in public health institution but the effectiveness of the system is questionable because of leakage, under-coverage, lack of training, lack of similarity of criteria to identify beneficiaries and service related factors such as; unavailability of drugs and other resources.

Marital status shows a significant association with utilization of waiver privilege. Divorced households were 7 times more likely to utilize waiver privilege than single [AOR=11.22 (CI: 2.05, 61.25)]. This result indicates divorced households may not have other mince rather than use there waiver privilege because of their income. A Study in South America indicates households who divorce suffer significant declines in family income, the family income dropped up to 45% after disrupted their marriage (34).

Illiterates were 14.1 times more likely to utilize waiver privilege than those who study college and above [AOR=14.14 (CI: 3.33, 59.96)], retrospective study in Gondor indicates the majority of free health service user were illiterates (10). And also this result showed beneficiaries who attend primary and secondary school were significantly associated to utilize waiver privilege than those who attend college and above by [AOR=4.97 (CI: 1.18, 20.98)] , [AOR=5.73 (CI: 1.49, 22.06)], respectively. This result may indicating beneficiaries who attend high level education (college and above) higher their income.

In this study households with 3-5 families and >5 families more likely utilize the waiver privilege compared to households with 1-2 families, AOR=3.66 (CI: 1.46, 9.16)] 4.041(P=0.001), [AOR=2.95 (CI: 1.02, 8.53)], respectively. These result is in line with a finding from Armenia (30). One of the beneficiary identification criteria were households with large family, and also the research confirms that the people with large family sizes are those who frequently visit the health facilities, because of high incidence of infections (38). On the other hand, households with large family may have economical burden than those who have small family.

Beneficiary who did not visit private health facility were 8.8 times more likely to utilize waiver privilege than those visited private health facility one or more times [AOR=8.82 (CI: 4.59, 16.96)]. This indicated that who never visit private health facility may the typical indication of real beneficiaries. Waiver policy implemented to those unable to pay for health service. On the other hand, among the waiver beneficiaries 44% was visit private health facility once or more times, showing similar results to the study done in Gondar, which had 39% of beneficiaries visit private clinics occasionally (10). Visited private health facility is another justification to the problem of the system, many studies had also shown that users are willing to pay when the quality of health care improves (32, 33).

Monthly income not significantly associated with utilization of waiver privilege, but study in Jimma showed beneficiaries who have low monthly income more likely to utilize waiver privilege (17).

Among 273 waiver utilizers 81% believed to have seen an increase in the utilization of health services at the time of illness once being introduced to waiver privilege. Many articles mentioned an increase of service utilization after the implementation of waiver and exemption policy. A prime example of this can be seen in Uganda's increase in primary care visiting, and in Nepal after introduction of free health care the utilization of primary health care increases by 57% (35, 31).

Above half of waiver utilize 64% thought that the services that were free were not at the same standards to the services that individuals pay for. These results were worse than the results in Gondar, where they saw only 36.7% (10). Some studies indicated in Africa better-off households get better quality care, even within the public sector than the poor (39, 40).

Twenty one percent and 9% of waiver utilizer got laboratory service partially and did not find totally, respectively. And 43% and 15% of waiver utilizer get medication partially and did not found totally, respectively.

This finding are supported by qualitative study, the service were not similar from those payer for service. Free health care does not protected beneficiaries because of unavailability of drugs and other materials. Study conducted in South Africa showed over all shortage of drugs and other resources for free patents highlighted in (36). These finding shows the waiver privilege did not safeguard patients against having to pay for laboratory and medication because of the unavailability of drugs, reagents and other resources in public health facilities.

Among those beneficiaries who had a health problem but never utilize waiver privilege, 40% of them thought that having free health care meant having poor health services. These result was similar with study's done in Gondar 44.5% of beneficiaries thought the free care service faced low attention and poor quality (10). Other study indicated, the waiver system raise utilization of outpatient services. But improvement in quality has the largest impact on utilization (41).

The source of information of this study for the majority (66%) of respondents were from health provider. This finding is greater than study from Kenya 46% of respondent get information from health provider and study in Jimma 19% of urban respondent get information from health provider. Our finding shows health provider have greet participation rather than others.

Twenty three percent of respondents reported possibility of under coverage while 10% claimed a possible leakage in the waiver system. This finding is less than was seen in the study in Jimma town were 44% and 37% and Bahir Dar area where 36% and 14.7% were findings for possible under-coverage and leakage respectively (18, 19).

The finding is supported by qualitative study, leakage and under-coverage were commonly happened, when the author of fee waiver renew the waiver card without revise the beneficiary status. This could imply the failure of equity goals, which are the primary aims of waiver policies. This problem that could possibly be alleviated by setting up a transparent and organized free health care provision system.

Lack of similarity was showed in beneficiary identification criteria woreda Health office administrator, woreda administrator and health center medical director stated that the system of waiver privilege have criteria. The criteria included households who have household monthly income≤500 birr, this may also include a household monthly income >500 birr with the family members may had chronic disease and households have large family under the age of 18 years is identified as a beneficiary. And community leaders agree by the two criteria that household had large family and chronic disease but they identified beneficiaries with monthly income less than 300 birr. And also Eder leaders not agree by this idea and he thought beneficiaries identified without criteria. When we show our study community leaders identify above half of the beneficiaries so this indicates beneficiaries identified under the standard and exposed to high level of under-coverage. This finding shows there is information linkage among government body and community leaders and lack of training.

This study indicates there were no current or refreshment training to concerning body about the policy and procedure of waiver, some of key informant have manual. This finding is line with study in Kapsabet hospital in Kenya were not have training that explain about waiver (15).

7. Strengths and limitations of the study

Strengths

- ✓ The study used primary data.
- ✓ Using simple random sampling method to select the study participants minimizes the selection bias.

Limitations

- ✓ The study did not discuss well due to lack of literature which fits with the study.
- ✓ There may also be a recall bias while assessing the service related factors.

8. Conclusion

Overall, the utilization of waiver privilege among beneficiaries in Addis Abeba is high. Majority of the respondent cannot find their medication in the public health institution. Among the remaining twenty six percent majority of them do not utilize waiver privilege because of poor quality. Age of the respondent indicated that majority of respondent were in the economically active age groups, twenty five up to sixty five, and also majority of respondents have monthly income of greater than five hundred birr. Majority of waiver utilizer were increase health care usage after introduction of fee waiver service. Greater than half respondent perceive free health service faced lake of similarity with those pay for services. Age, educational status, marital status and family size showed a significant association with outcome variable utilization of waiver privilege among the beneficiaries they are the final predictors for utilization of waiver privilege.

On the implementation of waiver police varies factors was examined. Leakage, under-coverage, inconsistently applied criteria, lack of training and meeting, unavailability of resources, and lack of communication with beneficiaries was evident from the finding of this study. Some beneficiaries do not know whether or not they fall under the beneficiary category. Effectiveness of the system is questionable. The waiver committee has not revised the beneficiaries, once they get the waiver privilege they continuously renew the card.

9. Recommendation

Effectiveness of the system is crucial. Based on the findings of the study the following points are recommended on the contribution of fee waiver system.

To program and policy makers

- Ongoing implementation and design changes may be required to ensure that the poor are adequately covered
- Follow up the process and quality of health service rendered to fee waived patients by health institutions.

To woreda administration

- There is possibility of leakage, Improved screening technique and creating awareness among community leaders on the financial impact of free health service and how eligible is identify is needed.
- Must revise all beneficiaries one by one according to criteria and revise at the time of renew the card.
- Monitor and follow up the authorized fee waiver beneficiaries in relation to accessing health services.
- Public education on waiver policy and inform the beneficiaries about can take their benefit after identification.

To health facility administration

- Improved drug and other resource availability to waiver beneficiaries, availability of service, medication and other materials in the public health facility is the major thing to full fill the waiver program.

To researcher

- Conducting a study with a large sample size is needed in order to evaluate further about the magnitude of utilization and service related factors.

- Facility based study (exit interview) is needed to assess availability of resources, may avoid recall bias

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Annexes

Annex 1: Subject information sheet

Addis Ababa University

School of public health

My name is …….. I am here on behalf of Hana Tesfaye student of Addis Ababa University School of public health. She is conducting a research on '**Assessment of utilization of fee waiver system**. In Addis Ababa for the partial fulfillment of master's in public health in Addis Ababa school of public health. She received permission from Addis Ababa university school of public health and the city health bureau for administrators to conduct this study.

The aim of this study is to assess the utilization and factors affecting utilization and the implementation process of fee waiver system. The study will help in providing a base line data for policy makers and other researchers on issues regarding fee waiver system.

You are selected randomly to participate in this study because you are eligible for waiver system. Your participation is purely based on your willingness. You have full right either to participate or decline to be a participant in this study. If you choose to take part in the study you may respond to all the questions or you may not answer questions you don't want to, and have the right to stop the interview at any time. You also have the right to choose not to take part in this study. Participating in this study will not have any risk or harm. Whether you are willing to participate, refuse or decide to withdraw later, you will not be subjected to any ill treatment

If you agree to participate in the study, you will be asked to answer some questions about yourself, the interview lasts with you will take about 20-30 minutes.

Any information that you provide will be kept confidential, names will not be written or specified and all the questionnaires will be coded for anonymity. No one will have access to the non-coded data except the principal investigator. Only the principal investigator will know the details and she will discard it after completing analysis. The data will not be used for purposes other than the study. Your willingness and active participation is very important for the success of this study. Contact details of principal investigator and the person to whom to contact at any time for further

Explanation:

Name of principal investigator: Hana Tesfaye
Cell phone No - 0911811480

E-mail: tesfayehana22@gmail.com

Annex II Informed consent

The above information regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time.

Respondent agree to participate?

YES ☐ No ☐

1. If yes, continue the interview

2. If no, skip to the next participant by writing reasons for her refusal.

Informed consent Certified by:

Respondent's signature/thumb print_____ Date _____

Interviewer: Name _____ Signature _____

Questionnaire ID number _____

Date of interview _____ Time started _____ Time completed_____

Result of interview:

1. Completed

2. Respondent not available

3. Refused

4. Partially completed

Checked by: Supervisor: Name _____ Signature_____

Annex III Questioners

Date…….. Study Site……. Code of the interview……

Encircle only one correct response and multiple responses where applicable. Only eligible to be beneficiary to the waiver program are eligible for this study.

1. **Socio demographic and economic factor**

No	Variable	Response	Skip
101.	Sex	1. Male **2.** Female	
102.	Age	----------	
103.	Marital status	1. Single 2. Married 3. Divorced **4.** Widowed	
104.	Educational status	1. Illiterate 2. Read and write 3. Elementary 4. Secondary school **5.** College and above	
105.	Occupation	1. Unemployed 2. House wife 3. Daily laborer 4. Merchant 5. Government employee	

		6. Private employee **7.** Others	
106.	Family size	----------	
107.	Monthly income	----------	
108.	House ownership	1. Rented 2. Private 3. Not have **4.** Kebele house	
109.	Number of room	----------	

2. Service related factor

No	Variable	Response	Skip
201	Who consider you as a poor?	1. Woreda Fee Waiver Committee 2. Labor and Social Affairs Bureau/Office 3. Food Security, and Disaster Prevention Desk 4. Community leaders 5. Other office	
202.	Is there any problem to get a free care card?	1. Yes 2. No	
203.	When you received the free card?	1. before 6 month 2. before 1 year 3. 2 year 4. 3 year and above	
204.	How long did you wait before getting the card/ free care paper?	1. Less than 2 hours 2. 2 -6 hours	

		3. 6-12 hours 4. one – two days 5. Three –seven days 6. More than one week	
205.	Did you renew the waiver card?	1. Every year 2. >1year 3. Not renew	
206.	Was the process smooth and timely?	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	
207.	Do you know anyone who could not get free card, when they should be given?	1. Yes 2. No	
208.	Do you know anyone who got free card, when they should not get?	1. Yes 2. No	

3. Utilization of fee waiver privilege

301.	Do you or your family had a health problem during the past year?	1. Yes 2. No	If no go to 401
302.	Have you used health service?	1. Yes 2. No	If no go to 401

303.	Have you used waiver privileges?	1. Yes 2. No	If no go to 311
304.	How was the approach of the staff?	1. Very poor 2. Poor 3. Neutral 4. Good 5. Very good	
305.	Did you get all laboratory service in health center?	1. Yes all 2. Partially 3. Not at all 4. Not have laboratory request	
306.	If get laboratory services, did you pay?	1. Total amount 2. Partial amount 3. Not pay	
307.	Did you get all drugs prescribed?	1. Yes all 2. Partially 3. Not at all 4. Not have prescription paper	
308.	If you get drugs, did you pay?	1. Total amount 2. Partial amount 3. Not pay	
309.	Did you increase used health service after introduce waiver privilege.	1. Yes 2. No	
310.	Is the free care service was similar from those who payer for	1. Yes	

	service.	2. No	
311.	What is the reason for not using waiver?	1. B/c of poor quality service 2. B/c lake of medication 3. B/c not have service for free patents. 4. Bad staff approach 5. Other	
312	Did you visit private health facility's once or more time after introduce waiver privilege?	1. Yes 2. No	

4. Information dissemination

401.	How did you get information about free health care service?	1. Sign posted at the health facility 2. From health provider 3. Relative 4. Friends 5. Media 6. Others	

Annex IV

አዲስ አበባ ዩኒቨርስቲ ጤና ሣይንስ ፋኩልቲ የህብረተሰብ ጤና አጠባበቅ ትምህርት ክፍል

የተጠያቂው / መላሾች የመረጃ ቅፅ

ጤና ይስጥልን እንደምን ነዎት

ስሜ———————— ይባላል፡፡ የመጣሁት በአዲስ አበባ ዩኒቨርስቲ የህብረተሰብ ጤና አጠባበቅ ትምህርት ክፍል ተማሪ የሆነችውን ሀና ተስፋዮን ወክዬ ነው፡፡ ለነፃ ህክምና የተመረጡ ሰዎች የጤና ተቋዋማት አጠቃቀም ላይ ጥናት እያደረገች ሲሆን ከአዲስ አበባ ዩኒቨርሲቲ ፣ አ/አ ጤና ቢሮና ከተመረጡት ክፍለ ከተማ ፍቃድ አግኝታለች፡፡

እርስዎ በዚህ ጥናት ላይ እንዲሳተፉ የተመረጡት በዘፈቀደ/በአጋጣሚ የናሙና አወሳሰድ ስልት መሰረት ለዚህ ጥናት አላማ ከተመረጡት ለነጻ ህክምና ከተመለመሉ ሰዎች ውስጥ አንዱ ስለሆኑ ነው፡፡ የእርስዎ ተሳትፎ ሙሉ በሙሉ በእርስዎ ሙሉ ፍቃደኝነት ላይ የተመሰረተ ነው፡፡በጥናቱ ላይ ያለመሳተፍ ሙሉ መብት አለዎት፡፡ ለመሳተፍ ፈቃደኛ ከሆኑ በኋላም በፈለጉት ጊዜ ማቆም ወይም ማቋረጥ ይችላሉ፡፡ በጥናቱ ባለመሳተፎ የሚደርስቦት ምንም አይነት ችግር አይኖርም፡፡

በጥናቱ ለመሳተፍ ከተስማሙ የተወሰኑ ጥያቄዎችን እንጠይቆታለን፡፡ በዚህ መጠይቅ ስለ ነጻ ህክምና እና ተያያዥ ሁኔታዎች የተመለከቱ ጥያቄዎች እጠይቅዎታለሁ፡፡ በመጠይቁ ጊዜ ጥሩ ስሜት ካልተሰማዎት በማንኛውም ጊዜ አቋርጠው መሄድ ይችላሉ፡፡ መጠይቁና ልኬቱ 30 ደቂቃ ይህል ይፈጃል፡፡

ይህ ጥናት ፖሊሲ አውጪዎችና የሚመለከታቸው አከላት ስለ ነጻ ህክምና እና ተያያዥ ችግሮቹን የመከላከያና መቆጣጠርያ መንገዶችን እንዲቀርፁና እንዲተገብሩ እንደ መነሻ ይሆናል የሚል ፅኑ እምነት አለን፡፡ በመጨረሻም ከእርስዎ የምንሰበስበው መረጃ ከስምዎ ጋር አይያያዝም፡፡ ስምዎት እንደማይጠቀስና ለማንም አካል አልፎ እንደማይሰጥ ልናረጋግጥ እንወዳለን፡፡ የዚህ ጥናት ውጤት ግን ተጠርዞ እና ተዘጋጅቶ ለሚመለከታቸው የጤና ድርጅቶ ወይም ለሌሎች አካላት ሊሰጥ ይችላል፡፡

የስምምነት መጠየቂያ/ማረጋገጫ ቅፅ

ከላይ በሰጠዎት መረጃ መሰረት በጥናቱ ላይ ለመሳተፍ ፍቃደኛ ነዎት?

1. አዎ
2. አይደለሁም

ፍቃደኛ ካልሆኑ ምክኒያቱን ፅፈው ወደሚቀጥለው ተሳታፊ እለፍ……..

የተሳታፊ enat ፊርማ

ፊርማ———————— ቀን————————

የመረጃ ሰብሳቢ

ስም————————————ፊርማ—————

የመጠይቁ ቁጥር————————

መጠይቁ የተካሄደበት ቀን————የተጀመረበት ሰአት——ያለቀበት ሰአት——

የቃለ መጠይቁ ውጤት

1. ሙሉ በሙሉ የተሞላ
2. በከፊል የተሞላ
3. ምንም ያልተሞላ

በተቆጣጣሪዎች ተረጋግጧል፡ ስም————————ፊርማ—————

ለተጨማሪ ማብራሪያ የዋና አጥኚውን አድራሻ ይጠቀሙ

ስም፡ ሀና ተስፋዮ

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ማሳሰቢያ፡ ተሳታፊዎች የሚሰጡትን መልስ ከተሰጡት አማራጮች ውስጥ ለይተው ያክብቡ

Annex V: መጠየቅ

1 የግለሰቧ ማህበራዊና ኢኮኖሚያዊ ሁኔታ በተመለከተ የተዘጋጅ መጠይቅ

ተ.ቁ	ጥያቄ	መልስ	ይዘለል
101	ፆታ	3. ወንድ 4. ሴት	
102	እድሜ	----------	
103	የጋብቻ ሁኔታ	5. ያላገባ 6. ያገባ 7. አግብቶ የፈታ 8. ባሉዋ/ሚስቱ የሞተበት	
104	የትምህርት ደረጃ	6. ያልተማረ 7. መጻፍ ና ማንበብ 8. 1ኛ ደረጃ 9. 2ኛ ደረጃ 10. ከፍተኛ ትምህርት ና ከዚያ በላይ	
105	ስራ	8. ሰራ አጥ 9. የቤት እመቤት 10. የቀን ሰራተኛ 11. ነጋዴ 12. የመንግስት ሰራተኛ 13. የግል ሰራተኛ	
106	የቤተሰብ ቁጥር	----------	
107	ወራዊ ገቢ	----------	
108	የቤት ሁኔታ	5. ከራይ 6. የግል 7. የለም 8. የቀበሌ ቤት	

109	የቤታችሁ ክፍል	----------	

2 የ አገልግሎት አሰጣጡን በተመለከተ የተዘጋጀ መጠየቅ

ተ.ቁ	ጥያቄ	መልስ	ይዘለል
201	ማነው ለ ነፃ ህክምና የመለመላችሁ?	ነ. የወረዳ ነፃ ህክምና ኮሚቴ 2. ሰራተኛ ና መህበራዊ ጉዳዮች ቢሮ 3. የምግብ ዋስትና ና አደጋ መከላከል ና ቅድመ ዝግጅት ዴስክ 4. የህብረተሰቡ ተጠሪ 5. ሌላ ቢሮ	
202	ነጻ ካርድ ለማግኘት ችግር አጋጥሞህ ነበር?	ነ. አዎ 2. አይ	
203	ለነፃ ህክምና መቼ ተመለመልክ(ሽ)	ነ. ከ 6ወር በፊት 2. ከ ነአመት በፊት 3. ሁለት አመት 4. ሶስት አመትና ከዛ በላይ	
204	ነጻ ካርድ ለማግኘት ምን ያክል ጊዜ ጠበክ?	1. ከ 2 ሰአት በታች 2. 2 -6 ሰአት 3. 6-12 ሰአት 4. 1 – 2 ቀን 5. 3 –7 ቀን 6. ከ አንድ ሳምንት በላይ	
205	የነጻ ካርዱን አሳድሳችሁት ታውቃላችሁ?	ነ. በየ አመቱ 2. ከ ነ አመት በላይ 3. አሳድሼ አላውቅም	
206	የ ነጻ ካርድ አሰጣጥ ሂደቱ ምቹ ና ሰአቱን የጠበቀ ነበር?	ነ. በጣም አልስማማም 2. አልስማማም 3. አላውቅም 4. እስማማለሁ 5. በጣም እስማማለሁ	

207	ነጻ ካርድ ማግኘት አያለበት ያላገኝ ሰው ታውቃለህ??	ነ. አዎ 2. አይ	
208	ነጻ ካርድ ማግኘት ሳይኖርበት ያገኝ ሰው ታውቃለህ?	ነ. አዎ 2. አይ	

የ ነጻ ህክምና አጠቃቀምን በተመለከተ የተዘጋጀ መጠየቅ

ተ.ቁ	ጥያቄ	መልስ	ይዘለል
301	በአርስዎ ወይም በቤተሰብዎ ላይ የጤና ችግር አጋጥምዎት ያወቃሉ?	ነ. አዎ 2. አይ	አይ ካሉ ወደ ጥያቄ 401 ይሂዱ
302	ወደ ጤና ተቁዋም ሄደው ነበር?	ነ. አዎ 2. አይ	አይ ካሉ ወደ ጥያቄ 401 ይሂዱ
303	የ ነጻ ካርዱን ተጠቀማችሁበት?	ነ. አዎ 2. አይ	አይ ካሉ ወደ ጥያቄ 311 ይሂዱ
304	የ ሰራተኞች አቀባበል እንዴት ነበር?	ነ. በጣም ጥሩ አይደለም 2. ጥሩ አይደለም 3. አላውቅም 4. ጥሩ ነው 5. በጣም ጥሩ ነው	
305	ሁሉንም ምርመራዎች በጤና ጣቢያ አገኙ?	ነ. አዎ ሁሉንም 2. የተወሰኑትን 3. ሁሉንም አላገኘሁም 4. ምርመራ አልነበረኝም	
306	የላብሮአቶሪ ማርመራዋን ካገኙ ከፈሉ?	ነ. ሙሉ በሙሉ 2. የተወሰነ ሂሳብ 3. አልከፈልኩም	
307	የታዘዘለዎትን መድሀኒት በ ሙሉ አገኙ?	ነ. አዎ ሁሉንም 2. የተወሰኑትን 3. ሁሉንም አላገኘሁም	

		4. መድሀኒት አልታዘዘልኝም	
308	መድሀኒቱን ካገኙ ከፈሉ?	ሙሉ በሙሉ 2. የተወሰነ ሂሳብ 3. አልከፈልኩም	
309	የነጻ ታካሚ ከሆኑ በኋላ ጤና ተቁዋም አጠቃቀምዎ ጨምሯል?	1. አዎ 2. አይ	
310	በጤና ተቁዋሙ ለ ነጻ ታካሚ የሚሰጠው አገልገሎት ከ ሚከፍሉት ጋር ተመሳሳይ ነው?	1. አዎ 2. አይ	
311	ለምን የነጻ ህክምና አልተጠቀሙም?	1. የህክምናው አይነት ጥራት ስለሌለው 2. የመድሀኒት አጥረት ስላለ 3. ለነጻ ታካሚ አገልግሎቱ ስለሌለ 4. በጤና ባለሙያዎች አቀባበል ምክንያት 5. ሌላ	
312	ነጻ ታካሚ ከሆኑ በኋላ የግል ጤና ተቁዋም ሄደው ያቃሉ?	1. አዎ 2. አይ	

4 ስለ ነጻ ህክምና መረጃ በተመለከተ የተዘጋጀ መጠየቅ

ተ.ቁ	ጥያቄ	መልስ	ይዘለል
401	ስለ ነጻ ህክምና መረጃ እንዴት አገኙ?	1. የጤና ጣቢያ ማስታወቂያ ቦርድ ላይ 2. ከ ጤና ባለሙያወች 3. ከ ዘመድ 4. ከ ጉዋደኛ 5. ከ መገናኛ ብዙሀን 6. ከ ሌላ	

Annex IV: Informed Consent for In Depth Interview (English version)

Woreda ----------

Code of the woreda _____

My name is Hana Tesfaye and I am carrying out a survey to assess utilization and factor affecting utilization and implementation process of fee waiver system. I would like to talk to you about your experiences on fee waiver system.

The interview should take less than an hour. I will be taping the session because I don't want to miss any of your comments. Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we're on tape, please be sure to speak up so that we don't miss your comments.

All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

I would like to ask you some questions to get information from your experience. Please be sure that this discussion is strictly secreted, confidential and that your name is not being recorded.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

May I continue?

Yes ☐ No ☐

Thank you!

Annex VII: Guiding questionnaire

In depth interview for health facility administrators

1. Are the poor exempted from fees? 1. Yes 2. No
2. Who is considered poor? ----------
3. Who determines eligibility as poor? ----------
4. How do they determine eligibility? (criteria) ----------
5. What information is required to determine eligibility? ----------
6. Who cover the cost of waived patent? ----------
7. Is the author reimbursing timely/ within what time? ----------
8. Is the budget enough to cover all price for beneficiary? ----------
9. Is the service giving for waived patent without discrimination?
10. Is the drug and other resource available for the waiver patent?
11. Dose referral format have place to explain the patent waived or pay?

In depth interview for woreda health office administrator and woreda administrator.

1. Woreda ----------
2. Position in your woreda? ----------
3. What is your responsible regarding to fee waiver? ----------
4. Who will write the free treatment letter? ---------- 1. Woreda\ kebele fee waiver selection committee 2. Woreda/city administration fee waiver selection committee 3. Other
5. How eligibility determined / what are the guide line? ----------
6. When is eligibility determined? 1. Is cared issued by the woreda before care is sought? 2. Is it made when the patent came and ask the kebele?
7. What information is required to determine eligibility? ----------
8. How long is waiver valid for? 1. < 6 months 2. 6- 12 months 3. 1-2 years 4. > 2 years
9. Did the system have motivation training? 1. Yes 2. No
10. If yes within what time? ----------

11. Did you think leakage and under-coverage is happened on the distribution of benefit?
12. Do you think there is a problem in the provision of free paper? 1. Yes 2. No
13. If yes, what are the problem? ----------

In depth interview for community leaders and Eder leaders

1. Position in your woreda? ----------
2. What is your responsible regarding to fee waiver? ----------
3. How do they determine eligibility? (criteria)
4. Did the system have motivation training?
5. Do you have guideline?
6. Did you think leakage and under-coverage is happened on the distribution of benefit?
7. Do you think there is a problem in the provision of free paper?
8. If yes, what are the problem?
9. Do you think the health facilities deliver similar service for free patents compared to those who payer for service?
10. Did the health facilities have adequate medication and other resource for beneficiaries?